HEALTHIER LIVING SERVICES EVALUATION

One You Leeds 2018/2019

Overview

A review of the One You Leeds (OYL) Integrated Service Model and the system it works with. The report includes insight from an in depth consultation with participants, One You Leeds staff and health professionals, as well as access and outcome data where it's available. The report explores the role of OYL within the system, its strengths, challenges, recommendations to improve and actions taken so far. The review has been developed and written in consultation with the OYL Service Managers and Public Health Specialists. Social Marketing Gateway were also commissioned to support the consultation with stakeholders.

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Table of Contents

Section 1: Executive Summary

An emerging evidence base regarding the clustering of risk factors (alcohol, smoking, physical inactivity and dietary risks), particularly in areas of higher deprivation, supports the notion of an integrated approach to providing support (Section 2). The One You Leeds (OYL) service model was designed and developed (Section 3) as part of a strategy to provide more integrated care in Leeds. The service has replaced a high number of singular adult healthier living focused contracts which were all focused on supporting the adoption of healthier living behaviours.

Following the service launch in 2017, an extensive consultation was conducted in 2019 to explore how well the One You Leeds (OYL) model had been working and assess what improvements could be made. Leeds also has a number of other healthier living related services that operate with OYL in a broader healthier living system. These include Community Health Development locality focused contracts ('Better together' delivered by the third sector), Forward Leeds (Drugs and Alcohol), Active Leeds (Physical Activity), and Social Prescribing. Therefore, the work will also seek to consider the functioning of OYL in the context of these other services.

Social Marketing Gateway (Section 4) were commissioned by Leeds City Council, Public Health to conduct the consultation to ensure neutrality to the enquiries. The consultation engaged a number of key stakeholders; Health Care Professionals (70 surveys and 7 interviews), OYL staff (16 surveys and 13 interviews) and Participants (pts) (328 surveys and 16 interviews).

Key OYL strengths from each stakeholder group;

Health Care Professionals (Section 5)

- Having an integrated service with one referral route was thought to be much easier to navigate.
- OYL was the most well-known of the healthier living services and the one they make most referrals to.
- Weight Management (ranked number 1), Emotional Wellbeing (ranked number 2) and Smoking Cessation (ranked number 3) were all ranked in the top 3 healthier living areas needing support.
- It was generally felt that the referral process to OYL was straight forward with the majority of staff making referrals on a weekly/ daily basis.

One You Leeds Staff (Section 6)

- Internal OYL staff also rated the service highly thinking that most elements of the service were either somewhat or highly effective.
- The OYL staff provided some very insightful, detailed and valuable feedback regarding the service. They highlighted many strengths of the service such as the team ethos and internal communication, their service user engagement methods, how the service supports maintenance through ongoing follow ups/ support and also the amount of knowledge and skill the team has.
- Overall, they have said they think it does support positive and sustainable behaviour change, particularly for people living in the more deprived areas of Leeds that the service targets. They commented that it is also good at helping those who are ready to change, older people (over 50 years), those who are less educated on healthier living, and people who can be flexible with their time.

One You Leeds Participants (Section 8)

- The majority of participants (pts) said they would recommend the service and rated both their experience and perceptions of staff highly.
- Where OYL was praised by pts this was consistently due to a good experience and feeling strongly supported by the OYL staff.
- The variety of options within the service enables accessibility for those with learning and physical disabilities.

There were a few themes that emerged across all the stakeholders regarding challenges;

- It was commonly shared that people felt the service needed more capacity to support the volume of people needing support for healthier living in Leeds particularly where there are complex needs (e.g. mental health, dietetic and language in particular). The greater complex needs could be associated with reaching people living in the more deprived areas of Leeds. Whilst, this was thought to be an issue across the system OYL was sometimes seen as the only answer.
- There is a need to improve awareness and understanding across health care professionals working in the healthier living broader Leeds system, how it interconnects and what the services offer.

Access data for OYL's first year (Section 7);

- OYL supported 1796 participants from the 20% most deprived neighbourhoods (quintile 1) in Leeds (31% of accesses) and a further 1500 participants from quintile 2.
- The age group with highest accesses were between 45-59 years old (n=1988, 34% of accesses), although all age bands were well represented.
- 23% of participants were from a Black, Asian and Minority Ethnic (BAME) group of those that indicated their ethnicity (n=777).
- 27% said yes to having a mental health condition (n=1574).
- 27% said yes to having a disability (n=1559).

First year outcomes (Section 8);

- Over 5000 people accessed at least one support session.
- Participants showed an increase in wellbeing, physical activity, cooking skills and fruit and vegetable consumption at follow ups. A high percentage of participants reported that they had abstained from smoking. A high number continued to manage their weight better following the programme, with an average of 6% weight lost since first attendance for those followed up at 12 months.
- Over 400 pts accessed more than one service element (e.g. 63% of these were living in 20% most deprived nationally).

Within the consultation aspect of the evaluation, it was agreed to focus some of the participant survey questions on the weight management and smoking aspects of the service.

Key findings for Weight Management;

- Weight loss was the most common reason for survey respondents wanting to access OYL (57%). A further 45% also said they wanted to improve their diet.
- The top 3 reasons for stopping attending weight management were due to holidays/ other commitments, inconvenient times and illness.

- The 3 top factors that helped people lose weight were 'learning', encouragement in a group setting, and getting weighed.
- The 3 main challenges when losing weight were avoiding temptation, sustaining a healthier diet and exercising.
- Most people attributed barriers to losing weight due to factors personal to them. A high number stated that other health issues were a barrier.

Key findings for Quitting Smoking;

- The OYL's coach advice/ support and direct access to nicotine replacement therapy (NRT) were rated highest as the most helpful aspects for quitting/ reducing smoking.
- For those who didn't attend all the sessions, it was felt that more regular and sustained support, ability to have ad hoc appointments and group sessions would have helped.
- Sometimes direct access to NRT from the coach was commented as a barrier. For example if they weren't able to see the coach, some alternative access routes may be needed e.g. via a pharmacy.

In Section 9, the value of an integrated service is explored in a bit more depth, specifically considering areas of the service that work particularly well together. Participants living in more deprived areas seemed to be more likely to access multiple aspects of the OYL service. There are clear advantages to having an integrated service, and opportunities to build on this.

Through collectively considering all of the findings discussed throughout the report, a number of recommendations were developed around the key emerging themes. These are discussed using a table format in Section 10 along with some detail regarding actions taken so far and future plans. There is a summary of key recommendations below.

Recommendations for OYL;

- *Increase session availability and accessibility particularly for people with mental health issues, and language barriers.*
- *Share and seek regular feedback.*
- *Ensure information is accurate and up to date.*
- *Improve communications with all stakeholders ensuring it is clear and transparent.*
- *Ensure continued investment in staff who are vital for a successful service.*
- *Embed peer support and longer term support to aid maintenance of behaviour change.*
- *Investigate the role of the OYL model further in supporting behaviour change for multiple risk factors.*

Recommendations for the Healthier Living System in Leeds;

- *Improve understanding of the Healthier Living System, and how the services work together.*
- *Develop a plan for better promotion and marketing of cooking courses.*
- *Identify clearer physical activity pathways.*
- *Raise awareness of self- help routes and resources across the system.*
- *Review and develop training opportunities for health care professionals across the system.*
- *Complete a local weight management need assessment for Leeds.*
- *Consider support options across the local system for low/moderate mental health needs and roles/responsibilities of healthier living services when working together.*

Section 2: Background

2.1 Context

Supporting healthier living remains a key priority in health and care systems and for both local and central government. Recently published documents such as the NHS Long Term Plan[1] and the prevention Green Paper 'Advancing our Health: prevention in the 2020s,[2]' clearly emphasise that *'Prevention is better than Cure'*. As these plans take shape and develop over time, integrated healthier living (or Health and Wellbeing) services will continue to be vital for supporting the delivery of these plans.

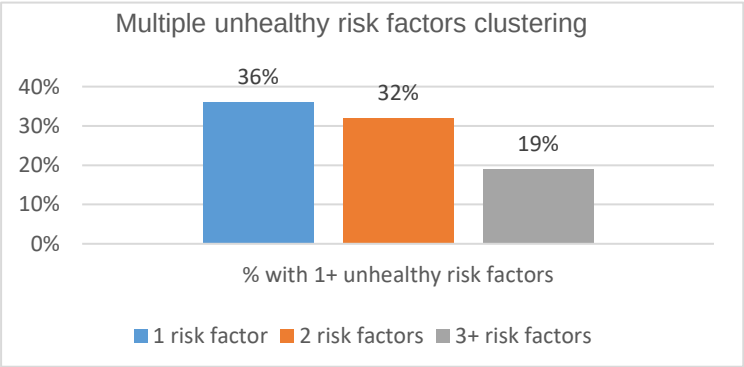
More broadly, an Integrated Health and Wellbeing service seeks to provide key services within community settings to support people to live as well as they can. These services have developed in a variety of ways across England, mostly focusing on bringing together the key lifestyle services such as smoking cessation, physical activity, weight management, healthier eating and drug/ alcohol (often lower level alcohol). For the purpose of this report this collection of services will be defined here as an 'Integrated Healthier Living Service'.

They also provide a support network for specialist support around specific lifestyle factors that can influence health. These can be an aid to a health care professional's role. For example, a GP may refer a patient for specialist stop smoking support. As this is part of an integrated service, the patient then may also access other aspects of support to live healthier without needing another GP referral. This may then help to address the potential clustering of risk factors that contribute to even poorer health outcomes.

Others endeavour to take an even broader community/ person centred approach which shall be defined as an Integrated Health and Wellbeing Service. These may also include social prescribing, emotional/ mental wellbeing services and advice on debt, housing, education and employment. All seek to address the individual's needs and goals in a more co-ordinated, seamless and empowering way than what can be achieved if delivering these services individually. In Leeds the healthier living system also involves services which specifically address the above. These include Community Health Development locality focused contracts ('Better Together' delivered by the third sector), Forward Leeds (Drugs and Alcohol), Active Leeds (Physical Activity), and Social Prescribing.

2.2 Clustering of risk factors

The 2017 Health Survey for England report looked at the clustering of these risk factors (Health and Social Care Information Centre, 2017[3]). At least a third of the survey respondents were likely to have two coinciding risk factors and one fifth could have three or more.



[1] https://www.longtermplan.nhs.uk/

[2] Department of Health and Social Care, 2019. *Advancing our health: Prevention in the 2020's consultation document.*

[3] Health and Social Care Information Centre (NHS digital), 2017. *The Health Survey for England 2017.*

In March 2018, The King's Fund also published a report discussing current practice and evidence for tackling multiple unhealthy risk factors (Evans & Buck, 2018[4]). The research builds on a previous report (Buck & Forsini, 2012[5]) that showed significant co-occurrence of smoking, physical inactivity and poor diet in England. The co-occurrence further impacts on life expectancy. For example, an adult in mid-life who smokes, drinks to excess, is inactive and eats unhealthily is **4 times** more likely to die in the next 10 years than someone who does none of these things (Khaw et al, 2008[6]). The questions that were posed more than five years ago by Buck and Forsini (2012) still remain largely un-answered creating a challenge when commissioning and delivering integrated services.

2.3 Evidence base overview: providing healthier living services

2.3.1 Stopping Smoking

Smoking cessation services are a key part of tobacco control and tackling health inequalities. It is estimated that a third of smokers try to quit smoking each year, but the probability of successfully sustaining an unaided quit attempt is typically only 3 to 4%[7]. Providing specialist smoking cessation support is highly cost effective and continues to offer smokers the best chance of quitting long term. People who access specialist smoking cessation services are up to 3 times more likely to quit successfully compared to those who try to quit either without help or with over the counter medication such as nicotine replacement therapy[8].

Furthermore, Public Health England (PHE) recommends having a specialist smoking cessation service **within a wider wellbeing service**. But it is not currently recommended to address smoking at the same time as other behaviours. This is due to a meta-analysis concluding that it is more effective to do this in sequence rather than at the same time (Meader et al, 2017[9]).

The National Institute for Health and Care Excellence (NICE) recommends focusing particularly on reducing the prevalence of smoking amongst people in manual groups, ethnic groups and disadvantaged communities. There are a number of NICE guidelines that provide key evidence based recommendations for the commissioning and provision of stop smoking services. These range from specific guidance for certain groups and settings, such as PH48 (smoking in acute, maternity and mental health settings) through to broader areas, such as NG92 (stop smoking interventions and services).

Additional guidance and training is provided from the National Centre for Smoking Cessation and Training (NCSCT). The NCSCT support the delivery of effective evidence-based tobacco control

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[4] Evan's, H., and Buck, D., 2018. *Tackling multiple unhealthy risk factors: emerging lessons from practice.* The King's Fund.

[5] Buck, D., & Frosini, F., 2012. *Clustering of unhealthy behaviours over time: implications for policy and practice.* The King's Fund.

[6] Khaw, K-T., et al, 2008. *Combined Impact of Health Behaviours and Mortality in Men and Women: The EPIC-Norfolk Prospective Population Study.* https://doi.org/10.1371/journal.pmed.0050070

[7] Hughes JR, Keely J, Naud S. Shape of the relapse curve and long-term abstinence among untreated smokers. Addiction. 2004:99;29–38.

[8] *https://www.ncsct.co.uk/publication_Stop_smoking_services_impact_on_quitting.php*

[9] Meader. N., et al, 2016. *A systematic review on the clustering and co-occurrence of multiple risk behaviours.* BMC Public Health **volume 16**, Article number: 657

programmes and smoking cessation interventions provided by local stop smoking services. The NCSCT training programme includes all the core competencies needed by stop smoking services and has shown to increase practitioners' knowledge, develop their skills and lead to improved practice.

2.3.2 Adult Weight Management

It is also recommended to adopt an **integrated approach** to weight management. That is both as part of a multi-component intervention and integrated in the sense of having an obesity care pathway;

'Local authorities, working with other local service providers, clinical commissioning groups and health and wellbeing boards, should ensure there is an integrated approach to preventing and managing obesity and its associated conditions. Systems should be in place to allow people to be referred to, or receive support from (or across) the different service tiers of an obesity pathway, as necessary. This includes referrals to and from lifestyle weight management programmes.' (NICE, PH53[10]).

There is a strong evidence base for adult weight management services having a more positive impact on 12-18 month behaviour change than no intervention (Loveman et al, 2011[11]; Johns et al, 2013[12]). Factors that increased perceived efficacy include personality of group leader, longer term support and follow ups. Barriers were reported to be due to competing commitments, stigma and not losing weight. **Multi-component weight management** interventions are recommended in order to address various aspects of lifestyle that could impact on health and weight. PHE also recommend **extended care** (12 months plus) for ensuring weight loss maintenance (Coulton et al, 2017[13]).

Another recent evidence review (Gidlow, 2018[14]) identified key factors associated with increased retention. A high number of Behavioural Change Techniques (BCTs; 7.9 on average needed) was generally associated with increased retention. Key factors that helped retention included; behavioural self-monitoring, setting behavioural based goals (rather than weight), a credible source (e.g., health professional), fostering social support, flexibility and convenience of the programme, an educational component providing instruction on how to perform behaviours (e.g. food labels), enjoyment, and inclusion of physical activity (see appendix i for further details).

In 2017, PHE published a report (Guzelgun et al., 2017[15]) involving consultation with both tier 2 and tier 3 adult weight management services. It highlighted a number of key opportunities for improving

[10] NICE guideline PH53, 2014. *Weight management: lifestyles for overweight and obese adults. https://www.nice.org.uk/Guidance/PH53*

[11] Loveman, E., et al, 2011. *The clinical and cost effectiveness of long term weight management schemes for adults: A systematic review.* Health Technology Assessment, 15.

[12] John, D.J., et al. 2013. *Diet or Exercise interventions vs combined behavioural weight management programs: a systematic review and meta-analysis of direct comparisons.* J Acad Nutr Diet. Oct; 114(10): 1557-1568. Doi:10.1016/j.jand.2014.07.005.

[13] Coulton, V., et al., 2017. *A guide to delivering and commissioning Tier 2 adult weight management services.* PHE publications gateway number: 2017052.

[14] Gidlow, C., et al., 2018. *Uptake and retention in group based weight management services*. PHE publication gateway reference: 2018154.

[15] Guzelgun, N., et al 2017. *Qualitative opportunities into user experiences of tier 2 and tier 3 weight management services. What is the user experience and journeys of children, families and adults using weight*

weight management services using both service user, commissioner and other stakeholder feedback. This included, the importance of both social and in depth emotional support, the influence of the group leader in fostering this, learning to navigate internal and external triggers, a flexible and modular approach, clarity on information provided on what to expect from the outset (including the role of the referrer in how this is approached), longer term support and an increased focus on participant wellbeing (less on weight loss). More detail on this is extracted from the report in appendix ii.

2.3.3 A cross-site evaluation across a number of North East England Integrated Health and Wellbeing Services (Cheetham et al, 2018[16]) reported the following key findings;

- Smoking (38%) and weight management (27%) were the most common reasons for joining. However, whilst 63% achieved physical activity goals, and 57% increased wellbeing, only 40% achieved weight management goals and 37% achieved stopping smoking goals. Whilst smoking and weight management goals were set more frequently, they were also the most difficult to achieve.
- Where there was greater capacity, there tended to be a higher rate of access.
- Access was higher for more deprived target groups, for women and older people.
- The study recommends utilising more co-produced options to measure impact, with less focus on compliance, contract adherence and performance monitoring.
- Integrated models take time to establish and require long term sustainable funding.
- Staff were recognised as critical and valuable for the successful delivery of services.
- Considerable flexibility was required in light of changing models of delivery, competing priorities, constrained resources, heightened expectations, reduced services and increased complex demands.
- Providers acknowledged that an integrated model can be seen as '*the answer to everything'* suggesting pressures on the availability of wider services. There was the suggestion that some areas of integration work well whilst others don't. Services can become overly diluted if looking to create a fully holistic model.
- There can be some confusion and different interpretations regarding integrated service models versus integrated systems.

2.3.4 As mentioned earlier, The Kings Fund published a report with eight case studies of IHWBS (Evans & Buck, 2018). It identified some key lessons for services to focus on. This has been useful for providing some specific insight for comparing services scope and priorities. It is clear that they can vary considerably depending on the needs of the area and resource available. However, it is highlighted in the report that academic evidence for integrated designs remains limited. *''More can be done at the national level to invest in research in this area but the quickest win is to support local areas providing these services to learn and self-evaluate in practice''*. Key recommendations from the Kings Fund report are discussed in appendix iii.

management services that are currently commissioned in England; and how does their experience align with the conceptions of service providers. PHE.

[16] Cheetham, M, Billett, A, et al. 2018. *Final report of a cross site evaluation of integrated health and wellbeing services in North East England.*

Section 3: The One You Leeds Model

3.1 Previously there were a number of individual services commissioned separately at varying costs which were;

- Weigh Ahead (Adult Weight Management)
- Stop Smoking
- Healthy Lifestyle
- Health Trainers
- Cooking and Healthy Eating (Ministry of Food)

This therefore meant multiple referral routes for potentially similar lifestyle issues. A health needs assessment was completed in December 2015[17] which reviewed policy, epidemiological context, evidence of effective services, the effectiveness of the services quoted above, and other integrated services across the UK.

3.2 One You Leeds (OYL) Model Description

The OYL model includes various components of the previous services with one single point of access. There is a designated referral pathway set up with primary care through an e-referral process. All professionals can signpost via website, email or telephone. Individuals can also self-refer through the same channels.

There are various assessment points throughout the participant journey from initial referral through to exiting the service:

1. Referral – assessment of referrer or of participant considering the service.
2. Booking/ initial contact – Programme Support Advisor carries out a Brief Assessment Questionnaire (BAQ) with the client to identify interest in service and where to start.
3. Getting started or initial assessment – this will be topic specific and involve weighing/ measuring and detailed lifestyle questionnaires. It may lead to a referral back to the GP, referral to an alternative service or continuing with the programme depending on the needs of the client.
4. Actual start with specific intervention - could be accessing more than one service.
5. Completion of intervention – participant completion of a post lifestyle questionnaire
6. Follow up – additional contact is made with participants who have completed their programme to review their progress.

Across the above assessment points there are various elements that participants can access which include;

- Smoke Free (mostly one to one support to stop smoking with one weekly group session).
- Weight Management (mostly group sessions of a 12 week rolling programme with one to one support options available for vulnerable individuals).

[17] *Health Needs Assessment: Leeds Integrated Healthy Living Service.* Leeds Observatory. https://leedsobs.wpengine.com/wp-content/uploads/2018/03/HNA-Summary-May-2016.pdf

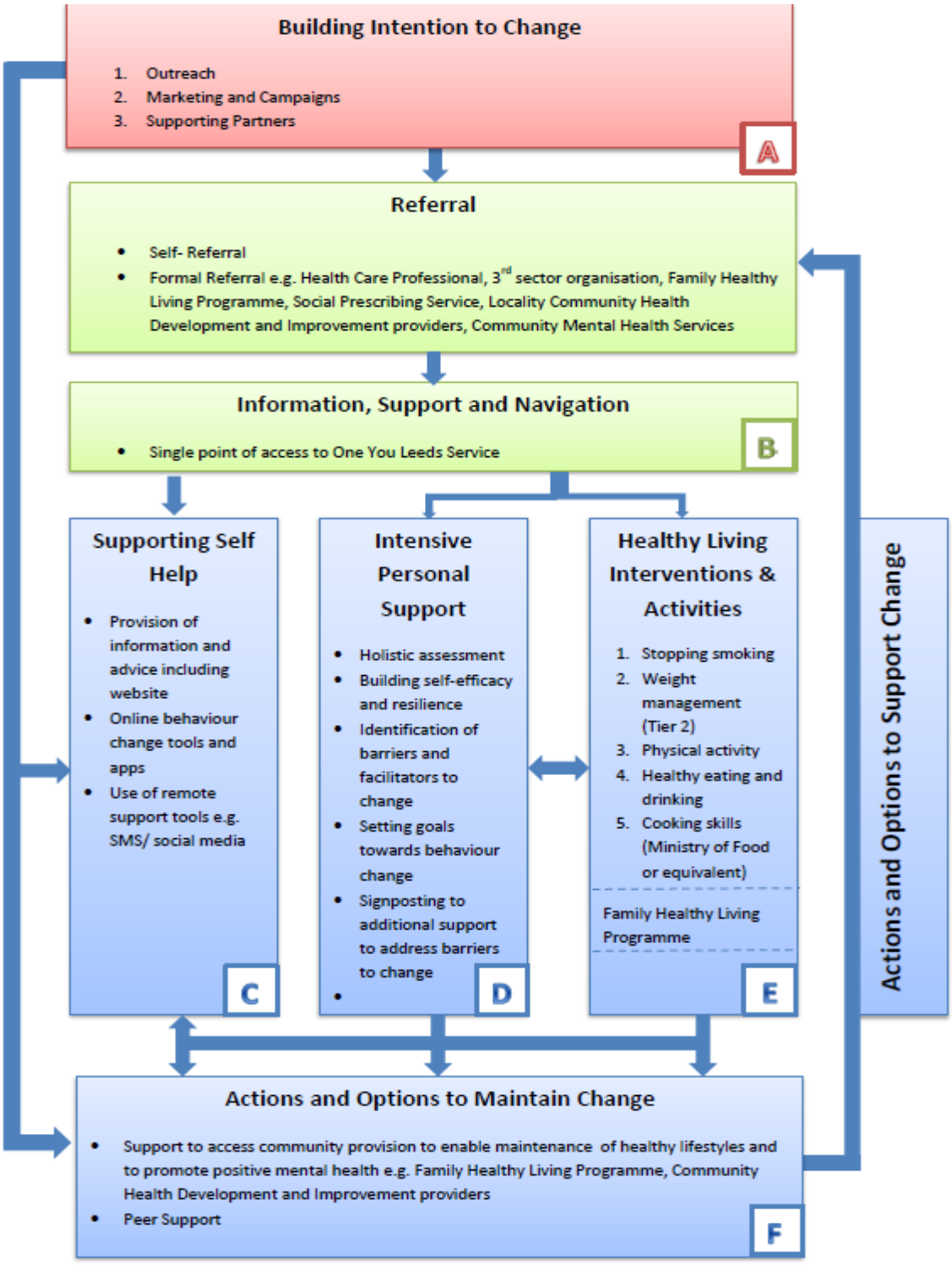
- Move More (includes an initial assessment followed by access to walking groups and physical activity sessions OR a referral to Active Leeds which may be more appropriate in some circumstances.
- Eat Well (one to one support for healthier eating and drinking, can also include low level support to reduce alcohol intake).
- Cook Well (8 week cooking courses through Ministry of Food brand, sub contracted delivery by Zest).
- Your Support (an additional support option to enable the client to start to make changes to their lifestyle if they have specific initial barriers or need a lot of additional support throughout their access to the service).

In addition the service is commissioned to provide digital self- help through their website and social media channels as well as running campaigns to promote healthier living.

https://oneyouleeds.co.uk/

The service aims to target areas of higher deprivation, therefore provision is focused in these parts of Leeds. The diagram illustrated on the next page is an extract from the One You Leeds service specification to show how the model was envisioned to interrelate.

3.3 One You Leeds Model Diagram (copied from Service Specification)



Please note that the 'Family Healthy Living Programme' referenced in box E in above diagram was withdrawn from the model.

Section 4: Evaluation Aims and Approach

4.1 The aims of this report are to:

- ***Explore how One You Leeds is operating using various perspectives, particularly regarding the added value of an integrated model.***
- ***Review how accessible the One You Leeds service is through both consultation with participants and demographic data.***
- ***Understand the current healthier living system in Leeds through consultation with a range of stakeholders.***
- ***Build on the current evidence base relating to integrated services and systems for healthier living.***
- ***Consider any actions and recommendations for making improvements to OYL and/ or the Leeds system.***

4.2 Approach to Evaluating

A project team comprising of Leeds City Council (LCC) and One You Leeds staff (Reed Wellbeing) was set up to plan the evaluation. It was agreed that the external provider Social Marketing Gateway (SMG) would be commissioned to implement the consultation aspect of the evaluation. This was in order to provide an independent element to enable those consulted to engage anonymously. It also helped to minimise any bias that LCC or Reed Wellbeing may impose onto the evaluation. The consultation was agreed to be with OYL participants, OYL staff and also a broader enquiry with other healthier living providers and referrers.

A semi-structured survey was developed for each target audience as well as consultation guides for more in depth interviews. During the project scoping and survey development process, it was agreed to predominantly focus the surveys towards the adult weight management and stop smoking service components. This was due to these being the most highly accessed programme areas. It was agreed not to include the campaigns and outreach in the scope of this evaluation. The surveys were published online by SMG and appropriate links were then forwarded to the relevant recipients as widely as possible. Reed Wellbeing used the links to forward the survey to their staff and participants. The consultation was completed between February and April 2018. Findings from the consultation will be highlighted and discussed throughout this report where appropriate in relation to the service data. Below is an overview of the sample size of the respondents.

Table 1: Consultation Sample Size

Audience	Sample Size	
	Semi-structured Surveys*	Interviews
OYL Participants	328	16
OYL Staff	16	13
Health Professional Staff	67	7

*Number of complete responses

In addition to the consultation, data from the Orion system that OYL use for monitoring participants has also been extracted for the purpose of this evaluation. This will be discussed and reflected upon throughout the report in comparison to research/ other interventions where it is available, and the evidence base as appropriate.

Section 5: Findings - Health Care Professional Views & the Healthier Living System

5.1 Introduction

There were 67 health care professionals who responded to the consultation survey. Seven of these also consented to have further in depth interviews. The job roles/areas were:

- Primary Care (45 surveys; 1 interview)
- Better Together Providers - Community Health Development (Third Sector) (7 surveys)
- Other third sector (6 surveys)
- Social Prescribing Services (5 surveys; 1 interview)
- Secondary Care (1 survey; 4 interviews)
- Active Leeds (1 survey; 1 interview)
- Leeds City Council (1 survey)
- Financial Capability (1 survey)

The aim of this part of the consultation was to explore the views of health care professionals working across the spectrum of healthier living. This mostly included primary care professionals, and other health improvement service providers who have varying roles in supporting individuals and communities to live healthier. These were cascaded via a number of channels including Leeds CCG communications, primary care distribution lists, and local health and wellbeing networks. It was agreed to focus the questions on five key health improvement focused services which were One You Leeds, Active Leeds, Forward Leeds, Better Together and Social Prescribing.

5.2 Level of awareness and knowledge of Healthier Living Services

Of all the services listed, One You Leeds was the most well-known with 64% saying that they had good knowledge/ understanding of the service. Social Prescribing and Forward Leeds both had over 50% saying they had good knowledge. The least well understood was Better Together with 50% saying they had little/ none. For Better Together, this is a community development approach and isn't something that primary care (the main respondent) would necessarily refer to. Overall, this would suggest some room for improvement in the system for ensuring that health care professionals have a good understanding of the range of services.

Table 2: Knowledge/understanding of Healthier Living Services

What level of knowledge/understanding do you have about the following Healthier Living services?	Little/none	Some	Good	Total Responses
One You Leeds	11% (7)	26% (17)	64% (42)	66
Active Leeds	22% (14)	38% (24)	41% (26)	64
Forward Leeds	15% (10)	34% (23)	51% (34)	67
Better Together	50% (32)	25% (16)	25% (16)	64
Social Prescribing	14% (9)	32% (21)	54% (35)	65

Health care professionals were also asked how often they refer/ signpost to these services. One You Leeds was utilised the most often by respondents with 45% signposting or referring to the service on

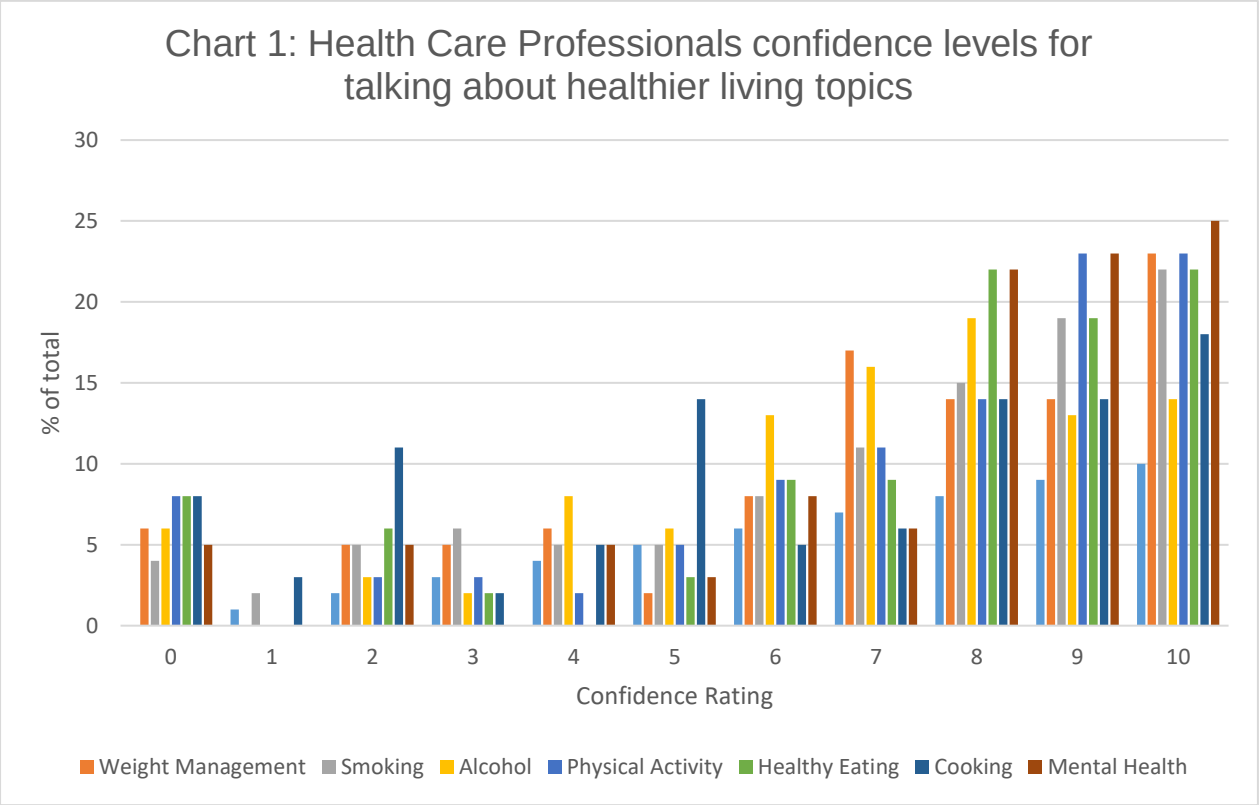
a daily or weekly basis. Social prescribing was also referred/ signposted to regularly by this group of respondents.

Table 3: Frequency of referring/signposting to services

How active are you at referring/ signposting people to each of these services?	Daily	Weekly	Monthly	Less than monthly	Rarely/ never	Not relevant to my role	Total Responses
One You Leeds	12% (8)	33% (22)	23% (15)	8% (5)	17% (11)	8% (5)	66
Social Prescribing	8% (5)	22% (14)	19% (12)	22% (14)	19% (12)	11% (7)	64
Forward Leeds	5% (3)	14% (9)	23% (15)	24% (16)	21% (14)	14% (6)	66
Active Leeds	3% (2)	14% (9)	21% (14)	21% (14)	30% (20)	11% (7)	66
Better Together	3% (2)	10% (6)	8% (5)	11% (7)	59% (36)	10% (6)	62

5.3 Confidence talking about Healthier Living topics

For the most part, health care professionals felt confident in having discussions around healthier living. Respondents felt least confident in holding conversations relating to alcohol and cooking.



When asked to rank these areas in order of the frequency of support requested from patients of Health Care Professionals, weight management was ranked highest (when aggregated).

Table 4: Ranking of support needs

What healthier living area do you find people are most in need of support with? Please rank the following from 1 (most support needed) to 7 (least support needed)	
Topic	**Rank**
Weight management	**1**
Emotional wellbeing	**2**
Smoking	**3**
Alcohol	**4**
Physical activity	**5**
Healthier eating	**6**
Cooking	**7**

Professionals commonly referred to how emotional and social difficulties were connected with capability to adopt healthier behaviours;

"There is more demand than supply for emotional support"

"Poor emotional health, being or feeling isolated is often the common reason for someone accessing our services, or this will come up in conversation as something they are struggling with"

"Huge obesity crisis which impacts on emotional wellbeing"

"Most patients need help with developing motivation, confidence and an inherent belief for being worthy enough to look after themselves. Many are limited by social difficulties e.g. finance and a lack of likeminded people around them to keep them going with healthier lifestyles. Many don't know how to cook so struggle to implement healthier eating and go for convenience packaged foods"

''Often patients have all of the above needs which impact on their health and it would be hard to prioritise!"

5.4 Multiple Referrals

Reinforcing the above comments, when combining the responses 'always', 'very often' and 'sometimes', 93% of the respondents stated that multiple referrals were stated as needed. Only 5 respondents said rarely or never.

Table 5: Frequency of multiple referrals

How often are multiple referrals needed for the same person with more than one need?	% and no. of respondents
Always	5% (3)
Very often	36% (24)
Sometimes	52% (35)
Rarely	5% (3)
Never	3% (2)
Total Responses	67

*due to rounding of figures, these do not precisely add up to 100%

5.5 Where to refer/ signpost?

On the whole, health professionals felt they understood where to refer most appropriately for each of the topics. However, there were still some respondents stating that they were 'not sure'. This was most common for healthier eating, cooking and emotional wellbeing. Weight management seemed to have the most clarity with 52 people stating OYL and only three people saying they were' not sure'. Clearly some people ticked more than one response for weight management demonstrating that there may still be additional options such as Active Leeds which will aid weight maintenance.

Table 6: Signposting by topic and service

When someone needs support on any of the areas of healthier living listed, which service would you refer/signpost to? (Select all that apply)	One You Leeds	Active Leeds	Forward Leeds	Better Together	Social Prescribing	Not sure	Total Responses
Weight management	62% (52)	24% (20)	1% (1)	4% (3)	5% (4)	4% (3)	84
Smoking	75% (47)	2% (1)	3% (2)	-	5% (3)	11% (7)	63
Alcohol	9% (6)	-	77% (53)	-	6% (4)	6% (4)	69
Physical activity	33% (32)	42% (40)	1% (1)	7% (7)	9% (9)	5% (5)	94
Healthier eating	61% (46)	5% (4)	1% (1)	11% (8)	8% (6)	12% (9)	76

Cooking	51% (40)	3% (2)	1% (1)	13% (10)	14% (11)	17% (13)	78
Emotional wellbeing	9% (8)	4% (3)	6% (5)	15% (13)	40% (34)	14% (12)	85

5.6 Confidence navigating the system

When asked what would help professionals navigate the system, the highest response related to increasing public awareness and promotion of the services (65%) and increasing understanding of what the services offer (60%).

*'It is not necessarily more information on what the services offer, but **clearer** information''*
"a system that doesn't need "navigating" i.e. one stop shop"

Table 7: Support to enable confidence navigating the Leeds Healthier Living System

What would help you/your organisation be more confident and able to navigate the healthier living system in Leeds? (Select all that apply)	% and no. of respondents
More public promotion of Healthier Living services	**65% (42)**
More information about what the services offer	**60% (39)**
More information/guidance on the referral process/options	**54% (35)**
Training to increase knowledge about healthier living	**40% (26)**
Training to raise and have a conversation about healthier living with people	**38% (25)**
A better/easier referral process	**25% (16)**
Total Responses	**65**

5.7 One You Leeds – Health Professionals Views

5.7.1 The most common reason for referring/ signposting to OYL **was in response to someone demonstrating motivation to make a change to their lifestyle.**
Other reasons included:

- A clinical need for a person to get healthier.
- Staff training *"All staff are aware of the service and what is available".*
- A lack of other options, stating that OYL is *"the only commissioned service currently for what is essential in general practice in terms of patient need".*

Reasons that prevented professionals from referring/ signposting included:

- Language barriers.
- Patients not willing to travel and OYL are not being able to deliver programmes from every GP surgery across Leeds.
- A "*lack of communication/ feedback and interaction with surgery about our patients".*

- Not knowing enough about all of OYL's services, stating that they were "*not familiar with all of their services",* and that they only really used OYL for weight loss and smoking cessation.

5.7.2 Strengths:

The fact that OYL offers a **single point of access** to a range of methods to live healthier was highlighted frequently as a positive aspect of the service. This was deemed convenient, particularly in terms of simplifying the referral process and considered an improvement on previous services.

"One strength is that all the services are provided by one organisation"
"Much better now it is all in one place"

Both the **online and offline promotions** that OYL have were also regarded as a strength, such as the widespread promotion and campaigns.

"*Good website - makes it easy to see what services are available"*
"*Great website, easy to navigate"*
"*The Stall in the Leeds market is very useful*"
"*Promotion. Have heard a lot from/about them"*

The **timeliness of OYL responses** was also commented on positively;

"Pretty good response times"
"See patients quickly"
"Quickly, bringing people with the same goal together"

High Patient satisfaction communicated to referrers;
"*Heard good reports from patients"*
"Have had good patient feedback once they do agree to go."

5.7.3 Areas for improvement suggested by health professionals;

There is definitely an opportunity for OYL to **report back to professionals more on referrals which in turn would also help to improve communication**. This was commented on by a high number of the professionals completing the survey.

"Find a way to provide timely and meaningful feedback''

"I have no experience of any feedback from the service"

"No closing of the loop in terms of capturing the outcomes or performance so not able to be assured that we are actually addressing or improving health inequalities''

"To have better communication with GP surgeries with regards to what services they are providing and the information that they're gathering about our patients or treatment outcomes etc."

Provide more **openly accessible details** to professionals on the venue, time and activities on offer, as this could increase likelihood of referring.

"*More info to referrers about the services offered, what the patient can expect (e.g. waiting lists, group vs individual sessions etc.)"*

"There isn't much information about the actual services in detail. If I want to find out about services I would want to see the venue, times and where it's a drop in or referral only. Patients or health professionals need to ring or refer online"

Increase session availability across different parts of Leeds and in evenings.

"Coverage across the area is not brilliant despite us being in their target area"
"Too far away from us"
"Huge demand and limited resources"
"More delivery of classes in the community on an evening"

Improve service accessibility
OYL's use of telephone calls or voicemail as a primary method of engagement were highlighted as off-putting for people with mental health needs, some of whom were not comfortable answering calls from unknown numbers. Informal drop-in sessions or in-person visits from staff were preferred. The health care professional weblink for referring doesn't allow space for notes which was felt to be a barrier for some health care professionals, particularly when referring people with a mental health condition. It was suggested that a specific pathway would be beneficial when referring a person with a mental health condition. It was also felt that providing materials in additional languages would increase accessibility.

Consider direct booking
Respondents also noted that OYL should consider **letting practices book for patients**, rather than through referrals: *"Allow practices to book appointments direct in to the system"*

Review OYL image and branding
Some people's perceptions of OYL: *"It's very corporate in its feel and branding which I think can put people off".* The promotional approaches used by OYL are too "*one size fits all"* and could be more tailored to the needs of different areas within Leeds.

Consider the scope of the services provided where there may be some gaps or duplication.
Some respondents highlighted certain gaps whilst others felt there was duplication.

"One You Leeds doesn't have anything on sleep which is important for health"
"One You Leeds doesn't have anything for alcohol or mental health… It's not really one service for all patient needs as still need to navigate to other services if multiple health needs"

Active Leeds also suggested that there may be duplication regarding physical activity and the two providers could work together more efficiently to address that.

Simplify resources
The high level of detail in the weight management written materials was felt to be off-putting to some people, especially those with a lower literacy level and it was suggested that a lighter version of the weight management materials would be beneficial.

5.8 Section Summary

5.8.1 Whilst the health care professionals commented on how they valued a more integrated healthier living service model, some did comment that they still thought OYL didn't cover enough. There were suggestions relating to sleep and stress management needing more attention.

Complexity in support needs including mental health issues were often mentioned throughout the consultation.

5.8.2 Being the most well-known service could be putting more pressure on OYL in terms of capacity. There were some comments that it was seen as the only option. It may be that there needs to be some work on raising awareness of the variety of other options available around self-help. OYL was very clearly seen as the main provider for weight management and smoking cessation.

5.8.3 Weight management was quoted by health care professionals as their number one most frequent healthier living issue with references to the connections with emotional wellbeing. It was acknowledged that many health behaviours cluster and that they can be difficult to prioritise.

5.8.4 There was a lack of understanding regarding cooking skills and physical activity. This could be due to there still being multiple access routes for these and less general understanding on what is available across the system. There was also less awareness on the Better Together service which interestingly OYL staff have also highlighted as a service area that other referrers/ partners would benefit from having a better understanding of (Section 6).

5.8.5 There was clearly a need to improve other professionals understanding of OYL and broader healthier living landscape in Leeds. This shows the value in work developing through the LCC led commissioner forum which could have a role in addressing some of the above. Respondents did say they would value clearer information on healthier living services. Training was suggested as one way of providing this.

5.8.6 A key area that still needs addressing is the request from health care professionals for greater transparency regarding specific feedback on their referrals. Despite numerous discussions with Reed Wellbeing in relation to this, it is still unclear how best to proceed. The challenge is finding a mechanism to provide meaningful feedback whilst retaining client confidentiality. With current rules relating to client confidentiality, service providers have concerns around the sharing of personalised feedback with referrers. Options on how best to ensure the right level of feedback that satisfies the referrers needs as well as being manageable for providers is yet to be identified. However, the development of the new healthier living referral template in primary care may help to resolve this. In addition, the template launch may make some progress to further clarify the roles of individual providers and referral pathways of One You Leeds, Active Leeds and Forward Leeds.

Section 6: Findings - One You Leeds Staff views

6.1 A key part of the evaluation was to collate One You Leeds (OYL) staff views of the service. In total, 16 members of staff participated through an online survey and interviews.

A breakdown of the job roles is shared below;

- Reed Wellbeing Coach (6)
- Reed Wellbeing Manager (3)
- Zest Cookery Trainer (2)
- Programme Support Team Member (2)
- Zest Manager (2)
- Clinical Support (1)

6.2 Staff's understanding of the wider healthier living system

Staff varied in their understanding of other health professionals and providers roles in the wider Healthier Living system. Active Leeds was the most well understood service which is positive to see considering the important role this service has to work with OYL.

"Meeting with Active Leeds every other month gives me the opportunity to shadow classes and get up to date with all the latest news in physical activity with Active Leeds and LLGA".

Table 8:

To what extent do you know/understand what the roles of other players is in the wider Healthier Living system i.e. know what they do for participants?	Completely clear	Good/ reasonable understanding	Some understanding	Don't know what their role is	Total Responses
Active Leeds	56% (9)	19% (3)	19% (3)	6% (1)	**16**
National Diabetes Prevention Programme (NDPP)	44% (7)	38% (6)	19% (3)	-	**16**
Health Care Professionals	38% (6)	50% (8)	6% (1)	6% (1)	**16**
Community Mental Health Services/IAPT	38% (6)	31% (5)	19% (3)	13% (2)	**16**
Forward Leeds	38% (6)	25% (4)	25% (4)	13% (2)	**16**
Social Prescribing Services	33% (5)	7% (1)	33% (5)	27% (4)	**15**
Better Together Providers	20% (3)	20% (3)	20% (3)	40% (6)	**15**
Family Healthy Living Providers	13% (2)	31% (5)	38% (6)	19% (3)	**16**
Other Third Sector Providers	7% (1)	33% (5)	27% (4)	33% (5)	**15**
Tier 3 and 4 Specialist Weight Management Services	7% (1)	33% (5)	33% (5)	27% (4)	**15**

Many staff (n=7, 44%) reported having very little or no contact with referrers. Of those saying they do have contact, it was mostly through email only, or fairly top level – e.g. *"I see health care professionals at clinics but nothing more than a hello".*

The majority of managers had a good knowledge of the healthier living system, but lacked detail. For example:

- **Social Prescribing –** Some managers themselves felt they knew about this, but that others' – i.e. the coaches' understanding is *"still quite wishy-washy".*; *"Coaches have heard the term, but I do not think they understand what it is and what they do".* Even some of the managers

felt they have a broad overview of social prescribing, and would know detail about providers in certain areas where they've worked previously, but that there are still gaps where knowledge could be improved.

- **Better Together** – Broad overview but no detail.

Managers felt it was important to find a balance between *"how much knowledge is too much and how much is not enough".* To strike this balance, it was proposed that coaches should know about the services in the local area where they are running a group:

"It's the local bits that are important really, because that's generally where those participants will attend. So those coaches don't necessarily need to know about everything in Leeds, but about where they're working from".

It was commented that they would like to know more about the role of NDPP. Some participants get referred from there: *"I know they work on prevention of diabetes, but I don't know if they focus on the diet and exercise side of things".* It would be useful to understand how they help the participants before they get to OYL. Similarly, interviewees from the Programme Support team commented that more information would be beneficial on the NDPP; Family Healthy Living Providers; and Social Prescribing Services.

6.3 Perceived Efficacy of the One You Leeds Service

Of the 15 responding in below table, all felt that the overall OYL service has been at least somewhat effective in helping users make positive and sustainable lifestyle changes. Of these, 38% said it is 'very effective'. The area considered to be least effective is the website.

Table 9: Perceived effectiveness of OYL programmes

How effective do you feel each programme/activity is?	Little/no impact	Not very effective	Somewhat effective	Very effective	Can't Say	Total Responses
Weight Management	-	-	40% (6)	53% (8)	7% (1)	**15**
Cook Well	-	-	27% (4)	67% (10)	7% (1)	**15**
Be Smoke Free	-	-	20% (3)	67% (10)	13% (2)	**15**
Eat Well	-	-	53% (8)	27% (4)	13% (2)	**14**
Move More	-	-	40% (6)	40% (6)	20% (3)	**15**
Your Support	-	14% (2)	43% (6)	21% (3)	21% (3)	**14**
One You Leeds Website	-	10% (3)	33% (5)	40% (6)	7% (1)	**15**

The **6 and 12 month follow up calls** were used to support their rationale for thinking the service is supporting longer term change. By following high portions of participants up at 6 and 12 months, the Service is finding out whether pts are able to sustain changes: *"I think we're good at it, from the 12 month calls that we're doing" (Manager).* A manager highlighted that the 'good news' stories show

that *"there are some real life changing experiences that come out of the service…definitely sustainable changes".*

OYL Coaches also commented that OYL is effective in encouraging and supporting positive outcomes:

"I think it is good, it is effective. I've been here over a year now and people do stop smoking through the services we provide i.e. the treatments and supports". (Coach)
"I think with all the research behind it, with all our protocols, the way we deliver the treatment, all the behaviour change, I think it's set up really good for helping people stop smoking". (Coach)

One manager was less sure about the sustainability aspect of the changes that participants make, but felt that this was a result of the wider circumstances facing the people they support, rather than of any failure within the service:

"Whether it's sustainable is questionable, but I don't think that's reflective of our service, I think that's reflective of the demographic that we work with generally – long term changes are difficult for most people to make". (Manager)

Reasons given for changes not being sustained when explored in the follow up calls often included a life event – i.e. "something getting in the way".

"We're focusing on deprived Leeds, so often, a lot of people have got a lot of other issues, and what's important for them when they make that behaviour change is not important for them 3/6 months down the line when something else happens". (Manager)

6.4 OYL Staff Views on the Service Model's Strengths

OYL staff were broadly positive about the service: *"I think overall it's brilliant!"* Specific **strengths** highlighted by staff included:

Delivering Good outcomes	Some examples given by staff included: • People reversing from diabetic to pre-diabetic. • Social benefits for older people e.g. walking groups that help with isolation. • Legacy/building local assets – such as a longstanding walking group member taking over the group and becoming walk leader.
Communication across streams	It was suggested that there have been improvements in internal communications since a new manager joined. Whilst there is still room for further improvement, significant progress has been made: *"It's changing, and from starting back in January last year to where we are now, there's been massive changes, in a positive way". (Manager).* Staff will try to resolve issues through having a face to face conversation: "*Having a face to face conversation and explaining what went wrong and how we can fix it, is better than just sending an email." (Manager)*

A team that cares	*"Excellent coaching team…They care about the service, they care about the people, and they want to have a positive experience".* It was felt that it's filtering through from managers who also care a lot about the service.
Team ethos	*"The team approach is really strong, and that filters down and comes through in terms of service delivery, and I think that's one reason why participants are getting positive experiences on the programmes". (Manager).* For example, if a coach needs to be off at short notice/leave early, they'll pull together and cover for each other: *"They all support each other and look out for each other". (Manager).* This strong team approach was reiterated across the team: *"It doesn't feel hierarchical – even managers wade in and do referrals, phone calls etc. Everyone is equal". (Programme Support).*
Sharing best practice and discussing individual participants	This was felt by managers and coaches to be an innate part of the practice. For example, having conversations about individual participant's cases and best ways to support positive outcomes.
Continuous improvement	Service delivery is continuously reviewed with staff supporting managers to enhance and tailor sessions that maybe quiet or in need of more resource. "It all feeds in and helps the partnership manager – we can focus meetings with referrers/community hubs where they're needed" (Manager)
Supporting people living in more deprived parts of Leeds, who want to be helped, are flexible in terms of time, less educated about healthier living, and those who are older.	*"You have people coming together from all walks of life with similar goals. They motivate each other". (Coach)* *"It is predominantly helping people in deprived areas of Leeds".* *"I feel that the service is great at helping people who want to be helped. Those that want to improve their wellbeing and health seem to get the most out of the services that I have seen". 'I'll tend to see a lot of good news stories from older people, 50 and above…I don't know whether that's because they're more engaged with doing a good news story and promoting it, or whether that's because we're getting more of those outcomes."*
But also reaching a wide range of people	*''You have people coming together from all walks of life with similar goals. They motivate each other.''*
Persistent initial engagement attempts with new referrals	This was felt to have improved significantly from the early days of the service, when they would only call once, send a letter and then close the case.
Frequent & ongoing contact with participants such as courtesy calls, text reminders and the follow up call system	Programme support team members felt that this process is a key strength of the service, and is valuable for demonstrating positive outcomes.
Intelligence, qualifications and passion of the coaches	The OYL staff and coaches were identified as being one of the key strengths of the programme. As well as being highly trained in the areas they work within, there was a feeling that the staff are good at working with participants to help them overcome challenges to change: *"Coaches are good at understanding the participants' barriers and helping to come to solutions together."*

6.5 Challenges

6.5.1 Time and capacity limitations to meet demand on resources

In particular, **time** was identified as an issue, in terms of;

- Appointments not being long enough to fully engage with the client.
- Lacking in time between appointments to do admin.
- Wasted time for coaches having to travel between sessions.
- Participants being late or not turning up.
- Difficulty getting through all of the material required particularly in induction sessions.
- Sometimes long waiting times for people to be assigned appointments.

Coaches**:** *"Occasionally, you have clinics where you can be slightly rushed."* – This can be because a coach is not able to block out the diary for reserved spaces, or suddenly receives an influx of people wanting their initial sessions in the same area. It was suggested that the **volume** of participants being enrolled in the programmes are causing the strain on time, and there may be a need for more staff to balance the workload.

Managers**:** Challenges around competing demands relating to staff and programme management as well as needing to cover sessions.

"I always think it's easier to cover and get my KPIs up, than cancel everything and then have to answer a question at the end about why we've not hit this and that"

"If we're free we'll always go and cover, but those weeks when you're covering it is challenging to get everything done on time…but we're here because we enjoy that kind of environment" (Manager)

Specifically with regard to building partnerships with external parties, it was recognised that ideally, a proactive approach would be better. However, the high volume of information requests leads them to be more reactive than they would like.

In Programme Support**:** The fact that it's a **small team** can be a challenge, so if someone is off sick it's difficult to manage the workload:

"We get strapped for numbers. I would prefer having an extra two people on because we are really, really busy. To give the quality of service, which is personal conversations with participants, we need more people" (Programme support)

6.5.2 Supporting participants with more complex needs

Language Barriers

Translation services are used to support with language barriers but in practice this is still very difficult. The challenges include:

- Engaging participants during the booking process with appropriate triage to the correct service.
- Building a rapport through a third person.
- Some medication related terms such as brands are not translatable in other languages.
- Difficulty using behavioural change techniques such as motivational interviewing.

- Varying cultural context to health that require different information.
- OYL coaches feeling unsure whether they are communicating effectively with participants when there are language barriers.

"I'm not going to lie, it's challenging. It's very very challenging for the coaches, especially in the translation sessions" (Manager)

"So we struggle on the initial calls – we always say have you got a family member we can speak to or anything like that, and they tend to fumble their way through, but it is difficult"

"The practicalities, and just getting the message across, and not being able to get a rapport with the person, because you're going through a third party"

"So you can't include everything in a session that you would if you were speaking to a person directly"

"Sometimes the interpreter doesn't speak exactly the same language, so then I don't always know exactly what they're saying, so it's harder to do in a behaviour change way…trying to use motivational interviewing and CBT is almost impossible" (Coach)

Complex Mental Health Issues

Mental health came up frequently as a concern for OYL staff. This related to a number of factors including whether:

- Another external wellbeing service would be more appropriate in some cases (e.g. IAPT, Social Prescribing or Third Sector organisations such as Better Together).
- Staff could be trained more effectively to support mental health issues.
- The internal OYL triage system has been working as effectively as it could to ensure that one to one support is offered.
- The effect this has on time and resources due to a higher level of need.
- A reflection on how limited capacity is across the system for mental health support needs.

"In terms of people's mental health, we get a lot of complex people accessing the service. From speaking to the coaches, they might want to be upskilled in that area, because they're having to deal with people's mental health first of all – are they ready to make a change yet if they're not in the right place"

This is also discussed further under the next heading relating to referrals.

6.5.3 Issues with Referrals

This may relate to **quality**, and **appropriateness** of referrals or potential participants being **incorrectly informed** leading to un-realistic/ inaccurate expectations. Referrers may promote the service inaccurately: *"People come in saying that their GP has said they'll get a diet plan, or free exercise sessions at every gym" (Coach)*.

Many referrals are appropriate but there are concerns about the quality of some referrals for participants with **complex needs relating to mental health and/or diet**. There was a sense that this was due to pressures on mental health/ dietetic services with insufficient capacity. Health professionals may be seeing OYL as the only option:

"[They're] clutching at straws…struggling to find something appropriate for people…'

"I think the wait times in mental health services are so long, we may be the only option at that time, in terms of we have the capacity and the time to see individual people. GPs have the 8 minutes to see them in and out. It's six months for IAPT now – the MH services – so, maybe from a GP's point of view, maybe we're the only other option"

It was highlighted that there are other services that might be more appropriate;

"Maybe, other things such as 'Better Together' could be more appropriate – more gentle groups around social isolation…a gardening group…something to get that interaction, but that doesn't require you to absorb information and utilise that in your day to day life"

Complex dietary needs – Some participants were reported to have complex dietary needs, such as allergies and eating disorders. They require dietetic and/ or nutritional support but were having to wait too long for these appointments.

"We can't provide this service because they actually need diet plans…You get people who need a dietician's help, who have got liver failure. It's not that kind of service – we're not advisors, we're coaches. That's a big thing people get confused with – we coach people to make healthy decisions, we don't advise as such. But doctors see it as different – I don't know if it's the name or the way it's advertised. All we do is have to refer them back."

6.5.4 Staff turnover

Retention of staff was considered a particular challenge in the Programme Support team causing frustrations with continuously needing to train new team members.

"We appreciate that we're a stepping stone along the way for a lot of the coaches in terms of their career development, so for us to be able to retain them for a year is good."

2.5.5 Issues with monitoring systems

The service system itself was viewed by managers and coaches as a significant challenge. It was described as 'clunky' and 'restrictive', with the reporting mechanism being particularly criticised:

"There must be a better system for us to work with." (Manager)
"We had to mould to fit Orion; Orion wasn't built for the service." (Manager)

6.6 Recommendations from OYL staff to improve the service

6.6.1 Ensuring information is accurate and up to date

Further work to ensure **GPs** are up to date with accurate service information to improve referrals was suggested. This could include:

- More outreach work
- Encouraging GP staff to shadow OYL staff
- Producing a OYL **summary 'standpoint'**.
- Increased opportunity to meet with GP staff to discuss the offer and answer questions: *"If I've got time in my diary, I'd be more than happy to go to GP practices and talk about what we offer, why we offer it etc." (Coach).*

- More frequent updating of information on the website/advertising: *"At the moment you have to go through about 6 people to get anything changed. There are courses up on the website that were cancelled months ago."*

6.6.2 Improve screening at the point of referral to ensure participants are signposted correctly
Encourage Programme Support to sit in on sessions before assigning people to services – one coach highlighted that sometimes people are sent to one service (e.g. Weight Management) when they are better suited to another (e.g. Eat Well).

6.6.3 Reduce barriers to accessing sessions
Consider **direct booking onto a service**: *"I know that's never going to happen, but in a dream world…It used to happen with the old service and it worked really really well – they could just book directly into a clinic."*

Introduce drop in clinics; 'Super clinic' i.e. with lots of services there. Some managers felt that **being able to drop in to register interest** could be useful, whilst other managers felt it is more about drop in appointments.

"There are people in deprived Leeds who struggle to stick to times/have got anxiety, so you could allow them a two hour slot, and then have drop in's and speak to people as they go"

6.6.4 Clinics and appointment availability
Re-evaluate the distribution of clinics based on how busy an area is. Coaches highlighted that some areas could do with extra clinics, but recognised that having these would present challenges with regard to time and resources.

6.6.5 Maintenance and Follow up
Coaches thought that adding follow up drop-in clinics would be useful for supporting maintenance and ongoing support:

"because in a number of areas of Leeds we're really busy, and we're pretty much always at capacity – so potentially to keep some of the regular one to one or group clinics, but to also have one or two half days which are just purely drop in, to help with follow ups"

"It would alleviate a bit more time in the diaries to ensure that we don't have to rush, and also to keep the flow of people coming in where they want to come. So maybe 2 or 3 in North or South East would be good"

Drop-in sessions for those who have completed the 12 week sessions for weight loss in order to keep them engaged and prevent them from relapsing.

"I always say to my participants they can come see me half an hour before the session starts and I'll weigh them, but it would be good to have something formal. A drop in where people can come, have a 15 minute chat and get weighed" (Coach)

An example of an effective approach used by a previous service was **follow up texts**;

'so a participant just texts back with the word 'quit' and that registers as a successful stop smoking outcome, but that is no longer possible'

6.6.6 Staff training & development
- **Orion training** across the board: *"People [i.e. existing staff members] are just training new colleagues when they come in and so the mistakes are being passed down" (Coach)*

- Offer more career progression and incentives.

- **Additional training** on working with specific groups e.g.:
    - People with mental health issues
    - Older people – especially in relation to physical activity.

6.6.7 Managing Staff

Although some progress was acknowledged, ensuring that the coaches get their allotted administration times would be useful:

"I do quite a lot of cover, and sometimes I can come in on a Tuesday morning and I end up kind of guessing whether I have enough NRT treatment because I haven't had time for my admin. It works, but it's not ideal" (Coach)

It would be useful if the coaches were able to see their own **individual results** – i.e. a spreadsheet with individual targets, percentage of four week quits, attendance, stayed quits etc.

"It would be good to see how we're doing, and then obviously we'll want to do better!" (Coach)

"We do see overall figures, but some of that can be quite general and it would be good to see individual" (Coach)

Reliable technology is also something that would be beneficial due to a lot of their work being laptop based. A better software system, Orion has several features that make it difficult, clunky and time-consuming to use, so a better system could improve efficiency.

6.6.8 Accessibility

In order to **improve access for individuals with disabilities, mental health issues or language barriers**, the following suggestions were made:

- Increase the provision of home visits/ assisted transport options for those with specific access issues.
- Simplifying and/ or translating resources.
- More face-to-face interpreters, increased multi language skills in the team and resources in languages other than English were suggested. Having members of the team who are fluent in at least one of the most common languages amongst participants (e.g. Polish, Farsi etc.) would be very helpful. *"It would be good to have even just one coach to do a Farsi group or something along those lines" (Coach)*. Going forward is would be good to encourage participants to ring a friend/ family member who have a good understanding of English to their appointments: *"I think sometimes they come along and expect the interpreter to be there, rather than on the phone" (Coach).*
- A more thorough screening process, which could identify language barriers in advance of participants attending groups to ensure that necessary measures are in place:

"A better screening process – more often than not I will have participants who cannot speak, read or write English and it makes it very awkward to have to communicate to them that they are not suitable for a group in front of other group members"

- Advanced training for staff, in order to put them in the best position to help these groups. This was felt to be particularly helpful for those with mental health issues, as the coach may be able to suggest techniques and coping strategies.. It was also suggested to have more training in the context of mental health issues related to emotional eating and working with people with learning disabilities.

- A separate group session could be held to offer further support to this cohort.

- There was a general agreement that mental health is an area where more in-house capacity could be hugely beneficial:

"Because we're working with so many people with those kinds of challenges…so we either need better, really strong links, or something additional" (Manager)

6.7 Section Summary

The OYL staff provided some very insightful, detailed and valuable feedback regarding the service. Overall, they have said they think it does support positive and sustainable behaviour change, particularly for participants living in the targeted more deprived areas of Leeds. OYL staff also commented on how the service is good at helping those who are: ready to change, older people (over 50 years old), less educated on healthier living, and people who can be flexible with their time. They also highlighted many strengths of the service as described under section 6.4.

There are capacity issues in the system relating to more complex needs around mental health and diet. OYL staff didn't fully understand the other services available to people in the area such as Social Prescribing, Better Together (Community Development) and the National Diabetes Prevention Programme. They commented on key challenges around supporting people with mental health issues and language barriers, issues with quality of referrals and most significantly a lack of time and capacity to meet the demand on resources.

A wide range of constructive recommendations were made by the staff which will be commented on further undersection 10 relating to actions that have been taken by OYL management since undertaking this evaluation in response to the feedback.

Section 7: Findings - Who Accesses One You Leeds?

7.1 This section contains an analysis of the demographic access data (defined as any participant attending ≥ 1 session of each intervention) for the 5,772 participants attending between January and December 2018.

The data metrics included in this analysis are:

- *Deprivation Quintiles*
- *Age*
- *Gender*
- *Ethnicity*
- *Mental Health Status*
- *Disability Status*

The data reported is collected at the initial point of contact by the OYL Programme Support Service (PSS) team, usually at two working days post referral. The data is self-reported and can be altered at a later stage (e.g. if a participant is later diagnosed with a mental health condition). As such OYL rely on participants to keep them up to date with any developments and/ or changes to their health. All 'Cook Well' data is relating to the courses only and does not include taster sessions.

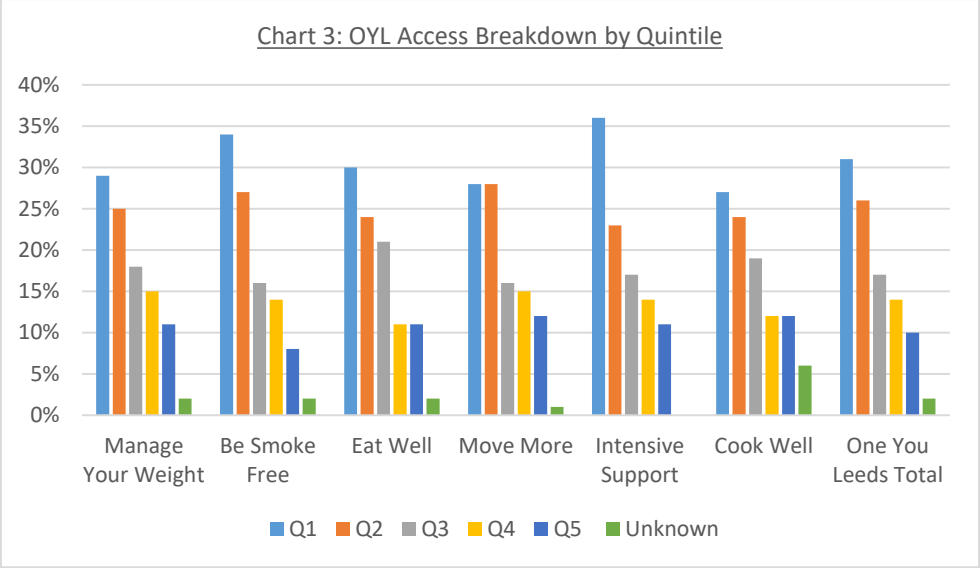
Please note that the tables and charts in this section were sent directly from Reed Wellbeing. Figures have been rounded up/ downwards which sometimes means they don't add exactly to 100%.

7.2 Access across Leeds Quintiles

The One You Leeds service model was developed with a targeted focus on the more socioeconomically deprived areas of Leeds in order to reduce health inequality. The service therefore aims to reach people living in quintiles one and two (40% most deprived in Leeds) by delivering the majority of services and outreach activities within these areas.

Table 10: Access to the service by quintiles one (most deprived) to five (least deprived)

Quintiles	Manage Your Weight		Be Smoke Free		Eat Well		Move More		Intensive Support		Cook Well		OneYou Leeds Total		
	Total	*%*	*Total*	*%*	*Total*	*%*	*Total*	*%*	*Total*	*%*	*Total*	*%*	*Total*	*%*	*Cumulative %*
Q1	519	29%	873	34%	119	30%	121	28%	54	36%	110	27%	1796	31%	31%
Q2	460	25%	699	27%	94	24%	117	28%	34	23%	96	24%	1500	26%	57%
Q3	325	18%	403	16%	84	21%	68	16%	25	17%	78	19%	983	17%	74%
Q4	278	15%	352	14%	44	11%	65	15%	21	14%	50	12%	810	14%	88%
Q5	200	11%	201	8%	43	11%	50	12%	16	11%	47	12%	557	10%	98%
Unknown	31	2%	60	2%	8	2%	4	1%	0	0%	23	6%	126	2%	100%
Total	**1813**	**100%**	**2588**	**100%**	**392**	**100%**	**425**	**100%**	**150**	**100%**	**404**	**100%**	**5772**	**100%**	



Quintile is analysed using the self-reported postcode supplied by the participant on registration with the service. As a measurement, quintile is well reported with a small range (0-6%) unknown between the service strands. Table 10 indicates a descending percentage of each quintile from one to five with 31% of the OYL cohort being from quintile one and only 10% being from quintile five. This suggests a high degree of success in engaging with deprived communities in Leeds.

In addition, 57% are listed as living in key target areas whereas only 24% are in quintiles four and five. The range in quintile one is 27-36% with Intensive Support seeing the highest percentage (36%), closely followed by Be Smoke Free (34%).

The consultation sample was less representative of those who access OYL in relation to deprivation as the distribution was fairly equal across the quintiles.

Table 11: Service User Survey Responses

Leeds Quintile	Survey Respondents % (n=)
1	17% (56)
2	20% (65)
3	18% (59)
4	17% (56)
5	18% (60)
N/A	10% (32)
Base	328

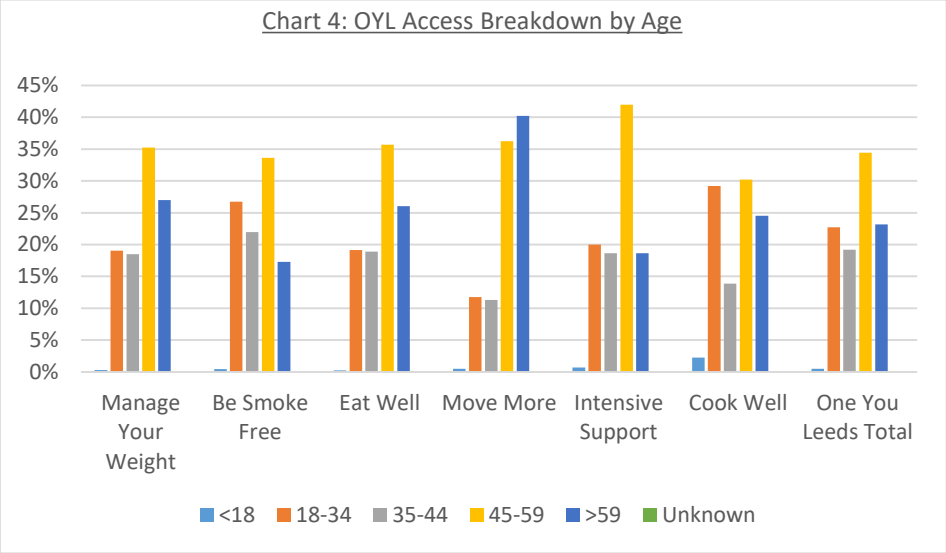
7.3 Access by Age

The OYL service primarily accepts referrals from Leeds residents aged 16 and over. If a participant under the age of 16 would like to access OYL, then acceptance on to the service will depend on the initial assessment. As OYL has been developed to target and support adults, it is expected that numbers under 16 years old will be very low. The only exception is for the Adult Weight Management service which is only available to participants over 18 due to the existence of a child weight management programme in Leeds and limitations in the data collection ability of the OYL database for participants under 18 years old. However, a few exceptions have still been made to this

in the rare instance that a younger person has been referred. Additionally, a younger person may still be supported to adopt a healthier lifestyle without a specific focus on weight through the Eat Well and Intensive Support service programmes. The support for younger age groups warrants further enquiry.

Table 12: Access to the Service by Age

Age	Manage Your Weight		Be Smoke Free		Eat Well		Move More		Intensive Support		Cook Well		OneYou Leeds Total		
	Total	*%*	*Total*	*%*	*Total*	*%*	*Total*	*%*	*Total*	*%*	*Total*	*%*	*Total*	*%*	*Cumulative %*
<18	5	0%	11	0%	1	0%	2	0%	1	1%	9	2%	29	1%	1%
18-34	345	19%	692	27%	75	19%	50	12%	30	20%	118	29%	1310	23%	23%
35-44	335	18%	568	22%	74	19%	48	11%	28	19%	56	14%	1109	19%	42%
45-59	639	35%	870	34%	140	36%	154	36%	63	42%	122	30%	1988	34%	77%
>59	489	27%	447	17%	102	26%	171	40%	28	19%	99	25%	1336	23%	100%
Unknown	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	100%
Total	**1813**	**100%**	**2588**	**100%**	**392**	**100%**	**425**	**100%**	**150**	**100%**	**404**	**100%**	**5772**	**100%**	



Age is a well reported metric with no unknown data. The OYL service as a whole appears to be successful in engaging with older participants as 57% are over 45 years old, 23% are over 59 years old and only 23% under the age of 34. The largest total is observed in the age 45-59 category (34%) with 42% in Intensive Support. Move More appears to appeal to older participants with 76% of its participants being over 45 years old compared to 61% in Be Smoke Free. Cook Well and Be Smoke Free are most frequently accessed by younger people (31% and 27% respectively) under the age of 35.

In the Service user survey, the majority of respondents were over 45 years with the majority of those being aged between 45 and 64 years. Although the age groupings here are different, they appear to be mostly representative of the OYL population.

Table 13: Service User Survey Age

Age group (years)	Respondents % (n=)
16-24	2% (6)
25-34	10% (34)
35-44	15% (48)
45-54	24% (77)
55-64	26% (86)
65-74	18% (60)
75+	4% (12)
Prefer not to say	1% (3)
Base	326

7.4 Access by Gender

Table 14: Access to the service by gender

Gender	Manage Your Weight		Be Smoke Free		Eat Well		Move More		Intensive Support		Cook Well		OneYou Leeds Total	
	Total	*%*	*Total*	*%*	*Total*	*%*	*Total*	*%*	*Total*	*%*	*Total*	*%*	*Total*	*%*
Female	1281	71%	1487	57%	262	67%	294	69%	106	71%	236	58%	3666	64%
Male	469	26%	1084	42%	119	30%	126	30%	43	29%	146	36%	1987	34%
Prefer not to say	6	0%	3	0%	1	0%	0	0%	0	0%	4	1%	14	0%
Other	2	0%	3	0%	0	0%	0	0%	1	1%	1	0%	7	0%
Unknown	55	3%	11	0%	10	3%	5	1%	0	0%	17	4%	98	2%
Total	**1813**	**100%**	**2588**	**100%**	**392**	**100%**	**425**	**100%**	**150**	**100%**	**404**	**100%**	**5772**	**100%**

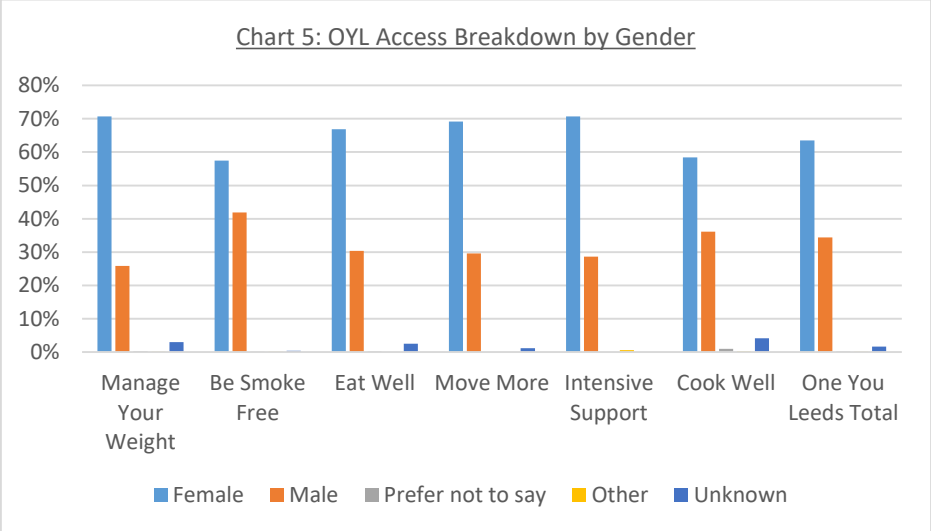


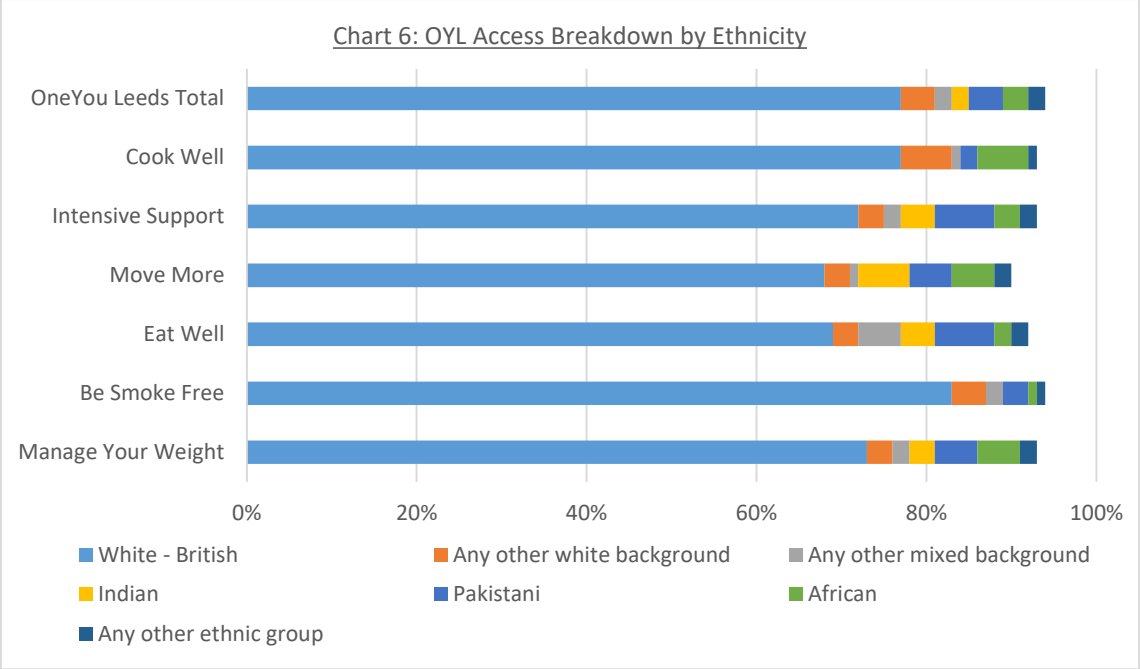
Table 14 and Chart 5 show a consistently higher percentage of female participants across all services (64%) compared to male (34%). Intensive Support and Adult Weight Management had the highest percentage of females (both 71%) compared to the lowest for Be Smoke Free (57%). Be Smoke Free had the highest percentage of male participants (42%) and at the reverse of female, Intensive Support and Adult Weight Management had the lowest (29% and 26% respectively).

For the participant survey sample, 68% (n=223) were female, 29% (n=94) were male, 3% (n=8) preferred not to say and 1 person said non-binary. This was therefore highly representative of the OYL population with very similar proportions.

7.5 Access by Ethnicity

Table 15: Access to the service by ethnicity

Ethnicity	Manage Your Weight		Be Smoke Free		Eat Well		Move More		Intensive Support		Cook Well		OneYou Leeds Total	
	Total	*%*	*Total*	*%*	*Total*	*%*	*Total*	*%*	*Total*	*%*	*Total*	*%*	*Total*	*%*
White - British	686	73%	1279	83%	180	69%	150	68%	91	72%	181	77%	2567	77%
White – English	0	0%	6	0%	0	0%	0	0%	0	0%	0	0%	6	0%
White - Welsh	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
White - Scottish	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
White - Irish	11	1%	14	1%	3	1%	5	2%	0	0%	3	1%	36	1%
White – Northern Irish	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Any other white background	24	3%	65	4%	8	3%	6	3%	4	3%	13	6%	120	4%
White and Asian	4	0%	7	0%	0	0%	1	0%	0	0%	2	1%	14	0%
White and Black African	7	1%	2	0%	0	0%	1	0%	3	2%	2	1%	15	0%
White and Black Caribbean	11	1%	13	1%	5	2%	0	0%	1	1%	2	1%	32	1%
Any other mixed background	22	2%	35	2%	12	5%	2	1%	2	2%	2	1%	75	2%
Bangladeshi	4	0%	8	1%	0	0%	2	1%	1	1%	1	0%	16	0%
Chinese	2	0%	1	0%	0	0%	0	0%	0	0%	0	0%	3	0%
Indian	28	3%	5	0%	11	4%	14	6%	5	4%	1	0%	64	2%
Kashmiri	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Pakistani	47	5%	43	3%	18	7%	11	5%	9	7%	5	2%	133	4%
Any other Asian Background	20	2%	14	1%	6	2%	4	2%	2	2%	1	0%	47	1%
African	47	5%	10	1%	5	2%	12	5%	4	3%	14	6%	92	3%
Caribbean	11	1%	4	0%	2	1%	1	0%	1	1%	2	1%	21	1%
Any other Black background	9	1%	18	1%	6	2%	9	4%	1	1%	2	1%	45	1%
Arab	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Gypsy or Traveller	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Any other ethnic group	21	2%	22	1%	5	2%	4	2%	3	2%	3	1%	58	2%
Total recorded	945	101%	1546	100%	261	100%	222	100%	127	100%	234	100%	3344	100%
Not recorded	859	47%	1041	40%	131	33%	203	48%	23	15%	170	42%	2427	42%
Overall total	**1813**		**2587**		**392**		**425**		**150**		**404**		**5771**	



The accurate recording of ethnicity data has been a challenge for the OYL service resulting in a higher than desirable percentage of unknown participant ethnicities. Of a total 5,771 participants, 2,427 (42%) were unknown (this number was comprised of 2,240 not recorded and a further 187 not stated by the participant). In addition to this, a recent improvement to the ethnicity questionnaire has seen OYL add several additional categories. As this was finalised in July 2018, many of these categories (including Kashmiri, Arab and Gypsy or Traveller) have no entries to date.

OYL anticipates that this data will be more accurate in future reporting. This breakdown of percentages included in Table 15 includes only the recorded data to give a more representative picture of access. Chart 6 includes only the recorded ethnicities representing >1% of the total cohort.

In all services the significant majority of participants accessing each strand were of 'White British' origin totalling 77% of the participants and followed by 'any other white background' and 'Pakistani' which were both 4%. Considering 23% of those reporting ethnicity did not consider themselves to be 'white British' shows some positive in reach into other ethnic communities. The variation between services for all ethnicities was small with services ranging from 68% (Move More) 83% (Be Smoke Free) for White British participants and a maximum of 0-7% for all other ethnicities on each service.

For the service user survey the vast majority of those who responded identified as white (90%), with 86% being White UK/Ireland. This could have been due to the nature of the online survey only being available in English. However, it is positive to see that there was some representation from African (n=4), Caribbean (n=4), Indian (n=5), Bangladeshi (n=1), Kashmiri (n=1), Pakistani (n=3) and Arab (n=1) ethnic backgrounds. Overall, the survey sample was slightly less representative of ethnic diversity than the OYL population and findings may not fully reflect the experience of black and minority ethnic groups.

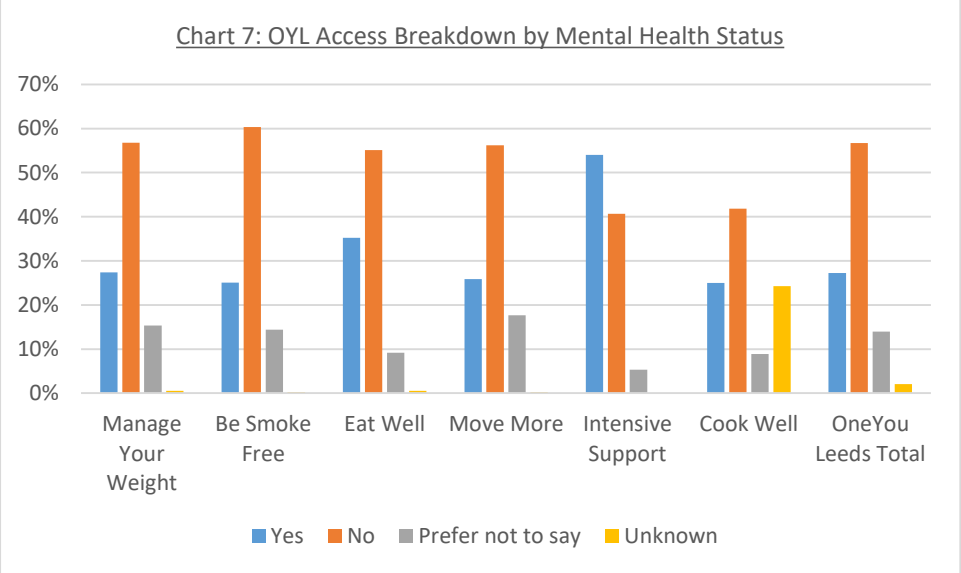
7.6 Access by Mental Health Status

Table 16 and Chart 7 show that OYL successfully engaged with participants who reported mental health conditions. When asked if they have a mental health condition, the majority of participants

selected ‘no’ (57%) but a high number (27%) selected ‘yes’ and a further 14% of participants opted not to answer the question.

Table 16: Access to the service by mental health status

Mental Health	Manage Your Weight		Be Smoke Free		Eat Well		Move More		Intensive Support		Cook Well		OneYou Leeds Total	
	Total	*%*	*Total*	*%*	*Total*	*%*	*Total*	*%*	*Total*	*%*	*Total*	*%*	*Total*	*%*
Yes	496	27%	648	25%	138	35%	110	26%	81	54%	101	25%	1574	27%
No	1029	57%	1561	60%	216	55%	239	56%	61	41%	169	42%	3275	57%
Prefer not to say	278	15%	373	14%	36	9%	75	18%	8	5%	36	9%	806	14%
Unknown	10	1%	6	0%	2	1%	1	0%	0	0%	98	24%	117	2%
Total	**1813**	**100%**	**2588**	**100%**	**392**	**100%**	**425**	**100%**	**150**	**100%**	**404**	**100%**	**5772**	**100%**



An anomaly observed in this dataset is that a relatively high number of participants were missing mental health status in the Cook Well service (24%) compared to 0-1% for all other services. This may slightly skew the accuracy of the data for Cook Well.

The highest numbers of participants reporting a mental health condition are seen in the one to one focused services which have been developed with this in mind as 54% reported ‘yes’ in Intensive Support and 35% reporting ‘yes’ in Eat Well. Intensive Support also saw the lowest number selecting ‘prefer not to say’ which may suggest that the participants guided to this service had engaged with supportive services previously and were accustomed to discussing their diagnoses.

These results suggest that not only is OYL engaging with this target group well but that these participants are also being correctly triaged into appropriate services on first contact with the PSS team. The service user respondents were not asked about their mental health status.

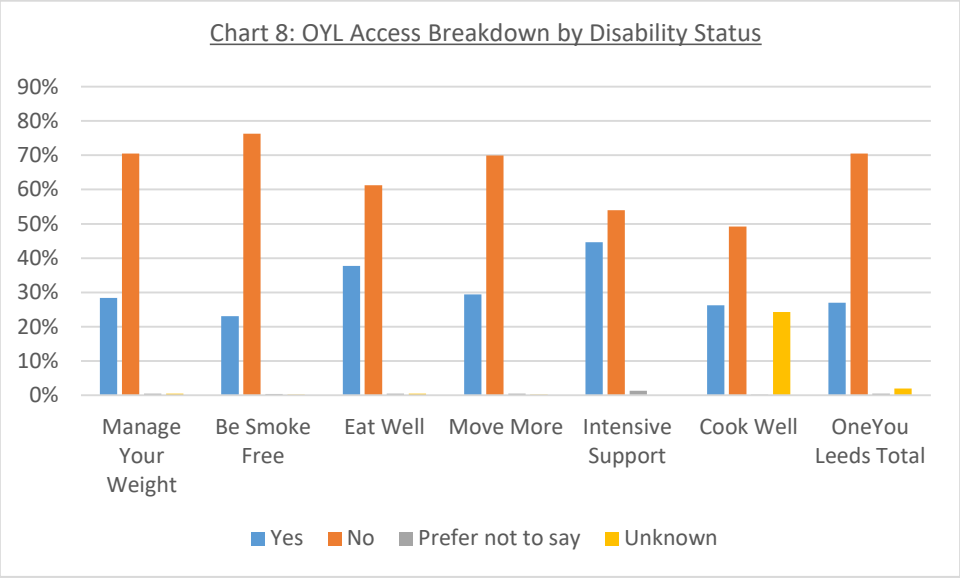
7.7 Access by Disability Status

The process for recording participant disability has also been recently updated and at the point of data collection was a generalised question with no clear definition. As such it was open to interpretation

by the participant and PSS member. On reporting a disability the data could then be sub-categorised as 'learning, mental or physical' if the participant wished to volunteer further information. As with ethnicity, the improvements to disability (such as adding further sub-categories and providing examples) were made in July 2018 and as such OYL anticipates more detailed disability demographic data in future quarters.

Table 17: Access to the service by disability status

Disability	Manage Your Weight		Be Smoke Free		Eat Well		Move More		Intensive Support		Cook Well		OneYou Leeds Total	
	Total	*%*	*Total*	*%*	*Total*	*%*	*Total*	*%*	*Total*	*%*	*Total*	*%*	*Total*	*%*
Yes	515	28%	598	23%	148	38%	125	29%	67	45%	106	26%	1559	27%
No	1278	70%	1974	76%	240	61%	297	70%	81	54%	199	49%	4069	70%
Prefer not to say	10	1%	10	0%	2	1%	2	0%	2	1%	1	0%	27	0%
Unknown	10	1%	6	0%	2	1%	1	0%	0	0%	98	24%	117	2%
Total	**1813**	**100%**	**2588**	**100%**	**392**	**100%**	**425**	**100%**	**150**	**100%**	**404**	**100%**	**5772**	**100%**



1,559 participants who attend OYL reported having a disability. As with mental health, the highest percentages are seen attending the most holistic service streams, Eat Well (38%) and Intensive Support (45%), which are intended to address barriers to change on a more one to one basis compared to the other services. This may again indicate successful triage at the first point of contact.

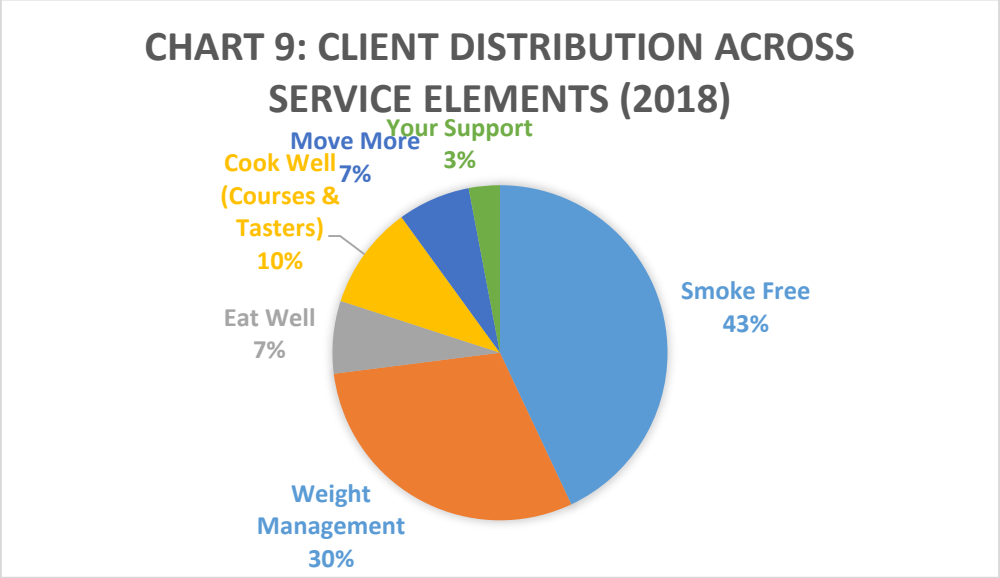
In contrast to mental health reporting, a high majority of the participants disclosed their disability status with only 27 people saying 'prefer not to say'. The fact it is low for disability, allows more accurate conclusions to be drawn from this data. It also suggests that OYL is accessible to disabled communities. In the modified questionnaires, mental health is captured under the disability question rather than being considered separately in future service monitoring. This change has been to align the monitoring with LCC guidelines.

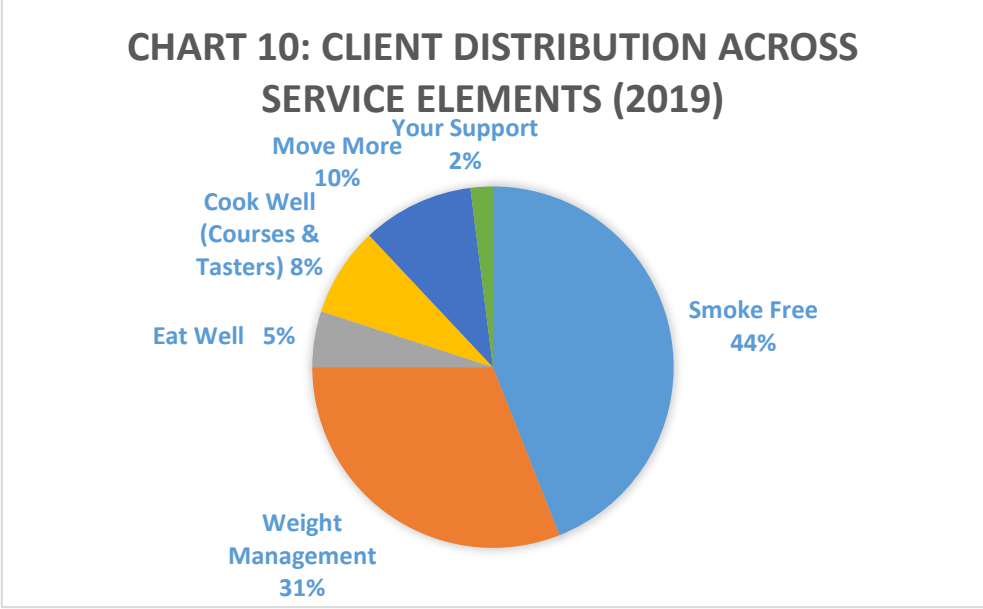
Section 8: Findings - Participant Uptake, Outcomes and Feedback

8.1 Participant Distribution

5772 individuals attended at least 1 session at One You Leeds between January and December 2018 (excluding Cooking tasters). In 2019, this remained at a very similar figure of 5,731 people attending at least 1 session.

The distribution across the different service streams is shown in the following pie charts. Be Smoke free and Adult Weight Management represent 73% of the participants accessing at least one session in 2018. The third highest was Cook Well (Ministry of Food – Jamie Oliver). Move More and Eat Well were both 7% of the accesses. However, the picture has changed somewhat in 2019. The largest change was to Move More (increasing) and Cook Well (reducing).





8.2 Key Survey Findings from Participants

The survey asked a number of over-arching questions regarding participants overall experience of OYL. **86%** (n=320/373) of respondents said they would recommend the OYL service to others. For those accessing Move More, 100% said they would recommend the service and Cook Well participants also scored very highly at 97%. Over all, across all OYL services over 81% said they would recommend the service(s) they used.

For initial access experience, over half (53%) gave a rating of 10 (10 being 'very easy') with a further 21% choosing scores of 8 or 9. The **overall mean score was 8.4 out of 10** indicating, on the whole, that they found it easy to access OYL services.

The majority of responses also scored location and timings of appointments to be convenient, generating a **mean score of 7.6 and 7.7 out of 10** respectively. Of those who said appointments were less convenient (scoring under 5), the vast majority lived in the less deprived areas of Leeds (64%/n=44; Quintiles 3-5) and 13% (n=9) didn't provide a recognisable postcode (incomplete/ inaccurate). Given the fact the service is targeting areas in quintile 1 and 2, it's understandable that venues will be less convenient for people living outside these areas.

When asked how the service could be improved, 43 people took the opportunity to say how happy they were with access to the service:

'Can't think of any improvement and keen to try other aspects of the service'

'I can't think of a way in which the service could be improved, it has been fantastic so far, convenient and staff are very helpful'

'I don't believe there are any issues that need addressing in that regard'

'I am not sure it needs to improve, I was happy with my experience of the two courses I did through them'

'I think it was easy enough to access so when you say improve, I think it's great already'

'No improvement needed for me'

'In my opinion I can't see any way you could improve it. It's a fabulous service and extremely well run'

'Can't think of any improvement and keen to try other aspects of the service'

'The service can only be described as excellent. It really helped me – thank you'

'…the service was very efficient with very supportive and helpful staff'

For those who provided suggestions to improve the service (n=134), the two main factors related to locations and appointment availability:

- **51 respondents** suggested **more locations.** A high number of these (n=34/67%) were identified as living in quintiles 1-3 whilst 27% (n=14) were quintiles 1-2. However, this does still seem to be a high number who suggest more locations.
- **40 respondents** suggested **more appointment times.** This included suggestions around *'being able to do one of the sessions at a later date in case of missing sessions for illness/ holidays'* and *'more availability for the stop smoking at each location'*. In particular, more flexible access for people who are working was mentioned, for example *'More evening options to allow people that work varied shift patterns'* and *'More appointments available*

for people working full time'. More appointments in busier locations and the need for more staff was also highlighted.

- Better communication (n=12), more advertising (n=12), *'If the public realise it is for them and free of charge. When I first read the leaflets I thought it was too good to be true. It was only because I was reviewing the Change4life campaign that I read more about OYL'.*
- Maintenance support (n=7) *'By having a drop in weigh/in place to go for advice'.*

A few others that were suggested included; different methods of contact (n=3) *'I would have preferred email as I could not always answer my phone at work',* have groups of similar types of people (n=3), and reduce staff changes (n=3).

Finally, the following suggestions were individually given; crèche facilities, fewer worksheets so it feels less like school, help people who smoke drugs too, improve record keeping, increase awareness with GPs, link with other quitters, more sessions per person, online courses, online account to keep track, non-rolling format and telephone advisors to understand Leeds geography better when advising which sessions to attend.

8.3 Participants Views of OYL staff

Staff were viewed as being very friendly overall by the respondents with an average mean score of 9 out of 10, staff knowledge was perceived as an average of 8.5 out of 10 and finally helpfulness was perceived as 7.9 out of 10.

In terms of impact, the majority of respondents felt the service had helped them to make positive lifestyle changes. 47% (n=151) said they had been able to make positive changes and for a further 28% (n =91) that they could maintain them too. Only 16% (52) felt that there was no impact and 13% (n=42) said they had made positive changes but were unable to sustain them.

'I have not been so breathless since I stopped smoking'

'I've picked up small amounts of information that I did not know before'

'I have lost weight and my HbA1c results have improved dramatically'

'I have made some new friends'

'I have made friendships within the group and I enjoy the company'

'It helped me see it's not going to be a quick fix'

'Loss of waist circumference'

However, for those who were unable to sustain changes, there needed to be something more to keep them motivated.

'Started smoking again after 2 months'

'I made some positive changes but had to join slimming world to keep myself motivated'

'I was able to make some positive changes in the beginning but I've not been able to sustain them and might go back to where I was'

'It had impact whilst there but returned to the weight I was and bad habits straight away'

The following table also shows the breakdown for respondents for the service streams of OYL that they engaged with. The largest majority attended for the Adult Weight Management programme (54%).

Table 18: Survey responses for service accessed

Which part of the service have you accessed **(select all that apply)**	Respondents % (n=)
Adult Weight Management	54% (177)
Be Smoke Free one to one sessions	25% (81)
Eat Well one to one sessions	11% (36)
Cook Well (Ministry Of Food)	10% (33)
Move More physical activity sessions	8% (27)
Your Support one to one sessions	6% (21)
Self-help via OYL website	8% (26)
Other	6% (19)
Total Responses	328

57% (n=184) of the survey sample said their reason for engaging was to lose weight, whilst 45% (n=145) stated their reason being to improve their diet. Despite the service being focused on lifestyle changes, still nearly a quarter wanted to improve their mental health and wellbeing demonstrating how they see the two are connected.

Table 19: Survey responses for reasons/ motivation for engaging

What was your reason/ motivation for engaging with the service **(select all that apply)**	Respondents % (n=)
I want to lose weight	57% (184)
I want to improve my diet	45% (145)
I want to improve my all round health	37% (121)
I want to get fitter/ more active	36% (117)
I want to give up smoking	25% (81)
I want to improve my mental health and wellbeing	22% (71)
I want to improve my cooking	11% (37)
My referrer suggested I make contact	5% (15)
Other	2% (8)
Total Responses	325

8.4 Be Smoke free

8.4.1 Participant uptake & outcomes for stopping smoking

In 2018, **1416** participants set a quit date with an OYL coach through the service. Of these, **856** (60%) participants quit smoking (measured at four weeks). An additional small number of pregnant women also accessed the service and quit smoking where home visits were also provided.

The majority of the stop smoking support across the country is provided on a one to one basis similarly to OYL. Some evidence shows that group support can also be effective at achieving high quit rates. As OYL only operates one group per week, this is something to consider. This is also suggested by participants which is highlighted under their feedback section below.

The service have been following up participants who quit smoking at 3, 6 and 12 month time points. Continuous abstinence for 12 months is a good predicator for long term abstinence, and from January to December 2018, a total of 531 people (62% of the four week quits) were successfully followed up at 12 months. Of these, 48% were still not smoking (n=255). Measuring long term abstinence is resource intense so it is commendable that 62% were successfully followed up at 12 months post intervention. Studies that have collected 52 week follow up data from UK stop smoking services have mixed results ranging from 6% - 56% 12 month abstinence, therefore it is also encouraging to see that 48% of this large sample were still abstaining from smoking.

Table 20: Monitoring Overview for the Be Smoke Free Service

Smokers (not including pregnant)	Jan - Dec 2018	Jan - Dec 2019
Number of quit dates set	1416	1355
Number who were quit at 4 weeks (%)	856 (60%)	851 (63%)
% confirmed by CO reading	92%	89%
Number of 4 week quits followed up at 12 months	531 (62%)	
Number still not smoking (%)	255 (48%)	
Pregnant only	Jan - Dec 2018	Jan - Dec 2019
Number of quit dates set	128	88
Number who were quit at 4 weeks (%)	45 (35%)	49 (56%)
% confirmed by CO reading	94%	91%
Number of 4 week quits followed up at 12 months	25 (55%)	
Number still not smoking (%)	11 (44%)	

8.4.2 Participant feedback

81 of the 328 survey respondents had accessed the Be Smoke Free service. Over half (60%) of these respondents said they had attended all their stop smoking sessions. Only 17% had attended less than half of the sessions.

69% of respondents said they were still not smoking at the time this survey was shared (15% reduced smoking, 7% started smoking again, 9% had continued smoking as normal). When asked what helped them to quit, the most common answer was the OYL coach advice and support (66%). The second most common reason was being able to access NRT directly (45%).

Table 21: Support that helped them quit smoking

What helped you quit/ reduce smoking? (tick all that apply)	Respondents % (n=)
OYL coach's advice and support	66% (45)
Direct access to NRT (patches etc.)	45% (31)
Other	28% (19)
Friends and family support	16% (11)
E-cigarettes	7% (5)
Doctor/ nurse's additional support	4% (3)
Total Responses	68

The majority of 'other' responses specified Champix (prescribed medication for quitting smoking), with one respondent highlighting that their wife had helped them.

Those who hadn't quit smoking or hadn't attended all the sessions were also asked how the programme could have supported them better. A number of people talked about the programme itself suggesting more regular and sustained support, the ability to have an ad hoc appointment when needed, and group sessions rather than just one to one.

'I feel that more regular visits would have been helpful. However, as the support network is stretched so thin, I was finding that my appointments were sporadic'.

Whilst many found the direct supply of NRT from a coach helpful, some felt that this could be a barrier if they couldn't see a coach for some reason. The ability to go straight to a pharmacy for NRT might help to avoid running out of tablets.

Some also mentioned reasons more personal to themselves and current situation such as illness or not feeling like they needed the support *'I felt I'd made sufficient progress by the time I left'.*

Other reasons provided were due to:

- Not feeling supported by the coach 'I *felt that the support just wasn't enough. The person operating it was stretched to her limit', 'I felt that I was not getting the support I needed because he did not like the fact I would not use Champix'.*
- Access difficulties *'No time slots available' and 'Time and place'*.
- Being discharged from the service *'She felt I was not motivated to quit and felt it was no use to continue the sessions after the first one'*.
- Not using scare tactics *'that I wouldn't be allowed to continue if I had one puff of a cigarette'.*

8.4.3 Section Summary

There is a high demand for stop smoking support in Leeds with it constituting nearly half of the OYL services delivery for both 2018 and 2019 (40% of first accesses). The service does appear to be having some capacity issues with meeting the demand with key themes coming through the consultation around a shortage of sessions and support. To really make a difference to smoking rates in Leeds, it is necessary to scale up capacity both within OYL and the wider system where possible. This could be achieved through more creative solutions to increase efficiency of the service provision through digital approaches and increase group/ drop in support. It may be worth considering the role of primary care (GP and pharmacy) when it comes to supporting smokers to quit.

There is also some inconsistencies in participant experiences with their coaches. Whilst many said this was a key strength, there were others who commented that they didn't feel supported. Some constructive suggestions were made around increasing the availability of group sessions and

considering longer term peer support to remain a non-smoker**.** A few concerns were highlighted relating to the feeling that Champix was the only option which will need looking into further. Positively, the 12 month follow ups are demonstrating some longer term abstinence and the service is very proactive at keeping in contact with previous participants.

Only 7% of participants that responded to the survey indicated e-cigarettes as part of their quit attempt, however national surveys consistently show e-cigarettes as the most popular quit smoking aid. Furthermore a recent trial by Queen Mary University of London showed that e-cigarettes were twice as effective as NRT at helping smokers quit and remain abstinent from smoking tobacco long term when used with behavioural support. A growing number of areas are utilising the popularity and effectiveness of e-cigarettes within their services and there are plans for Leeds to trial e-cigarettes within the service.

8.5 Weight Management

8.5.1 Participant uptake & outcomes for weight management

In 2018, **1239** people attended at least one session of the Weight Management 12 Week Course and678 completed (defined as attending at least 8 sessions) completed the course, of these, **over 80%** lost some weight. In 2019, the number attending increased to **1322**. The below table shows data from January to December 2018 as well as comparing April to September for 2018 to 2019 (it is not possible to compare to 2019 past September due to the length of the programme). These time periods were included to see the most useful data comparison.

Table 22: Monitoring Overview for Weight Management

	Jan to Dec 2018	Jan to Dec 2019	April to Sept 2018	April to Sept 2019
Getting Started session	1792	1790	1012	936
Attend 1 session of course	1239 (69%)	1322 (74%)	782/ 77%	704/ 75%
Attend min of 8 sessions	678 (56%)	NA	399/ 51%	**433/61%**
Attend 8 sessions & lose weight	560 (83%)	NA	332/ 83%	**376/ 87%**
Attend 8 sessions & lose 5%	174 (26%)	NA	95/ 24%	**106/ 25%**
Number successfully contacted for 12 month follow up (completers only)	NA	NA	213/ 64%	
Number with sustained weight loss at 12 month follow up (weight loss from baseline)	NA	NA	146/ 68%	
Average weight loss (self-reported) since baseline weight of those sustaining weight loss	NA	NA	6%	

It can be seen that the service has improved retention and short term weight outcomes when comparing 2018 to 2019. Whilst the uptake is slightly lower, the numbers completing is higher. The percentage attending more than 8 sessions has increased by 10%. The number of people who attended more than 8 sessions who achieved a 5% weight loss also increased. So although the 2018 annual retention was 56%, this has improved significantly since the service has become more established. It is also worth noting that other research has used lower thresholds when defining retention. For example, only half the scheduled sessions needed to be attended to count as a completer in the previously referenced PHE uptake and retention review. With OYL, a completer is defined here as attending at least 8 of the 12 sessions.

Whilst other behavioural factors relating to physical activity, food intake and wellbeing are also measured at both baseline and at the end of the course, these will not be reported here. At the moment, wellbeing is not measured at the 12 month follow up point. However, this is something that should be considered in future monitoring and reporting considering the emerging importance of this in relation to weight. Furthermore, the emphasis on weight loss as a performance indicator may need to be reconsidered in light of newer evidence since the service specification was developed. Whilst the programme appears to be largely effective at supporting weight loss, it is questionable whether this should be the main factor for deciding whether the intervention is successful or not. There should be a greater emphasis on retention, participant engagement and satisfaction, evidence of co-production and quality marking indicators.

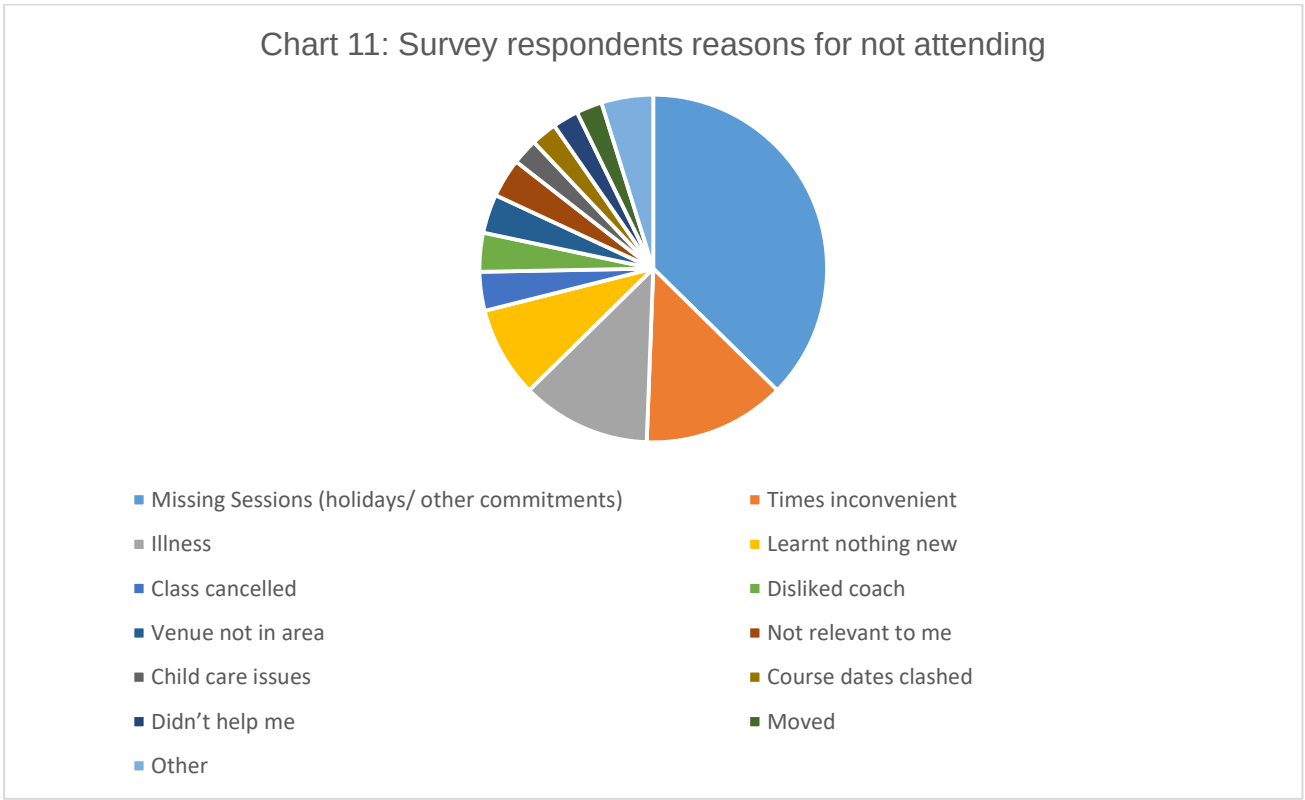
8.5.2 Participant feedback on weight management

As stated earlier, there was a very high response from the service user survey for participants attending weight management (n=177 respondents). These participants were asked how many sessions they attended. 34% had attended all the classes, 39% had attended most (more than 6), 7% attended half (6 classes), and 20% had only attended a few (less than 6).

Where a participant had stopped attending, they were asked if they could provide a reason for this. Reasons given were as follows;

- Missed due to holidays/ other commitment (n=31).
- Inconvenient times, particularly due to work (n=11) worth noting that all these 11 people were all living in the less deprived quintiles.
- Illness (n=10).
- Learned nothing new (n=7).
- Class cancellation (n=3).
- Didn't like the coach (n=3).
- No places in my area (n=3) worth noting that all 3 participants were living in quintile 4 (again less deprived area).
- Not relevant to me (n=3).
- Child care issues (n=2).
- Course dates clashed (n=2).
- Didn't help me (n=2).
- Moved (n=2).
- Other individual responses included; not losing weight, lack of confidence in a group of strangers, problems with session planning and not being contacted following an initial session.

Chart 11: Survey respondents reasons for not attending

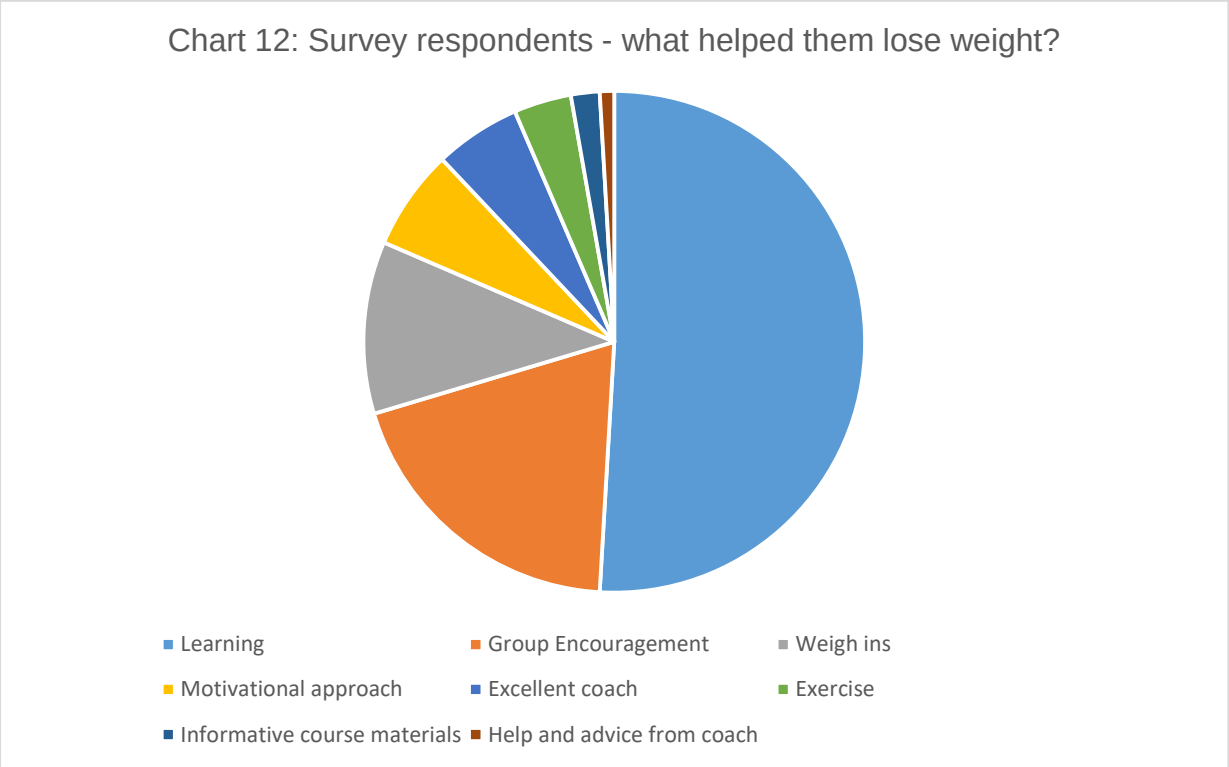


The reasons for stopping attending were mixed between intrinsic individual factors and by some that could be minimised/ controlled to some degree by OYL. The most common reasons were due to missing sessions because of holidays or other commitments, inconvenient times of sessions and illness. There seems to be a theme that in general, life commitments can make attending a 12 week course challenging when juggling family, work etc. Some people felt that they were learning nothing new. Others mention their coach being an influencing factor. An issue with venues being out of their area was mentioned however all these participants were living outside the target areas.

62% of those responding said they had lost weight, 33% said they had maintained their weight whilst 6% felt they had gained weight.

Conversely to the above, those who lost weight were also asked what helped them.

- Learning (n=55)
- Encouragement in group setting (n=21)
- Getting weighed (n=12)
- Motivational approach (n=7)
- Excellent teacher (n=6)
- Exercise (n=4)
- Informative course materials (n=2)
- Help and advice from coach (n=1)



When asked about their challenges when attempting to lose weight, the biggest challenge was avoiding temptation.

- Avoiding temptation (n=30)
- Sustaining a healthy diet (n=13)
- Exercising (n=10)

- Social eating (n=8)
- Swapping to healthier options (n=7)
- Cutting down portion sizes (n=6)
- Thinking about what I was eating/ making time (n=6)
- Sticking to the programme (n=4)
- Cravings (n=3)
- Difficult to make changes with family (n=3)
- Medical issues (n=3)
- Mental health issues (n=3)
- Calorie counting (n=2)
- None (n=2)
- A few people also said, eating enough without starving (n=1), felt I was supporting others but getting nothing back (n=1), missing classes (n=1), stopping binge eating (n=1).

When asked how confident they felt about maintaining their weight loss from very unconfident as 0 to very confident as 10, the mean score was 6.3 out of 10. Along with the list of challenges above, this shows some hesitance in participants in saying they are confident. Although there were some people stating high scores, with 41% giving a score between 8 and 10, there were also 23% scoring a 4 or below.

Most people stated reasons personal to them for finding barriers to weight loss rather than viewing it as issues with the course itself. A high number of people also stated that 'other health issues' make it difficult for them to lose weight. These included chronic illness and medications (steroids), low vitamin D, mental health issues including stress, conditions that physically make exercise difficult (e.g. arthritis, back problems) and stopping smoking leading to weight gain.

Another frequent factor was dietary issues, including an emotional relationship with food, challenges with working on portion size, someone else cooking and needing a meal plan. Lack of exercise was recognised as a factor as were wider life issues. One participant mentioned fighting against entrenched habits and the yo-yo process of weight loss/ gain. Another felt they had inaccurate expectations of what the course would involve.

It does suggest that perhaps the course content needs to consider these issues in the delivery to increase the level of support participants feel with these. For example, an increased focus on generating peer support embedded within the approaches could be helpful.

However, a number of people said they were very happy with the course;

'Support was good'

'I have all the support I've needed'

'Gave lots of support, ideas and suggestions'

'I don't feel that the programme could have helped me anymore at the time… I still try to adhere to the message I learned so something good came out of it'

Some people did give some specific suggestions relating to improving the course. These included, a need to address emotional eating, could provide recipes or exercise classes, smaller groups, problems with scheduling, improving the course environment and again inconsistencies in effectiveness of the coaches was mentioned. For people who gained weight, again health issues

were given as the main challenge such as hypothyroidism and medication for bipolar disorder. One person commented that '*I think it has been overwhelming to realise how many things I do wrong'.*

Other reasons included being a wheelchair user, needing a more strict approach, lack of understanding the information, lack of continuity, general lifestyle such as late meetings after work and difficulties changing eating habits.

8.5.3 OYL staff

Similarly to some participants, a non-rolling group format for Weight Management was also suggested by staff. It was commented that a rolling programme format can make it more difficult to retain participants. As people don't start/finish at the same time, they are less likely to form bonds with each other. **Recipe books** e.g. for the Weight Management service – that's what participants want.
New ways of engaging e.g. virtual interaction; online sessions; self-help encouragement.

8.5.4 Section Summary

Overall the Weight Management programme is supporting a number of people to lose weight and is viewed positively by those who have attended it. Key strengths appear to be offering the opportunity to learn, being in a group setting to support each other and the weekly weigh ins. However, there does seem to be some inconsistencies in the way this is delivered in terms of the coach's approach and also how the group is set up. A lack of appointments to meet the need at certain times has caused groups to be over subscribed. There is a question over whether the service is able to meet the high demand for weight management support. The fact that the service is driven towards certain post codes can also be seen as an issue to those living outside these areas.

It is also very clear that existing health problems (both physical and emotional) are major barriers to losing weight as well as entrenched habits that are difficult to change. Avoiding temptation and changing eating habits is challenging in the current environment which also needs to be considered. The course content and delivery would benefit from a review in relation to this feedback. Whilst losing weight and eating healthier to improve health seems to be the main driver for engaging in a OYL programme, at the same time there seems to be a real challenge to change relationships with food and overcome barriers created by health conditions.

8.6 Cook Well with Ministry of Food Leeds (subcontracted to Zest)

8.6.1 Participant uptake & outcomes for cooking

Zest have been delivering the Ministry of Food (MoF) cooking programme for many years in Leeds. Prior to One You Leeds, it was a single standalone service. On contract award to Reed Wellbeing, it was agreed that Zest would continue to deliver the cooking part of the contract as a sub-contracting arrangement with Reed Wellbeing. Leeds City Council is responsible for managing the Jamie Oliver Group, Ministry of Food License to govern the use of the Ministry of Food model, which for the purposes of the OYL contract is referred to as "Cook Well with Ministry of Food Leeds".

The performance indicators weren't entirely the same in the new contract, but similar enough to make comparisons. The major change in service provision within the new model is the delivery of offsite cooking course within deprived communities as well as from the MoF Cooking Centre based in Leeds Kirkgate Market. This new model supports better accessibility for deprived communities and greater opportunity to align service elements to deliver in the community.

In 2018, Zest delivered 76 courses with 399 starting and 303 completing. Overall, this demonstrates an increase when comparing with the 2015-16 annual report (375 starting – 215 completing). Numbers of participants completing the course is much higher than it was in the comparison year. This may demonstrate the value to incorporating cooking into a health and wellbeing service.

The number of courses also increased from 56 to 76, however additional courses were not required to be delivered to meet demands. Moving forward the service is aiming to maintain an average of 62 courses per year focusing on increasing attendance on the planned courses.

Overall, more people appear to be completing the courses and the service is continuing to run effectively as part of the integrated service. It is also worth highlighting again from the previous section that 19% of Cook Well participants living in more deprived areas and 17% of the less deprived also attended the adult weight management programme. This shows a good level of integration between adult weight management and cook well. A lack of confidence in cooking healthy meals can be a barrier to eating healthier and losing weight. Previous work reviewing the outcomes data participants who access MoF following a Weight Management programme has shown that the participants achieve more substantial behaviour changes i.e. more likely to consume the recommended 5 a day of fruit and vegetables, reduce unhealthy snacks, change to more healthier meals. Cooking skills programmes have the unique ability to influence dietary knowledge, attitudes and behaviours. Cooking courses are able to promote healthier eating key messages in a way that is meaningful to people's daily lives.

Table 23: Monitoring overview for Cook Well with Ministry of Food Leeds

	Single Service (2015/16)*	As part of OYL (2018)
Started Course	375	404
Completed Course	215 (57%)	303 (75%)
Average number starting	5.6	5.25
Number of Courses	66 (includes follow on courses)	76

*Data taken from a Ministry of Food Annual Report by Zest

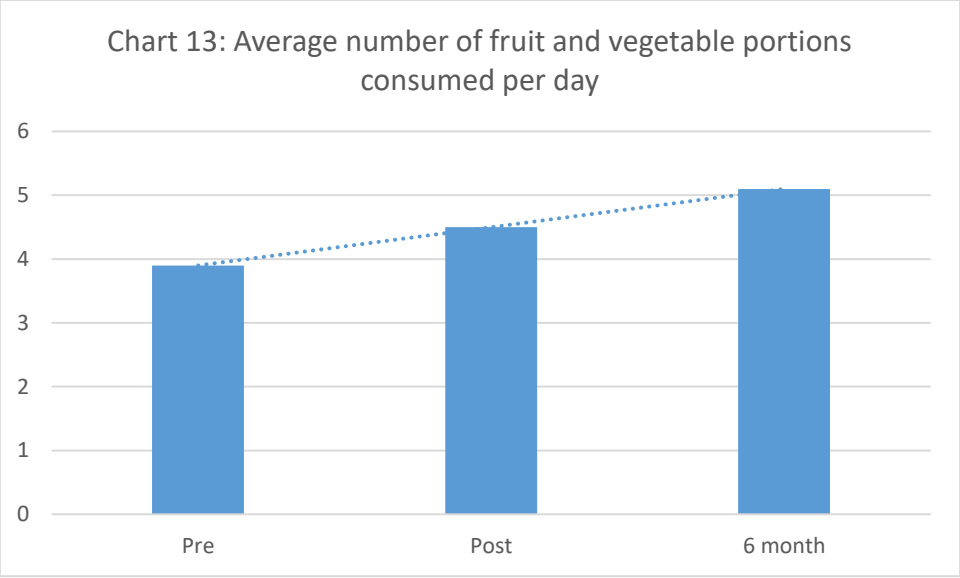
The above table shows a similar number of people starting the courses and an increase in the portion of people completing the courses. At present some courses are being cancelled due to not having enough numbers to run all the planned courses.

An average of 5 people starting is low compared to the potential numbers that could be accommodated onto courses maximum of 8. This also means that courses can be at risk of not completing if they suddenly have a high dropout rate. There is therefore scope with Cook Well to book more people on the courses and some unused capacity at present. Greater integration with other aspects of the programme would support increased attendance. Greater promotion is required due to findings from the health professional's survey which highlights that there is a lack of knowledge around the cook well offer.

Fruit and vegetable consumption and confidence to cook is measured for Cook Well participants at the start, end and 6 month follow up. The service dedicates time to following up participants. The table and graph below show how this increases at each time point.

Table 24: Average number of portions of fruit and vegetables consumed per day (Jan-Dec Cohort of 291/303 successfully followed up):

Time point	Average Portions per day
Pre-Questionnaire	3.9
Post- Questionnaire	4.5
6 month Follow up	5.1



8.6.2 Consultation feedback on cooking

10% of the survey respondents had attended a Ministry of Food cooking course which is reflective of the One You Leeds population which is also 10% attending cooking. Cook Well was rated very highly by participants with all 100% saying they would recommend the programme to others. An in depth review had already been completed on the Ministry of Food programme in 2014

http://eprints.whiterose.ac.uk/102844/3/repository.pdf. This concluded that MoF community based cooking interventions can have significant positive effects on dietary behaviour, food choice and cooking confidence which is mirrored by the performance data.

Four Zest staff participated in the staff survey. Cook Well was also rated very highly across the One You Leeds staff with 67% (10 out of15 staff) saying it is 'very effective' and 27% (4 out of 15) saying 'somewhat effective'. Fifty four percent of staff say they actively cross refer to cooking (7out of 15) which is good but has some room for improvement. The majority (51%) of health professionals said they would signpost to One You Leeds for cooking. However awareness did seem lower for this element with 17% saying they weren't sure which was the service professionals were most unsure where to signpost.

Additionally, it was ranked the lowest by professionals in terms of participants needing support along with healthier eating. It could be because participants are less likely to go to health professional asking for help with cooking specifically. It therefore does seem to work well when integrated with other healthier living interventions like weight management and there is good evidence to support Cook Well staff referring into different element Eat Well and Weight Management and vice versa. It does emphasise the importance of maximising opportunities to promote the service with OYL participants and cross referring internally. More work could also be done in increasing health professional's awareness of the programme as well as its effectiveness as being part of the One You Leeds service.

8.6.3 Section Summary

Cook Well with Ministry of Food continues to demonstrate significant behaviour changes to support healthier eating. The course attendance figures show that more work needs to be done to promote the service and increase numbers starting on courses. This could be improved by better promotion of the service, particularly in acknowledgement that health care professional feedback that shows that there is limited awareness of the service.

The Ministry of Food programme has a strong brand supported by the status of Jamie Oliver. This could be capitalised on better especially as the service approaches its 10th anniversary in Leeds.

The service shows good retention of participants and improved completion figures compared to the previous year which highlights that the service is viewed favourably and the course is accessible, acceptable and appropriate to meet that range of participants.

The participant evaluation has shown that Cook Well is viewed as an effective service which would be highly recommended. This has also shown that a large number of participants access the OYL service to lose weight (57%) or to make changes to their diet (45%). It would be valuable to promote the range of offers available to participants to support with these objectives i.e. promotion of Weight Management, Eat Well and Cook Well offering a range of support services.

In regards to feedback noted from OYL staff in regards to managing complex nutritional needs that working relationship that MoF staff have with Leeds Community Health Care dietetics could be strengthened to support information sharing and trouble shooting. MoF staff are required to get dietetics support as a term of the Jamie Oliver Group license.

8.7 Eat Well

8.7.1 Participant uptake & outcomes for healthier eating

The Eat Well service stream provides one to one coaching over 6 sessions specifically focused on improving eating and drinking habits. The focus of the sessions will depend on the client's goals. Some participants may also have goals around wanting to lose weight however they will not be weighed on this programme. In 2018, 392 people accessed the Eat Well programme which is a similar number to both Cook Well and Move More.

Table 25: Monitoring overview for Eat Well

	Jan - Dec 2018	**Jan – Dec 2019**
Attend at least one session	392	285
Attend 4/6 Sessions	181**(46%)**	179 **(63%)**
Number with a recorded fruit and veg score who received a 12 month follow up	85/181 **(47%)**	NA
Number with **increased** fruit & veg score from start to 12 months	57/85 **(67%)**	NA
Average change in fruit & veg score	+ 1 portion	NA

Please note that follow up outcome data is not yet fully available for 2019.

For January to September 2019, 160 out of 232 people (69%) completed the Eat Well service showing a large improvement in the services ability to retain participants since 2018. There has however been a reduction in the numbers deciding to sign up for the Eat Well service in 2019. This could be due to a reduction in sessions and staff provision dedicated to this service stream.

Preliminary data on fruit and vegetable intake shows an average increase of 1 portion per day from starting Eat Well to 12 month follow up (baseline= 4 per day to 12 month=5 per day). There is a trend whereby it increases at each time point reaching its highest at the 6 month follow up, and then showing a slight decline at 12 months.

8.7.2 Consultation feedback on healthier eating

In the survey, 81% (n= 29) of Eat Well participants said they would recommend this service. Overall, there were 36 survey respondents who had accessed this service (11%). Additionally, there were six Eat Well participants involved in the in depth interviews. Two of these were referred from Cook Well to Eat Well and a further two were referred from Eat Well to Cook Well showing some good integration between these two services. Similarly to the Weight Management service, for these participants, the main driver to engage with Eat Well was to lose weight. Furthermore, there were also additional health reasons motivating them. Mental health concerns were an issue for participants and contributed to their struggle with food.

'I don't feel good about myself. I will eat a bag of sweets instead of an evening meal… (the coach) is giving me psychological support, not just food advice'

Whilst four participants shared having had experience with Weight Watchers and Slimming World in the past, the OYL programmes were preferred.

'Weight Watchers and Slimming World are too restrictive, they just concentrate on food and I want something different'

Furthermore, participants with learning difficulties *'don't get the concept of calories and syns used in Slimming World'*. For them the added benefit was that Eat Well is free which was helpful considering their finances could not stretch to membership fees.

With regards to the resources, Eat Well participants said;

'It has loads of useful information and diagrams so you can see different things at a glance. It's a very good reference'

'(Coach) listens to what is important and tailors what we talk about to that using the handbook. For example, we looked at snacking and found out about better choices'

Two Eat Well participants had learning difficulties and one had physical disabilities. All had a very positive experience with Eat Well.

The two participants with learning difficulties attended their sessions with a support worker. They both liked the coach who really got to know them and it was very personal for them. The coach adapted to accommodate her participants' needs and they enjoyed the one to one attention:

"[Coach] took time and patience and made it an enjoyable experience for both of them."

"Both have chocolate addictions and go overboard for bread but [Coach] helped them with coping strategies so that they could go into town and not buy chocolate."

"[Coach] has been fantastic, absolutely brilliant. She has answers for me. She emails me leaflets and information and has put me in touch with people who know about people who aren't mobile."

"I would 100% recommend [Coach]. She is knowledgeable, she listens, she answers questions with empathy and compassion and understood where I was coming from. She has lived up to her promises and her conversation is very easy – she explains things very clearly."

8.7.3 Section Summary

The flexibility of the Eat Well option has provided an alternative option to the core weight management programme. It's particularly helpful if someone would like to manage their weight better and eat healthier but not necessarily have their weight monitored. It has been delivered in a client focused way and resources are easily adapted. It works particularly well for people with learning/ physical disabilities who need tailored support for eating healthier. On the other hand, there has been limited capacity in this service stream as can be seen in the reduction in sign-ups from 2018 to 2019. Additionally, there is no group support around eating well. A recommendation would be to consider whether interactive/ practical group support sessions could be made available.

8.8 Move More

8.8.1 Participant uptake & outcomes for physical activity

The physical activity component was developed a little later into the contract and only fully commenced in April 2018 as only 5 participants accessed the programme before then. A total of **425** participants attended at least one Move More session in 2018, mostly from April to December (n=420). The below table shows numbers who attended an assessment, engaged with the physical activity sessions (attended at least 1), attended more than 4 physical activity sessions (defined as a completer), and some outcome data. The service uses the International Physical Activity Questionnaire tool (IPAQ) for measuring change in physical activity. Participants are asked to complete at first assessment, on completion and also at 6 and 12 month follow up.

Table 26: Monitoring overview for Move More

	Jan - Dec 2018	**Jan – Dec 2019**
No of sessions run	222	422
Attend one to one Assessment	425	566
Engage with Group Sessions	247 **(58%)**	397 **(70%)**
Attend 4/6 Sessions* (July to Dec only)	141/182 **(77%)**	
Number **contacted** with IPAQ score at 12 months since starting	105/190 **(55%)**	
Number with **increased** IPAQ score from start to 12 months	71/105 **(68%)**	

*this is only representing data collected for participants starting between July- December 2018. This was due to changes in the KPI's that were introduced later in contract.

The one to one assessment involves completion of a Par-Q as well as a discussion on options available and personal goals. It may be identified that a referral to Active Leeds Health Programmes is more appropriate for the participant. However in 2019, with service developments, and additional training for the Move More coach, the service is able to support a higher portion of participants. The service doubled the number of sessions they ran for Move More in 2019 when compared to 2018. Move More has a very high number of participants attending more than four group sessions at 77%. Furthermore, a high portion of the 12 month follow up participants are still more active than they were at the start (68%).

8.8.2 Consultation feedback on physical activity

Move More was highly regarded by the survey respondents with 100% saying they would recommend the service. 8% (n=27) of the participant survey respondents had accessed this part of OYL. In the in depth interviews, there were three Move More participants. It's noteworthy that none of these participants were signposted to any other longer term activities. One of these attended due to having diabetes and mental health issues. However, the other two appeared to already be physically active and were attracted to the service for the free sessions. They also voiced some concerns that they may have been making up the numbers. This perception seems to conflict with the aims of the Move More programme. However, it is difficult to draw conclusions on just a few people's perceptions. The physical activity component may need further review.

8.8.3 Section Summary

The evaluation of Move More suggests OYL are delivering a quality physical activity offer that participants find engaging and effective, leading in the majority to increased maintenance of physical activity. However in comparison to other aspects of the OYL offer, Move More lacks sufficient qualitative information with which to make meaningful assumptions about if and how the current service offer could be improved. To address this, a further review of the Move More offer should be considered in respect of the wider system availability of physical activity opportunities. Since the completion of this consultation, a local consultation has been taking place in Leeds around physical activity, 'Get Set Leeds'. One You Leeds have been contributing to the development of this consultation. There may also be some learning from the 'Get Set Leeds' work which could also be utilised for any OYL service developments around physical activity.

8.9 Your Support (Intensive personal support – IPS)

8.9.1 Participant uptake & outcomes for Your Support

Your Support is the OYL branding which is referred to as intensive personal support in the service specification. It was commissioned for participants with more complex needs who may not be ready to make sustainable lifestyle changes. It is completely dependent on participant need and the most holistic of all the service streams. The main focus is on improving the person's emotional wellbeing and increasing self-efficacy to make changes. It may also provide a stepping stone into one of the other OYL services. However, behaviour change could result across any of the areas from this support.

150 people accessed the Your Support option throughout 2018 making it the least used service stream. Furthermore, this number saw a drop to 117 in 2019. The follow up rate seems particularly low for Your Support compared to other service streams when comparing numbers who initially access to those are successfully followed up (21%). However, of those who are followed up, 91% still show an increase in wellbeing when comparing baseline scores to those reported at 12 months. To measure change in wellbeing, participants are asked questions using a wellbeing measure (WHO-QOL). These are as follows;

- How would you rate your quality of life? (very poor, poor, average, good or very good)
- How satisfied are you with your health? (very dissatisfied, dissatisfied, average, satisfied, very satisfied)

These questions are also asked for other OYL service streams with the exception of Cook Well. However, whilst the service can monitor impact, this is only currently reported for Your Support.

Table 27: Monitoring Overview for Your Support

	Jan to Dec 2018	Jan to Dec 2019
Number accessing Your Support	150	117
Number of successful 12 month follow ups (%)	32 (21%)	
Number who increased wellbeing at 12 months (from start)	29 (91%)	

The next table shows examples of the types of needs some participants had when accessing Your Support, the variation in how many appointments were needed and what programme they were being supported to access. The information captured below are the participants who accessed Your Support between October and December 2018. 8 of the 15 participants (53%) only required a small number of appointments (ranging from 1 to 4) before being able to access other internal OYL services. Only two participants needed more than four sessions. **This suggests that this service stream is actually more of a light touch support than an intensive option. It provides an initial first step to help prepare participants to access and move onto more intensive support services.**

Table 28: An example from Oct - Dec 2018 of participants needs when attending 'Your support'					
	M/F	Age	Number of Appointments needed	Supported to access...	Additional support needs
1	M	54	1	Diabetes Team	Type 2 Diabetes
2	F	78	2	National Diabetes Prevention Programme	Depression
3	F	55	1	Shantona	Stress
4	M	71	2	Diabetes Team, Andy's Man Club	Depression, Type 2 Diabetes
5	M	22	1	Cook Well	ADHD, Autism
6	M	52	2	Manage Your Weight	ESOL
7	F	54	2	Manage Your Weight	ESOL
8	F	59	6	Diabetes Team	Insomnia, Type 2 Diabetes
9	F	55	3	Tier 3 specialist weight management	Type 2 Diabetes
10	F	62	5	Counselling Services	Stress, Anxiety
11	M	45	3	Eat Well	Learning Difficulties
12	F	45	1	Eat Well	N/A
13	M	48	4	Manage Your Weight – Tier 3 specialist weight management	ESOL, Depression
14	M	37	3	Move More	N/A
15	F	32	1	Manage Your Weight, Move More	N/A

8.9.2 Consultation feedback on 'your support'

In the survey, 6% (n=21) of participants had accessed this service stream and 81% (n=17) said they would recommend it. This is reflective of the small numbers who access this service stream when compared to other more specific OYL services. However, 'Your Support' was the only service stream to have OYL staff ranking it as 'not very effective' (14% of respondents, n=2). At this point in time only one coach was delivering this service stream, which could have effected other staffs interpretation of the element. It's also worth noting that this service stream is not actively promoted by OYL, with no mention of it on the website or direct external referral pathway into it. Participants would only become aware of this option when talking to the Programme Support team.

8.9.3 Section Summary

Participants who access this element rate it highly, but there can be some confusion within OYL on what the role and function of this element is. It is not currently actively promoted as an option.

Whilst the service model identifies this element as a more intensive support option for people with additional or more complex needs, in reality it acts more as a light touch 'first steps' into the OYL service. It is the least accessed part of the service, and yet the most flexible of the elements with very few KPI's. It's the only element that does any follow up for emotional wellbeing, but has the lowest follow up success rate. This may also reflect the lack of clarity over the role of this element. There would appear to be a benefit to retaining this element but developing the idea of it being a light touch option that facilitates engagement for people with lower initial self-efficacy. This element requires further service development and review. It may benefit from some revisions in the service specification and KPI framework. Coaches could have more clarity if they were directly involved in delivering this. It would be worth considering if this should be offered as part of all the coaches delivery as a first step into the service when an individual is identified by programme support as having lower self –efficacy/ more complex needs. All staff could be trained to deliver this with a portion of one to one sessions within their diaries. This could be a mixture of face to face, or remote delivery. Additionally, it would be beneficial to also consider promoting this as an option through the website and other promotional materials. Wellbeing should be captured at follow up for all service elements.

Section 9: Findings – The Value of an Integrated Service

9.1 Introduction

In order to evaluate the value of having an integrated healthier living service, it is important to consider how many people utilise the integrated nature of the service. The following data considers the numbers of participants who attended more than one service stream for OYL for 2018. Table 29 below shows the numbers of participants living in non-deprived versus deprived areas who attended one to five services either concurrently or consecutively. In this context, 'deprived' is based on the OYL definition of deprivation which includes both Leeds quintiles 1 and 2 and the 20% national most deprived postcodes.

Table 29: Numbers of people accessing one vs more than one service by deprivation status

Number of Services Attended	Non Deprived Leeds		Deprived Leeds	
	Total	*%*	*Total*	*%*
1	1817	91.4%	2616	90.5%
2	147	7.4%	229	7.9%
3	20	1.0%	43	1.5%
4	3	0.2%	2	0.1%
Total	**1987**	**100%**	**2890**	**100%**

From this data, 9.5% of people living in more deprived areas have attended more than one aspect of OYL whilst 8.6% of those from less deprived areas attended more than one. Based on this, participants in deprived locations are only very slightly more likely to book onto multiple services. However, this interpretation may be limited by the way deprivation is defined. It could be expected that there may have been a larger difference for example if quintile 1 was compared to quintile 5.

Although overall percentages for those booked onto two services (7.4% non-deprived and 7.9% deprived) may seem low, they do represent a high number of participants (147 and 229 respectively, totalling 376). **Therefore, in total 444 of the participants accessing OYL in 2018 attended multiple service streams. Proportionally, a majority of these people were living in the deprived areas (62% deprived, 274 people versus 38% non-deprived, 170 people).**

This will be looked at closer in terms of which service streams tend to coincide and support multi-usage of the service.

9.2. Access to both Move More (MM) and Weight Management over 12 months

The following table demonstrates the numbers and percentage of OYL participants attending Move More who also attended Weight Management. Of the Move More participants, almost half also attended Weight Management at least once showing a high level of integration between these two service streams. It's also worth noting here that a high number of participants were signposted to Active Leeds if they had a specific long term condition that could be better catered for here.

Table 30: Numbers from Move More who also accessed Weight Management

Post Code Area	Move More (MM)	Weight management (out of the number on MM)	%
Deprived	235	118	50
Non- Deprived	160	70	44
Total	**395**	**188**	**48% (average %)**

9.3 Access to Cook Well (including tasters) and Weight Management over 12 months

The next table shows the numbers and percentage of participants who attended both a Cook Well (Ministry of Food) session and a Weight Management at least once. Overall, 18% of the participants attending a Cook Well session also attended Weight Management.

Table 31: Numbers who accessed Cook Well who also accessed Weight management

Post Code Area	Cook Well	Weight Management (out of the number on CW)	%
Deprived	330	62	19
Non- Deprived	270	45	17
Total	**600**	**107**	**18% (average %)**

Both of these tables, particularly show the benefit of having additional streams that support adult weight management within the same service. A high portion of participants wanting to improve cooking skills and increase physical activity are also wanting to lose weight and these service streams support that intention. This also demonstrates how recruitment for both cooking and physical activity is often via the adult weight management pathway.

9.4 Service user related findings on integration

Over three quarters (77%, N = 253) of respondents had attended one part of the service only and 20% (N = 65) had attended at least two (12 attended 3 elements and 3 attended 4 elements). A small number (N = 9) hadn't attended any parts of the service yet. The survey responses therefore had a higher proportion of people attending more than one service therefore making it more representative of this target group. As over half were attending for Weight Management, this may have increased likelihood of accessing more than one element.

A further more in depth consultation was completed with a further 17 participants. Of these, six attended Weight Management, six attended Eat Well, three attended Move More and two attended Smoke Free as their first point of contact with the OYL service. Table 32 below shows the extent to which these participants accessed other aspects of the service. This is a small number and only gives an indication of how the services within OYL may support each other. However, it does again suggest key areas of multi-use being between Weight Management, Eat Well, Move More and Cook Well with at least one cross referral occurring for each. It may be less likely to cross refer with stopping smoking although it's difficult to say from only two cases.

Table 32: Examples of service journeys for interviewed participants

Service Strand	Number of participants	Referred from	Referred to
Weight management	6	GP - 5 Self-Referral – 1	Not applicable - 4 Eat Well - 1 Healthy Eating Self-help web page - 1
Eat Well	6	GP – 4 Cook Well – 2	Not applicable – 4 Cook Well - 2
Move More	3	Weight Management – 1 GP – 1 Self-Referral – 1	Not applicable - 3
Be Smoke Free	2	GP -1 Self-Referral - 1	Not applicable - 3

The Weight Management referral to Eat Well was initiated due to Weight Management not being the right service to suit her needs. The Eat Well service was then offered as an alternative on a second attempt to access the service and found to be much more satisfactory to the client due to being a one to one support more tailored to client need.

9.5 Referrers views on integration

Respondents were asked how often they need to make more than one referral for the same person due to multiple needs. 36% (n = 24) said very often and 52% (n = 35) said sometimes. Only 5% said rarely. In particular a correlation was noted between physical activity, eating and weight management.

Health professionals were also asked who they most frequently refer to for specific healthier living needs. One You Leeds was most commonly referred to for weight management, smoking, healthier eating and cooking. Physical activity seemed the least clear in terms of who to refer to with 33% to OYL and 42% to Active Leeds. Only a small number of people were referred to OYL for alcohol (9%). 75% were referred for stop smoking support but less (62%) for weight management. 17% said they weren't sure where to refer for cooking, showing a lack of awareness that OYL offered cooking skills support.

The single point of access was highlighted as a key strength by health professionals.

'One strength is that all the services are provided by one organisation'. This was felt to be convenient, particularly in terms of simplifying the referral process. It was felt that was an improvement on the previous services, with a sense that *'much better now it is all in one place'*

9.6 Staff views on integration

In terms of the staff views, there were mixed views about how well integrated it is. Some staff highlighted cross referring internally dependent on client need between OYL services as a key strength. Others however flagged it as a weakness stating that communication between coaches can be poor, working in 'silos'.

Of the 16 staff who participated in the consultation, 10 staff (63%) stated that they actively refer to Manage Your Weight and Eat Well:

- 80% (4 out of 5 staff) of Cook Well staff cross refer to Weight Management and 75% of Weight Management refer to Cook Well
- 60% (3 out of 5 staff) of Cook Well staff cross refer to Eat Well
- 75% (3 out of 4 staff) of Be Smoke Free staff cross refer to Weight Management whilst 50% (2 staff) to Eat Well
- 75% (3 out of 4) of Weight Management staff cross refer to Eat Well whilst only 25% (1 out of 4) from Eat Well refer to Weight Management
- 60% of Move More staff refer to Eat Well whilst 40% refer to Weight Management.
- 50% of Your Support refer to Eat Well whilst only 1 (25%) refer to Weight Management

Nine of the staff (56%) stated that they actively refer to Move More:

- 75% of both Weight Management and Be Smoke Free actively refer to Move More
- The least common to refer was Cook Well at 20% (1 staff)
- Two Your Support staff said they refer to Move More

Table 33: Staff survey responses regarding internal cross-referrals

Who do you actively cross-refer to within OYL?	Respondents % (n=)
Weight Management	77% (10)
Eat Well	77% (10)
Move More	70% (9)
Cook Well	54% (7)
Be Smoke Free	46% (6)
Your Support	46% (6)
One Your Leeds Website	39% (5)
I don't refer users to other programmes	8% (1)
Total Responses	**13**

9.7 What can be interpreted from this?

Firstly, not all staff are interpreting the service in the same way showing some strong inconsistencies in how they work. However, there are some trends emerging. The main starting point to accessing OYL appears to be with Be Smoke Free or Weight Management. It is a possibility that some staff don't cross refer at all, this may require some further investigation and/ or training. Weight Management, Cook Well and Move More cross refer frequently for accessing multiple interventions together. Eat Well, Cook Well and Move More also work in this way. Weight Management will tend to refer to Eat Well rather than the other way around. This is likely to be due to the client needing a different approach for more complex needs. At least half of the staff providing Your Support, see themselves as having a role referring to Eat Well, Move More and Cook Well.

Staff stated that they would benefit from more information, and understanding of other service areas within OYL to help them cross refer more. A couple of respondents suggested this would work best through attending other sessions/ shadowing each other.

'Observing other OYL sessions in action so that I have more knowledge of other OYL services'

Similarly, another said they would like to be trained on other programmes in order to fully understand their offerings. Others suggested having more information would be helpful, such as where and when all the other services are taking place and booklets to handout during the sessions. Finally, one person suggested that if more appointments were available then they would cross refer.

Coaches tended to have better knowledge of other service areas when they had worked in them previously and therefore retaining that knowledge. This could suggest that there would be a benefit of training staff in multiple areas of the service delivery. Most coaches had one or two services that they were less knowledgeable about, but had a basic understanding.

Be Smoke Free Coaches stated they prefer to wait before cross referring to other service streams.

'There's definitely a right time for it'

One Coach highlighted that she makes it easy for participants to move on by going through relevant questionnaires and directly booking them on rather than referring back to PSS to attend an initial session. She commented that *'you tend to find that little groups do it together'.*

There was a clear trend amongst staff that the various areas within OYL work well together.

'That's one of the big things that is 'sold' to referrers – the fact that all the different services work so well together'

'You'll get people calling up and saying 'If I stop smoking I'll put weight on'. And then we can 'You know what, focus on your stop smoking if that's your main priority and then we can move you onto weight management' PSS

One coach highlighted that MYW and Move More work particularly well together. Conversely, they felt that *'Your Support and Eat Well can be a little muddled'*

Overall staff seem to be referring appropriately within the model, but it does highlight some inconsistencies in how staff approach this. **Some improvement could be made to developing staff to understand roles of the service streams within the service to improve how well they integrate.**

9.8 Summary

The strongest integrations seem to be occurring between Weight Management, Eat Well, Move More and Cook Well. However, opportunities could definitely be increased further for this. Staff are not fully confident in their knowledge for each service stream. Health professionals appreciate having a single access point considering the frequent need to make multiple referrals. Participants living in more deprived areas seemed to be slightly more likely to access multiple aspects of the OYL service. It would be beneficial to look at in this in more depth across all the service strands.

Section 10: Actions and Recommendations

10.1 Key over-arching recommendations for One You Leeds (raised by all stakeholder groups)

Recommendations to improve services	Actions & Solutions
Increase session availability and accessibility particularly for people with mental health issues, and language barriers	Development of a virtual and remote offer which could enable easier access for some participants (telephone and/or video support, Whatsapp groups, Facebook groups). Explore other creative digital solutions using technology for completing online questionnaires and keeping in touch (e.g. recording smoking status etc.). Review of service capacity and redistribution of staffing. Review of resources, for example simplified handouts. Translation of resources for more common languages. Develop dedicated pathway for severe mental illness discharges utilising 'Your Support'. Consider and develop bespoke programmes for target groups. For example, BAME focused physical activity sessions. Create/ establish links to improve referrals to other services/ organisations and strengthen partnership working e.g. Forward Leeds, community groups/organisations.
Share and seek regular feedback	Embed evaluation and feedback processes in service delivery. Participants - regular general and targeted service user surveys as well as post questionnaires. OYL staff - regular staff meetings and anonymous survey requests. Health professionals – OYL are working with Public Health (Leeds City Council) to set up a system to provide feedback via primary care networks.
Ensure information is accurate and up to date	Staff suggested this could involve: - Increasing outreach capability. - Creation of a OYL summary standpoint. - More opportunities for staff to meet with GP staff/ other health professionals to build relationships. - Improve transparency and detail of information on website and ensure it is updated more frequently. Since this time, OYL have made some changes to their website by adding details of the management team, details of where sessions are held, updated blogs with service user's stories and a translating function. Work is ongoing to improve further for example another idea could be to recruit OYL ambassadors to monitor website, support re-promotion etc. which would in turn also increase peer support.

Improve communications with all stakeholders ensuring it is clear and transparent	In addition to the above, OYL have developed a quarterly e-newsletter to communicate with partners. Public Health have developed a number of provider platforms for supporting relationship building, communication and sharing of best practice. For example, a coordinated approach between LCC and Leeds CCG of an obesity network for providers across the weight management service pathway. Build productive relationship with primary care - OYL could attend practice meetings to update on KPI's, successes – upcoming events etc.
Ensure investment in staff who are vital for a successful service	OYL staff asked for more training, the opportunity to shadow and observe each other, frequent feedback on performance and increased development opportunities. In response, there have been changes to performance management and staff observation processes. Regular whole team meetings have become a higher priority which include opportunity to share work and discuss ideas. Programme Support have been shadowing services to improve their understanding. All staff have development plans and competency frameworks related to their roles. There is also smaller team meetings weekly and a monthly staff bulletin.
Embed peer support and longer term support to aid maintenance of behaviour change	Drop in sessions have been implemented for Manage Your Weight for longer term support. Furthermore, the service do follow up calls across all service streams at various time points. The calls are used to both collect data and also as a check in to re-engage client and provide further support. The role of peer support should be considered further particularly in the other service elements such as stopping smoking.
Investigate the role of the OYL model further in supporting behaviour change for multiple risk factors	OYL have been refining data intelligence systems to enable easier service monitoring. This aspect of the evaluation could be revisited to understand better how this works. It would be recommended to explore this as a unique research project looking at integration between all the service elements.

10.2 Additional recommendations that involve both One You Leeds and the system it operates in

Recommendations to improve services	**Rationale**	**Actions & Solutions**
Utilise co-production in service design and reduce emphasis on restrictive performance monitoring (quantity vs quality)	Supported through recommendations presented through other in depth service evaluations.	Participants are being consulted more frequently in service provision. Feedback is actively sought by OYL and acted upon accordingly. Quality indicators have been introduced in the contract KPI's which weren't originally included. Some KPI's have been reviewed and altered to prioritise quality and outcomes over throughput. Further changes can be considered further as the service develops.

Increase sustainability of funding	Promotes stability within the system, time for services to develop. Also provides some assurance of continuity for all stakeholders.	This needs to be taken into account when commissioning services in terms of length of contracts etc. The OYL maximum contract length is 6 years.
Ensure flexibility in contract development and commissioning to respond to change	The landscape is ever changing and services need to be flexible to meet local population needs and changes in health and care settings. This can be challenging with an integrated service design which requires many different specialisms and attention to detail. It can also be challenging to develop and amend systems in a timely manner to reflect changes needed.	The OYL service specification and performance frameworks have been reviewed and amended jointly between LCC contract management, Public Health and the service provider as an ongoing process. All changes have been discussed and agreed cooperatively to ensure the service can develop to meet local needs.
Review how OYL image and branding could be localised better	Some health professionals were less keen on the corporate feel of the OYL branding.	There appear to be mixed opinions on this. The OYL branding is based on the national One You campaign to align with this. Locally consider how the content of materials and website could be developed to reduce corporate perceptions.
Consider scope of service	Service can become diluted if it has too many elements. However, some health professionals suggested elements of mental health, stress management and sleep could be included. Additionally, there can be confusion relating to physical activity provision and pathways.	The service have started incorporating more emphasis on general emotional wellbeing and sleep in their provision. In addition to this OYL are exploring how they can have a clearer offer for maternal health (although not mentioned in the review, this has been identified as a potential gap).
Improve screening at point of referral	OYL staff commented that the triage system on entry to service needed more thought. For example, when booking participants with language barriers onto group sessions.	Programme Support staff have been shadowing service elements and have also been attending additional training relating to better conversations and brief advice. Furthermore, the service have implemented software for monitoring calls (for both safeguarding of staff as well as quality checks). A specific further review of the pathways would also be helpful.

Improve data monitoring systems	OYL staff were highly critical of the systems available to them for recording participants progress (the Orion database).	There are more limitations regarding the database issues. This is an ongoing challenge for many integrated services. OYL have been working on their systems such as developing other tools for extracting data. However, the issues that staff encounter with data inputting may well be ongoing and difficult to address. Ensuring regular training for staff on correct use of the database could be beneficial.
Reduce barriers services users may face for initiating first contact with service	Health professionals commented that some participants may be wary of making the first contact if they have low confidence.	Some suggestions depending on scenario could be to: -Introduce a text number for a call back. E.g. text 'quit' to XXXX for stop smoking support or 'move' for physical activity. Removes barriers for people not wanting to make initial contact by telephone or cannot sign up via website. Has worked well previously in stop smoking services. -Have drop in sessions that don't require booking on initially. -Direct booking by health professionals. -3 way transition first appointments with health professional (could be remotely delivered). -Explore online booking for sessions. OYL have developed 'a change for the better' sessions to provide an initial group introduction session to the service which could also be utilised. Review the service offer in terms of training so Health Professionals are familiar with the OYL offer. There is an acknowledgement from Public Health that the training offer within the contract needs strengthening.

10.3 Recommendations for specific service elements of One You Leeds

	Recommendations to improve services	**Actions & Solutions**
Be Smoke Free	Increase availability of group support and develop peer support maintenance sessions over longer term.	Conduct research into whether any other services have tested this or if there is any evidence regarding effectiveness. Conduct further investigations into participant's thoughts on this. Test and pilot a few sessions to assess whether it has any effected on longer term outcomes. Develop service model accordingly.
	Monitor and assess the different forms of treatment in order to compare effectiveness.	A brief review of the data could be carried out to look into this for OYL. From there it can be decided whether to embed in contract monitoring.
	Incorporate the popularity of e-cigarettes within the service.	A pilot project has been developed and co-produced with One You Leeds. This will enable the additional availability of vouchers to purchase e-cigarettes for participants.

Weight Management	Review course content in relation to more recent evidence base, the wider environment, entrenched eating behaviours, triggers, the effect of poor sleep etc. Consider a modular approach to delivery.	To be reviewed further as part of a broader health need assessment relating to weight. Some preliminary observations have taken place by Public Health and feedback to the service. Some service adaptations have been made where possible, however current licence with discover momenta limits any development. Options are being considered for developing an alternative programme.
	Develop peer support options and drop in session's longer term.	Drop in group sessions have been implemented to aid longer term maintenance.
	Review and amend KPI's relating to weight loss. Ensure wellbeing is discussed at follow up.	To be discussed and explored further between commissioning and service providers.
	Improve integration of element with other elements (i.e. Move More and Cook Well).	This process is being implemented. Service has already seen a sharp increase in accesses to Move More due to ensuring the stream is discussed and promoted by weight management coaches and allowing these coaches to directly book participants onto Move More without having to book them for another first assessment. Similar ideas are being pursued for Cook Well.
Cook Well	Better promotion of the service with health professionals and local communities. Better utilisation of Jamie Oliver MoF brand.	This element is now managed by the OYL partnership manager bringing fresh ideas to the programme. Plans are being developed to increase awareness.
	Maximise signposting and cross referral opportunities from other service elements into cooking.	There is some evidence that this is happening but stronger pathways require consideration.
Eat Well	Consider whether interactive/ practical group support sessions could be made available.	Some lighter touch group options for healthier eating could be beneficial e.g. healthy eating taster sessions.
	Review role and purpose of Eat Well within OYL and how it could be utilised most effectively and clearly.	A change in management of Eat Well may aid the development of this particular service stream.
Move More	To complete a further review of the Move More component of One You Leeds utilising focus groups from Move More participants, including those that do not complete four sessions or more and additional stakeholders from the wider physical activity system.	The service evaluation focused a lot more on weight management and stop smoking participants. It would be useful to do a separate evaluation specific to physical activity. Public Health could lead on the development of this working with OYL clinical lead and coach manager.
	Consider learning from the citywide Get Set Leeds physical activity conversations.	Leeds City Council has developed a local physical activity campaign to create a social movement towards more active living in Leeds. This has involved extensive consultation across the city. As the learning from this emerges, it would be useful to review this in relation to the OYL delivery and

		developments. OYL have been involved in some aspects of the consultation.
Your Support	Consider how Your Support could be a thread through all the service streams and part of all coaches portfolio which was the intention in service specification	This is being looked into and is in development.
	Allow direct referrals to Your Support as this service is not currently promoted.	This could be done through the initial sign up process via website. Add 'Your Support' to website and information resources.
	Consider how participants are triaged into Your Support (based on staff feedback).	Programme support ask all new participants to rate themselves from 1 (strongly disagree) to 5 (strongly agree) on the below statement *'I will be able to achieve most of the goals that I have set for myself'* If they answer disagree or strongly disagree, then a 'Your Support' session will be recommended first. This allows the service to triage participants with low self-efficacy to some additional initial one to one support.

10.4 Recommendations to improve the Healthier Living System in Leeds

Recommendations to improve services	Further comments
Improve understanding of the Healthier Living system, and how the services work together.	There is certainly a case for improving awareness across the range of services available that support healthier living. Whilst awareness was highest for One You Leeds, there was room for improvement across all the services. Furthermore, 65% of health professionals responding said there was a need for more and clearer promotion of all healthier living services. Considering how the spectrum of services can provide feedback to referrers should be explored. Public Health have developed a commissioner forum which has now been meeting for over 12 months. The aim of the forum is to improve how these services work together.
Develop a plan for better promotion and marketing of cooking courses.	Increase awareness of the cooking element of OYL in primary care. Should consider including in the adapted primary care referral template for healthier living to encourage direct referrals. Include references to benefits of cooking courses and evidence of the outcomes through training to primary care/ other community health professionals.
Identify clearer physical activity pathways.	There are multiple opportunities for physical activity across the city which is very positive but can create some duplication and confusion on where to refer to. Clearer identification of roles and responsibilities of physical activity providers could be beneficial.
Raise awareness of self- help routes and resources across the system.	The evaluation suggests an over reliance on services where capacity is limited to cater for a city with a high population. Increasing awareness in health professionals and community members of recommended local and national self-help tools and resources could help to reduce pressure on services.

Review and develop training opportunities for health professional across the system.	Whilst only 40% said they would like more training regarding healthier living, 60% said they would like more information. As training could help to achieve the goal of more and clearer information Public Health are looking at developing short e-learning sessions for local health professionals. Further auditing of health professionals needs may be necessary to deliver this effectively.
Complete a local weight management health need assessment for Leeds.	Weight management was highlighted by health professionals as the most frequently seen area of support that their patients/ participants need support with. A desire to lose weight was also the most common reason for the survey respondents accessing the service (57%). Weight management is the most integrated aspect of the OYL service, working particularly well with physical activity and cooking.
Consider support options across the local system for low/ moderate mental health needs and roles/ responsibilities of healthier living services when working together.	There is a clear need for more capacity and clarity regarding roles across the system when supporting people with low/ moderate mental health needs to live healthier. OYL staff frequently commented on challenges in meeting these needs where other services also have limited capacity.

Section 11: Conclusions

Overall, it appears that having an integrated service model for healthier living has added value to the local system in Leeds. Having a number of complimentary options under one umbrella has made it easier for health professionals when referring. There are signs that participants are benefitting as over 400 accessed more than one service stream in the first year. However, OYL staff did comment that further work could be done to support further internal cross referring and understand each other's roles better.

The service is demonstrating good accessibility in terms of participant specific characteristics. Of particular strength is the services reach into the more deprived areas of Leeds. Bearing that in mind, this is likely to have some impact on outcomes considering the greater socio-economic challenges faced by people living in these areas which can act as barriers to healthier living. Overall though, the outcomes seen so far also seem to be positive for participants living across the city.

Challenges mostly relate to the complexity of many participants needs, particularly relating to mental health and languages. Participants and staff commented on needing more capacity to manage the volume of people needing support. Despite this, the service was still rated well by both participants and staff. Many of the comments and findings echoed what was found in the report by Cheetham et al (2018) regarding the importance of service capacity and valuing staff, longer term and flexible commissioning, being seen as the 'answer to everything' and high portions of demand being for weight management and smoking cessation yet great challenges for service users to achieve their goals (page 9).

The evaluation also adds some additional insight to our understanding of the broader system that OYL operates in. This has reinforced the ongoing need for a service like OYL and the benefits of it being integrated. Many professionals reported the need to make multiple referrals relating to healthier living, some of which may fall outside of OYL's current scope. Professionals didn't always seem fully clear on what services are available. Weight management, emotional wellbeing and

smoking cessation were rated as the top three health and wellbeing areas that professionals felt they were dealing with most frequently.

This also supports the evidence base regarding multiple unhealthy risk factors clustering (particularly in more deprived areas) discussed in section 2. However, OYL only provides a small amount of support relating to alcohol (mostly in the context of a healthier diet and weight management) and the physical activity aspect is mostly to compliment the weight management programme. So whilst, OYL does cover all four unhealthy risk factors in some respect, their focus tends to be participant led towards weight management and quitting smoking. Other services such as Forward Leeds (alcohol) and Active Leeds (physical activity) have a sole focus on these areas of health and wellbeing. Further work is needed around integrating the broader healthier living system as well improving how this is understood and communicated locally.

Throughout the evaluation process, many changes were implemented to the service as the learning evolved. The service are now seeking regular participant feedback with this embedded throughout their programmes. Some co-produced amendments were made to the service's performance frameworks to support further development. The recommendations are being explored further and actioned accordingly.

Appendices Table

Appendix i; Uptake and Retention PHE Report

Higher retention was associated with:

- A higher number of Behaviour Change Techniques[1] (BCTs) on average 7.9 BCTs in studies achieving high retention (defined as more than 80% of participants attended at least 50% of the programme).
- The BCTs most associated with increased retention were instructions on how to perform a behaviour (for example, how to read a food label), having advice/support from a credible source (like a health professional), self-monitoring of behaviour (typically diet and exercise) rather than the outcomes of the behaviour (i.e. weight), and goal setting for those behaviours.
- The use of feedback on behaviour, including biofeedback (for example, heart-rate or blood pressure monitoring), and problem-solving.
- Giving people flexibility and choice regarding their programme.
- Social opportunity—both within and outside the programme. This includes support from the programme leader and other participants, as well as from family and friends.
- Psychological capability, highlighting the need for strong educational components of programmes.

[1] A BCT is defined as an ''observable, replicable and irreducible component of an intervention designed to alter or redirect causal processes that regulate behaviour; that is, a technique proposed to be an 'active ingredient'

Programmes should:

1. Prioritise efforts to foster social support through:
    - Ensuring that the group leader is supportive and that participants feel well-supported by them.
    - Including activities that encourage support between group members.
    - Including activities that can involve participants' family and friends, to generate social support outside of the group environment.

2. Develop participants' psychological capability to change their behaviour, with a strong educational component. Opportunities for learning can be used such that participants feel empowered, for example, through increased knowledge around dietary and physical activity behaviours, instructions on performing specific aspects of exercise or dietary programmes, and ways to respond to relapses and overcome barriers to implementing and maintaining lifestyle behaviour changes. *For example, increasing physical activity from 0 to 10 minutes per day in the first instance; incorporating one additional fruit/vegetable portion per day.*

3. Set goals for target behaviours *(for example, physical activity, diet)*, not only outcomes *(for example, weight loss; change in % body fat).*

4. Provide sessions that:
    - Include exercise components.
    - Are in a convenient location.
    - Allow flexibility
    - Ideally, allow the participant a choice of delivery mode, although feasibility is likely to limit the range of options.
    - Are perceived as enjoyable by participants and provide positive reinforcement

Appendix ii: Qualitative Opportunities (PHE, 2017)

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/622422/Qualitative_opportunites_into_user_experiences_t2_t3_weight_management_services.pdf

Refer to page 80 of the above report for the infographic which highlights the importance of certain components of a tier 2 service into 5 main themes.

- Social network & norms
- Wellbeing & self-image
- Aspiration & motivation
- Control & choice
- Experience of support

Initial Referral

- Quick access
- Changing the experience of waiting
- Timely referrals
- Better conversations (health professional discussions with patients about weight)

Initial Access/ triage & assessment

- Holistic assessment
- Readiness
- Modular approach
- Better segmentation

In the Service – main content

- Long term planning
- Psychological input
- Owning goals
- Setting shared goals
- A peoples person (the coach approach to engaging group)
- Self-monitoring
- Experiential learning
- Changing routines
- Problem Solving
- CBT for couples
- A whole family approach
- Individualising support
- Future planning
- Wellbeing Outcomes matter

After

- Volunteering
- Open door and follow ups

Appendix iii: Tackling multiple unhealthy risk factors – Key recommendations from the Kings Fund Report (2018)

1. Improve the targeting of those with multiple risk factors

More focused targeting of individuals with multiple risk factors would be beneficial. Services could identify where clusters of individuals with multiple risk factors are more likely to be located.

2. Address capability, opportunity and motivation to change (COM-B model of behaviour change)

Services which actively provide support for all three components are more likely to be effective in tackling multiple unhealthy risk factors. Consider how holistic behavioural factors, and how a person's environment can impact health behaviours, adherence and self-care.

3. Build stronger connections between interventions and organisations

Consider how services can be best integrated in the wider system. It remains important that these services dovetail for the benefit of people with multiple unhealthy risk factors. For example, in Suffolk this is done through ensuring that a clinical psychologist has an overview of all the interventions across the service, and encouraging advisors to attend sessions run by other advisors to cross refer.

4. Collect data and use it to learn what works, as well as for monitoring and feedback

The majority of evidence still focuses on individual risk factors. It is imperative that service evaluations and data monitoring attempt to understand the value of tackling multiple behaviours within one model design and effectiveness of various approaches to doing this.