

LINCOLNSHIRE HEALTH AND WELLBEING BOARD

Open Report on behalf of Derek Ward, Director of Public Health

Report to	Lincolnshire Health and Wellbeing Board
Date:	13 June 2023
Subject:	Evaluation of the Integrated Lifestyle Service, 'One You Lincolnshire'

Summary:

This report provides a summary of the findings from the University of Lincoln's evaluation of the Integrated Lifestyle Service (ILS). The report, completed in 2022, and based on data from 24,370 referrals, provides a key resource that will help to inform and shape the recommissioning of the service in 2024.

The evaluation found that the service exceeded current benchmarks for successful service delivery within national guidelines across all four pathways (smoking cessation, weight management, physical activity and alcohol reduction) and surpassed outcomes from Lincolnshire's previous, discrete lifestyle services.

The benefits of an integrated model were illustrated by the fact that a key predictor of successful outcomes was a person's participation in more than one pathway.

Reconfiguration of the ILS in response to COVID-19 pandemic lockdown restrictions did not have a negative impact on its overall reach, however, a decrease in referrals among the most deprived populations was seen and a increase in the bias of take-up towards women.

Actions Required:

The Health and Wellbeing Board is asked to note the contents of this report.

1. Background

1.1 Smoking Cessation

The ILS surpassed its target of 50% quits at four weeks, achieving a 56% quit rate. This is significantly better than Lincolnshire's previous standalone service (46% quit rate) and is well over double the non-supported quit rate (25%). Success was more likely with older clients but was not affected by gender, rurality, ethnicity or deprivation. There was no negative impact seen from attending multiple programmes.

1.2 Alcohol

The alcohol programme received fewest referrals, which was attributed principally to GPs' prioritisation of other referral pathways. However, despite this, there were high rates of alcohol reduction across the service as a whole, with 57% clients on the alcohol or health coaching pathways and 37% of all clients reducing their consumption to target levels.

This compares very favourably with the 10-30% success rate of national brief alcohol interventions. Participation in other pathways, particularly weight management, was strongly predictive of reducing alcohol consumption.

1.3 Diet and Weight Management

Thirty-three percent of clients accessing the weight management (WM) intervention or health coaches lost 5% body weight at 12 weeks. This increased to 40% amongst those who attended a sub-contracted WM provider.

Weight loss was not limited to those on the WM pathway, with 25% clients across the whole service losing 5% body weight. The average weight loss was 6%, the service thus exceeding NICE guidance of 30% achieving 5% loss with an average of 3%.

1.4 Physical Activity

43% of clients on the physical activity or health coaching programmes achieved the target of 150 minutes per week. This easily surpasses the 13-18% success rate of national, non-integrated exercise-referral models.

As with other pathways, high rates of increase in physical activity were recorded across all programmes. Other predictors of success were being female, older, accessing a health-coach and having a long-term condition. However, positive outcomes were less likely for the most deprived populations as well as for the unemployed and long-term sick.

1.5 Access & effect on Inequalities

Participation was heavily biased towards women, who made up 66% of all clients. Ninety-three percent were White-British and there was an even split between rural (51%) and urban (49%) residents.

Thirty-eight percent of referrals were for residents from the 30% most deprived communities, which was significantly short of the target of 50% for this group. However, in large part, this was an effect of the service reconfigurations, namely digital delivery and self-referral, that were made in response to lockdown restrictions. Prior to these changes the most deprived 30% had made up 45% of referrals. Nonetheless this demonstrates that the programme is targeting lower socioeconomic (SE) groups and successfully engaging this population at a higher rate than those in

higher SE groups. This represents evidence of a positive impact on health inequalities, as typically utilisation of preventative services is lower in more-deprived groups.

The majority of participants across the whole service were obese and aged 50+. The ILS was thus reaching an extremely important target group for preventative services, given the heightened risk of long-term ill-health amongst this population. Likewise, there was evidence that the physical activity programme was particularly successful among people with conditions affecting mobility and pain management, both of which are major barriers against exercise amongst people at high risk of deterioration in health.

1.6 Completion

Completion rates varied for each pathway. Weight Management exceeded NICE guidance of 60% with a 70% completion rate. Rates for smoking, health coaching and alcohol were 63, 56 and 46% respectively. Physical Activity data were incomplete so do not provide an accurate figure.

2. Impact of the Lincolnshire Model

2.1 Integration

The benefits of an integrated rather than segregated offer are clearly demonstrated by the number of positive outcomes for people accessing more than one pathway. For physical activity, weight management and alcohol, engagement with more than one programme was a key predictor of success; indeed, for physical activity it was the most important single factor, with participants being 2.7 times as likely to become active as those accessing just one pathway. Even smoking cessation, for which the literature has sometimes suggested integrated models were not suitable, was not negatively affected by engagement in multiple pathways.

2.2 Health Coaching

Health coaching support appears to be an important component of the current offer, being strongly associated with positive outcomes across weight management, physical activity, and alcohol, with those accessing a health coach being over 3.5 times as likely to reduce their alcohol to within target levels.

2.3 Referrals

The qualitative data indicated that relationships with GPs, which have historically been difficult for lifestyle services in Lincolnshire, had significantly improved under the current model. This was evidenced by the 36% of referrals that came directly from primary care. It is likely that a significant proportion of the 39% of self-referrals were also instigated by GPs during non-face-to-face appointments with patients. The high number of self-referrals ensured that the ILS could continue to deliver at volume during Covid, however, as self-referral is more likely to be used by people with higher existing motivation and health-seeking behaviours, it is likely that this contributed to the shift in uptake towards more affluent population groups.

3. Conclusion

Success rates across all lifestyle interventions exceeded national benchmarks, despite the clear challenges to service delivery through the COVID pandemic.

- The overall advantages of an integrated model were demonstrated by the fact that there were no negative implications of participation in multiple programmes and many benefits, including weight loss, increased physical activity and decreased alcohol consumption, amongst people for whom these interventions were not their primary pathway.
- Evidence suggests that the service is positively addressing health inequalities. Outcomes were not affected by socio-economic status, and analysis of service access by deprivation decile highlights that those in lower SE groups were effectively targeted by the service.
- There was a strong bias towards women, and physical activity outcomes and take-up from the most deprived populations fell short of target. It appears though, that these participation patterns were, at least in part, the result of service reconfiguration during lockdowns.
- The findings demonstrate that One You Lincolnshire is an effective model and will contribute to the service’s recommissioning process ahead of the contract end date in June 2024.

4. Joint Strategic Needs Assessment and Joint Health & Wellbeing Strategy

The Council, NHS Lincolnshire Integrated Care Board and the Lincolnshire Integrated Care Partnership must have regard to the Joint Strategic Needs Assessment (JSNA) and Joint Local Health and Wellbeing Strategy (JLHWS).

Healthy Weight is identified as a priority for Lincolnshire in both the Joint Strategic Needs Assessment and the Joint Health & Wellbeing Strategy and is a key part of the overarching Joint Health and Wellbeing Strategy theme of placing a strong focus on prevention and early intervention.

5. Consultation

Not applicable.

6. Appendices

These are listed below and attached at the back of the report	
Appendix A	Addressing Multiple Unhealthy Risk Factor – An Evaluation of Integrated Care in Lincolnshire

7. Background Papers

No background papers within Section 100D of the Local Government Act 1972 were used in the preparation of this report.

This report was written by Sarah Chaudhary who can be contacted at sarah.chaudhary@lincolnshire.gov.uk