Independent Evaluation of NHS Digital Weight Management Programme in five practices in Hampshire & Isle of Wight Integrated Care Board

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EVALUATION TEAM

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DISCLAIMER

This report presents the findings of an independent evaluation of NHS Digital Weight Management Programme in the context of five Hampshire and Isle of Wight (HIOW) Integrated Care Board (ICB) primary care practices. The findings of this independent evaluation are those of the authors and do not necessarily represent the views of HIOW ICB or NHS England.

DECLARATION OF INTEREST STATEMENT

Wessex AHSN supports innovators to bring their innovations to the NHS as well as provide an evaluation service more broadly to our members and others. On occasion, we evaluate innovations that we have also supported. Whilst these evaluations are independent, for transparency we disclose our dual role where applicable.

For this report we note the dual role of Wessex AHSN to facilitate both implementation and independent evaluation of the NHS Digital Weight Management Programme.

ACKNOWLEDGEMENTS

We would like to thank the practice staff and patients for their participation in this evaluation.

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EXECUTIVE SUMMARY

BACKGROUND

The NHS Digital Weight Management Programme (abbreviated in this report to 'the programme') is nationally commissioned by NHS England and aims to support the delivery of the NHS Long Term Plan commitments relating to obesity. A broad evaluation of the programme is currently being conducted by NHS England and the University of Oxford, investigating its impact across England. In addition, another broad evaluation by the National Institute for Health and Care Research (NIHR) is currently being conducted for the Department of Health and Social Care (DHSC)/Treasury, focused on all weight management services in England. This evaluation report focuses on a small number of practices in the Hampshire area and seeks to support the ongoing learning on the implementation, acceptability, and impact of the programme.

The Hampshire & Isle of Wight Primary Care Digital Roadmap has been established to create a consistent and coherent plan to further digitise primary care services in line with local, regional, and national agendas. The aim of the Hampshire & Isle of Wight Digital Self-Care Demonstrator project was to develop and embed a robust digital self-care offer. Wessex AHSN sought to support the embedding and evaluation of three digital self-care innovations, via the Wessex AHSN Primary Care Demonstrator programme. One of these innovations was the national NHS Digital Weight Management Programme, with Wessex AHSN providing deployment support and a locally focused evaluation.

The programme was launched nationally in July 2021 to offer online access to tier 2 weight management services for those living with obesity (BMI above 30), plus a diagnosis of diabetes or hypertension or both. With three levels of support (digital only, digital with 50mins of human coaching, and digital with 100mins of human coaching) and a choice of providers, it was designed to offer patients a personalised level of intervention to support them to manage their weight, improve quality of life and improve longer term health outcomes. The programme was intended to work alongside, and not replace, existing weight management services funded by local authorities.

THE EVALUATION

The evaluation used a mixed methods approach to gather quantitative and qualitative data concurrently to provide intelligence on the programme. Following data collection and analysis of each data source, a data synthesis process was undertaken to draw together the findings and to develop conclusions to the evaluation questions.

Originally, the evaluation sought to answer six questions on the extent of use (Q1), impact on patient care (Q2), whether the innovation was acceptable and implementable (Q3), impact on general practice (Q4), how these impacts had occurred (Q5), and what lessons could be gleaned from the experience (Q6). However, due to very limited data, it was not possible to meaningfully answer evaluation questions 2 (impact on patients), 4 (impact on practices), or 5 (how the impacts have occurred).

PARTICIPATING PRACTICES

Five practices consented to be demonstrator practices to explore the use of the programme. These included three practices from Primary Care Network (PCN) 1 (practices A, B, & C), practice D from PCN2, and practice E from the PCN3.

REFERRAL LEVELS

Between the launch in July 2021 and up to the end of data collection for this evaluation (May 2022), referrals to the programme were slow – only one referral up to January 2022 until they became more regular after that

at demonstrator practices. Referrals to the programme were a small proportion (referrals = 36; 4.2%) of referrals generally to all available weight management interventions (referrals = 852).

PRACTICE STAFF INTERVIEW THEMES

Seven practice staff shared their views on the programme and these were organised into seven themes:

(1) Limited clinician awareness about the content of the programme: Across the interviews it was apparent there was limited awareness about the content of the programme, and each provider option within it. It was possible to know the provider names and which level of support they were linked to, but it was not possible to know the specifics of what would happen to patients once they joined the provider's intervention.

(2) Limited awareness of the triage process managed by the national Referral Hub: Across the interviews, considerable confusion about the triaging process was reported. This had implications for clinician confidence in referring, managing patients' expectations, and whether patients continued with the programme.

(3) Mixed views from clinicians on their acceptability of the programme: Due to implementation challenges, some staff were reticent about referring to the programme due to the complexity of making a referral, the time pressures of a GP-patient consultation, and sustainability of the operationalisation of referrals via the Health and Wellbeing team.

(4) Internal practice organisation to operationalise the programme: The interviews highlighted different approaches to identifying patients, i.e., ad hoc through routine GP consultation for other issues or via practice-generated lists of patients to be managed by Health & Wellbeing practitioners. Furthermore, practices 'throttled' (limited) their efforts to refer due to various implementation challenges and to manage workload in the practice, e.g., one practice only considered the programme for patients under 65 years old.

(5) Considerations during the clinical encounter: practice staff found it difficult to communicate the value of the programme to patients due to limited access to provider intervention material. Also, associated with this was how to choose from the wide array of options (e.g., ShapeUp4Life) and how they could be compared. Patient preferences were also expressed and highlighted a preference for personalised face-to-face support.

(6) Considerations after the clinical encounter: All staff interviewed agreed the referral process was complex and time consuming. At a minimum it took time for medical secretaries to manage the referral process and in some cases it took GP time to action the process. There was a clear preference for a self-referral mechanism like other weight management interventions. Furthermore, considerable confusion about SNOMED coding and absence of feedback from the Referral Hub (e.g., discharge summaries) contributed to demotivation for the intervention amongst staff.

(7) Wider pressures in general practice: General practice is under considerable pressure at present, with increased demands, a heavier workload, and increased complexity and intensity of activity. It was clear from the staff interviews that wider pressures were a significant barrier to the engagement and operationalisation of the programme.

CONCLUSIONS

At the clinician level:

1. Practice staff had mixed views on their acceptability of the programme at this point in time.
2. Generally critical practice staff attitudes toward the programme led to low use of the intervention.
3. Practice staff's 'general attitudes toward innovation' did not appear to influence use of the programme.

4. Practice staff perceived many patients have preferences for personalised face-to-face weight management support.

At the practice level:

5. Practice digital readiness did not appear to influence use of the programme.
6. It was a complex programme to operationalise in busy general practice settings.
7. Practices took different approaches to referring to the programme.
8. Practice decisions to manage workload led to low use of the programme.

From the point of view of NHS Digital Weight Management Programme support/information sharing with practices:

9. A lack of detailed programme and provider intervention information led to low intervention use.
10. Challenges at the Referral Hub possibly contributed to low referrals.
11. The unknown triage process at the national Referral Hub presented challenges for clinicians.

When considering the wider context:

12. The pressures on general practice due to COVID-19 contributed to low referrals to the programme.

SUGGESTED NEXT STEPS

The evaluation findings suggest that the following support would benefit the adoption of the programme:

1. Make provider intervention materials and triage processes available to practice clinicians, so they can review the clinical acceptability and patient experience, in order to tailor their advice during clinical encounters.
2. Reduce the informational burden (in this case the absence of key information) by providing examples of referrals and case studies, potentially using short video format and other highly accessible media.
3. Provide clearer channels of communication regarding any challenges occurring at the practice level and at the Referral Hub (e.g., delays in allocating human-related support, in providing discharge summaries, coding confusion, e-referral location on the NHS e-Referral System). This should prevent disengagement from practice staff and automatically advocating other weight management options.
4. Practices need time and space to try new innovations. As seen in the referrals data in Table 1, a great deal of time (five to six months) passed between the July 2021 launch and beginning to refer to the programme. Whilst the programme is a complex intervention with an informational burden and other challenges such as wider pandemic pressures, it would be helpful for practices to investigate national programmes, particularly when they seek to support priority areas of need, as they did in the participating practices with high rates of obesity. The referral levels to date cannot give the intervention a chance to be internally evaluated by practices.
5. Practices need time to prepare for and investigate what they view as complex national interventions. It was estimated that two to three months is needed to orientate, train staff, and set up practice level processes to manage the workload. It is suggested that launch dates for national programmes are preceded by several months of socialisation of information at the practice level, to give sufficient time to implement and evaluate the complex intervention.
6. A fuller scoping of existing digital innovations at practices that expressed an interest may have led to different decisions about which innovation to offer and support. In addition, an understanding of interventions that permit self-referral compared to clinician-led referrals, and the pros and cons of each, would mitigate the likely implementation challenge of ‘clinician referral decisions based on ease of referral process’.

7. A fuller scoping of stakeholders would have helped deployment. Involving and gaining the views on the implications of deployment, from a wide range of staff during the expression of interest stage, would have been helpful to conversations with participating practices and secure timelines for implementing the innovation.
8. Practice engagement was highly variable. It would have been helpful to fully map out and routinely check that practices were comfortable with and understood the different roles and level of input required for the deployment and evaluation activities.
9. Single one-hour launch events are not sufficient on their own to provide enough information for practices and clinicians to decide quickly / within the project timeframe about which innovation they would like to adopt as a demonstrator site. It cannot be assumed that busy practice clinicians have time to read lengthy pre-launch event materials, nor grapple with the implications of introducing an innovation within a short timeframe of a few weeks. Deciding on what and how to implement took two months for most participating practices.
10. One year was not enough time to deploy and evaluate a complex intervention that has a 12 week intervention timeframe. There were multiple risks to the timeframe, from: many months of delays due to varying levels of practice engagement (arguably predictable under COVID-19 pressures); once practices were engaged there were also delays making referrals; the volume of referrals would not be high due to the limited number of practices involved in the evaluation, and referrals do not all happen at the same time (e.g. hypothetically, patient 1 is referred in July and patient 50 is referred in December); and referrals only happen when they are clinically appropriate. With the need to allow the 12 week intervention to play out (for hypothetical patient 1 this would be January to March and patient 50 December to February), it was clear there would not have been enough time to collect and analyse quantitative and qualitive data on all patients to address the evaluation questions and write the final report. The demonstrator model would benefit from revisiting its structure and potentially using short one year demonstrator evaluations for simple interventions with a high turnover of use, and longer two year demonstrators for complex interventions like the NHS Digital Weight Management Programme.

1. BACKGROUND TO THE DEMONSTRATOR PROGRAMME, NHS DIGITAL WEIGHT MANAGEMENT PROGRAMME AND EVALUATION

The NHS Digital Weight Management Programme (abbreviated in this report to 'the programme') is nationally commissioned by NHS England. A broad evaluation of the programme is currently being conducted by NHS England and the University of Oxford, investigating its impact across England. In addition, another broad evaluation by NIHR is currently being conducted for DHSC/Treasury, focused on all weight management services in England. This evaluation report focuses on a small number of practices in the Hampshire area and seeks to support the ongoing learning on the implementation, acceptability, and impact of the programme.

The Hampshire & Isle of Wight Primary Care Digital Roadmap has been established to create a consistent and coherent plan to further digitise primary care services in line with local, regional, and national agendas. A partnership between Wessex Academic Health Science Network (Wessex AHSN) and Hampshire & Isle of Wight Integrated Care Board (HIOW ICB) was developed to support delivery of the digital first primary care plans aligned with both organisations' strategic priorities.

The aim of the Hampshire & Isle of Wight Digital Self-Care Demonstrator project was to develop and embed a robust digital self-care offer. Wessex AHSN was involved to support the embedding and evaluation of three digital self-care innovations, via the Wessex AHSN Primary Care Demonstrator programme.

In June 2021, an online workshop focused on innovations to support diabetes and obesity was advertised across the area to encourage practices to participate in the demonstrator programme. At the workshop, a horizon scan of relevant innovations by Wessex AHSN was discussed and expressions of interest sought from practices.

Shortly after the workshop came the announcement of the launch of the programme. As the innovations selected by practice staff were the same as several providers within the programme, HIOW ICB took the decision to locally evaluate the programme as a digital self-care innovation to support patients living with diabetes or obesity. Importantly, this avoided duplication of evaluation activities locally. Also, as the programme is part of the Enhanced Service whereby practices would be paid for referrals, HIOW ICB predicted challenges in attempting to evaluate another weight management intervention whereby practices would not be paid for referrals.

1.1 BACKGROUND TO NHS DIGITAL WEIGHT MANAGEMENT PROGRAMME

The programme was introduced to offer online access to tier 2 weight management services for those living with obesity, plus a diagnosis of diabetes or hypertension or both. With three levels of support and a choice of providers, it was designed to offer service users a personalised level of intervention to support them to manage their weight, improve quality of life and improve longer term health outcomes. The programme was intended to work alongside, and not replace, existing weight management services funded by local authorities.

The different levels of intervention available are:

- Level 1: Access to digital content only.
- Level 2: Access to digital content plus up to 50 minutes of human coaching.
- Level 3: Access to digital content plus access to up to 100 minutes of human coaching, and additional features such as supported introduction to the programme, challenges, and games (depending on provider and availability).

The referrals were to be made via the NHS e-Referral System, for patients who met the eligibility criteria outlined below.

Inclusion criteria:

- Aged over 18 years;
- Had a BMI of >30 (adjusted BMI of ≥27.5 for people from Black, Asian, and ethnic minority backgrounds); and
- Has a diagnosis of diabetes (Type 1 or 2), or hypertension, or both.

Exclusion criteria:

- Recorded as having moderate or severe frailty;
- Is pregnant;
- Has an active eating disorder;
- People for whom a weight management programme is considered to pose greater risk of harm than benefit; or
- Has had bariatric surgery in the last two years.

Those who met all the inclusion criteria and none of the exclusion criteria were triaged following referral. The triaging algorithm which determined whether Level 1, 2, or 3 support was offered via the programme is unknown and managed nationally by the NHS Digital Weight Management Referral Hub.

1.2 OVERVIEW OF THE INTENDED EVALUATION

The purpose of the overall evaluation activity was to investigate the impact and innovation adoption of the programme. The evaluation questions and methods were developed to address this purpose.

The evaluation questions stated below were the original evaluation questions:

1. Evaluation question 1: To what extent and variation has the programme been utilised by demonstrator PCNs/practices?
2. Evaluation question 2: What impact has the programme had on service user care?
3. Evaluation question 3: To what extent is the programme acceptable, appropriate, used as intended, feasible and sustainable for service users?
4. Evaluation question 4: What impact has the programme had on the efficiency of general practice?
5. Evaluation question 5: How has the programme impacted on patients, staff, and related services?
6. Evaluation question 6: What lessons can be drawn from the experience of participating in a demonstrator project?

The initial data collection period was due to end on 1st March 2022, with an evaluation report written by 30th March 2022. However, due to deployment delays and limited practice engagement the data collection period was extended until 1st May 2022, with the evaluation report deadline extended to 30th June 2022.

As will be illustrated in this report, despite the demonstrator practices being aware of the service from its launch nationally in July 2021, there were challenges which affected the evaluation scope. These challenges were related but not limited to the implementation of the programme as well as practice engagement with the programme.

The analysis of the available data provided partial insights into evaluation questions 1 (extent of use), 3 (acceptability, implementation), and 6 (lessons learned). However, due to very limited quantitative data (e.g. on patient weight loss), it was not possible to meaningfully answer evaluation questions 2 (impact on patients), 4 (impact on practices), or 5 (how the impacts have occurred).

2. METHODS

The evaluation used a mixed methods approach to gather quantitative and qualitative data concurrently to provide intelligence on the programme. The quantitative and qualitative data sources included in this evaluation are detailed below. Following data collection and analysis of each data source, a data synthesis process was undertaken to draw together the findings and to develop conclusions to the evaluation questions.

Each section of this report includes synthesised findings, first reporting the quantitative findings followed by the related survey and qualitative findings to provide a 'what is happening' as well as 'why it is happening' discussion where possible.

2.1 EVALUABILITY

The original scope of this evaluation has been affected by a range of issues:

1. General practice is under considerable pressure at present, with increased demands, workforce challenges, and increased complexity and intensity of activity. It was clear from the staff interviews wider pressures were a significant barrier to the engagement and operationalisation of the programme.
2. Significant external pressures on primary care have affected the ability of all participating practices to engage with the Wessex AHSN deployment and evaluation teams and refer at the rate hoped for to ensure the programme impact could be quantitatively evaluated.
3. The deployment of the programme into the practices that expressed an interest was delayed by low levels of practice engagement.
4. Disengagement from half of the practices that expressed an interest led to the withdrawal of six practices from the evaluation.
5. The long intervention length of the programme (12 weeks) meant no patients at participating practices completed the intervention within the evaluation period.
6. The absence of discharge summaries (provided by the NHS Digital Weight Management Referral Hub) had two effects on the project. Firstly, practices were unaware of patients' progress and the absence of feedback on value affected clinicians' confidence in the intervention. Secondly, for the evaluation it was not possible to determine a key metric – patients' weight on entry and exit of the programme. The absence of patients completing the intervention also meant that demographic and clinical practice data was not able to be collected. These combined to affect the ability to answer evaluation question 2 about the quantitative impact of the programme.

2.2 DATA COLLECTED

Due to several constraints which affected the availability of data for this evaluation, it was not possible to collect the data required to fully address all the evaluation questions. However, the following data was collected/received:

1. **Utilisation metrics** – programme referral data was collected from each participating practice
2. **Staff survey about innovation attitudes** – 21 survey responses
3. **Staff survey about the programme** - 3 survey responses
4. **Demonstrator practice staff interviews** – 7 staff across the five practices were interviewed
5. **Patient acceptability surveys** – 1 survey response
6. **PAM self-completed surveys** – 1 survey response
7. **Patient interviews** – no patients consented to be interviewed.

3. PARTICIPATING PRACTICES

Five practices consented to be demonstrator practices to explore the use of the programme. These included three practices from PCN1 (Practices A, B, & C), practice D from PCN2, and practice E from PCN3.

3.1 PRACTICE PROFILES

Using publicly available information, it was possible to draw together a profile of each demonstrator practice on demographics and digitally related factors. This provided another data source to consider when triangulating the findings from different data sources.

Across all five demonstrator sites, administration, and non-clinical personnel account for the majority of staff (at least 45%). At Practice E, GPs account for just 11% of staff, compared to 14-24% for the rest. https://digital.nhs.uk/data-and-information/areas-of-interest/workforce

The demonstrator practices recorded that between 20-29% of their populations are aged over 65 years old. This is higher than the national average (17.4%) and it might be reasonable to expect to see a slightly lower rate of digital literacy in these populations based on recent Census data from the Office for National Statistics about the UK's digital divide: https://www.ons.gov.uk/peoplepopulationandcommunity/householdcharacteristics/homeinternetandsocialmediausage/articles/exploringtheuksdigitaldivide/2019-03-04#how-does-digital-exclusion-vary-with-age

As reported later in the staff interviews, we learned that some practices did not target this population for the programme, and so may have excluded a large proportion of their populations from the start. https://digital.nhs.uk/data-and-information/publications/statistical/patients-registered-at-a-gp-practice/april-2021

> *"I don't know if we'll offer the programme to those aged over 65 [patient list generated by practice to call were for those under this age] and the likelihood is they won't have a phone or have the means or expertise to access the programme. I think there's a realistic age limit to reach for in this case."* 3

Practice E was the only practice with a slightly higher deprivation score (score removed to anonymise practice) than the national average (21.7). This would indicate these patients may be at higher risk of obesity, may not have access to digital devices, and may not engage or have no health literacy to access support services. https://www.gov.uk/government/statistics/english-indices-of-deprivation-2019

Nationally, just under 50% patients are registered to use at least one online service. For the demonstrator practices, this ranges between 39-56%. This means that at least 44% of patients at each of these practices are not registered for any online services. This may suggest that either patients are not engaging with online services, or that practices are not yet able or willing to offer this to their patients. https://digital.nhs.uk/data-and-information/publications/statistical/mi-patient-online-pomi/mi-patient-online-pomi

Depression and Hypertension were the top QOF measures for all the demonstrator practices. Obesity and Diabetes Mellitus were the next highest conditions, which all align with weight loss being a priority for these practices. However, it is important to note that the QOF measures may not be a true reflection of prevalence, but rather how good practices are at reporting these conditions. https://digital.nhs.uk/data-and-information/publications/statistical/quality-and-outcomes-framework-achievement-prevalence-and-exceptions-data

Of the large range of GPIT indicators, 27 were chosen to be informing general digital readiness e.g., 'The practice promotes and offers email consultations for practice patients', 'At least 30% patients registered for patient online access appointment booking', and 'Practice system able to support patients to book/cancel

appointments online'. Practices self-report on these metrics and Practice D responded 'Yes' to the least number of GPIT metrics (55.5%), followed by Practice A (59.3%), Practice E (70.4%), and Practice B (77.4%). Practice C responded 'Yes' to 81% of the 27 GPIT metrics chosen, suggesting they are the most digitally mature of the demonstrators using the programme. They were also the practice with the highest proportion of patients registered to use at least one online service (55.8%). https://www.primarycareindicators.nhs.uk/

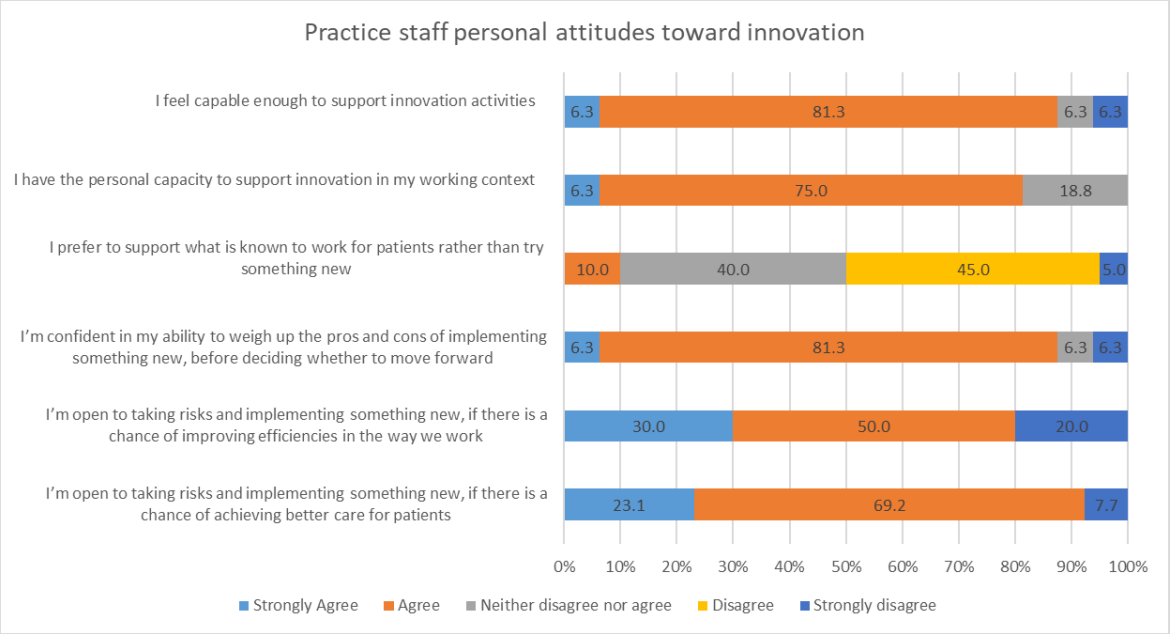
When considering the information above, it could be concluded that the five demonstrator practices all differ slightly in demographics and digital readiness. Although they appear to be managing and treating similar conditions, the age and level of deprivation of the populations served, the staff members employed to deliver care, and the digital maturity vary. This contextual information has been considered in the interpretation of the findings in this evaluation.

3.2 PRACTICE STAFF ATTITUDES TOWARD INNOVATION

To complement the practice profiles and understand more about the demonstrator practices, staff were invited to complete the Attitudes Toward Innovation Scale (ATIS) developed by Wessex AHSN. In total, 21 practice staff across the five practices completed the ATIS staff survey at the start of their demonstrator experience. This survey asked about their personal attitudes, their perceptions of their colleagues' attitudes toward innovation, and their perceptions of their practice's position on identifying and utilising innovations.

As seen in Figure 1 and by combining strongly agree and agree responses, 87.6% of staff felt capable and 81.3% had the personal capacity to support innovation activities. Furthermore, 87.6% were confident to decide on the validity of innovations, 92.3% open to taking risks to improve patient care, and 80% open to taking risks to improve efficiencies at the practice. However, 10% of responding staff did prefer to support what is known, rather than try new innovations.

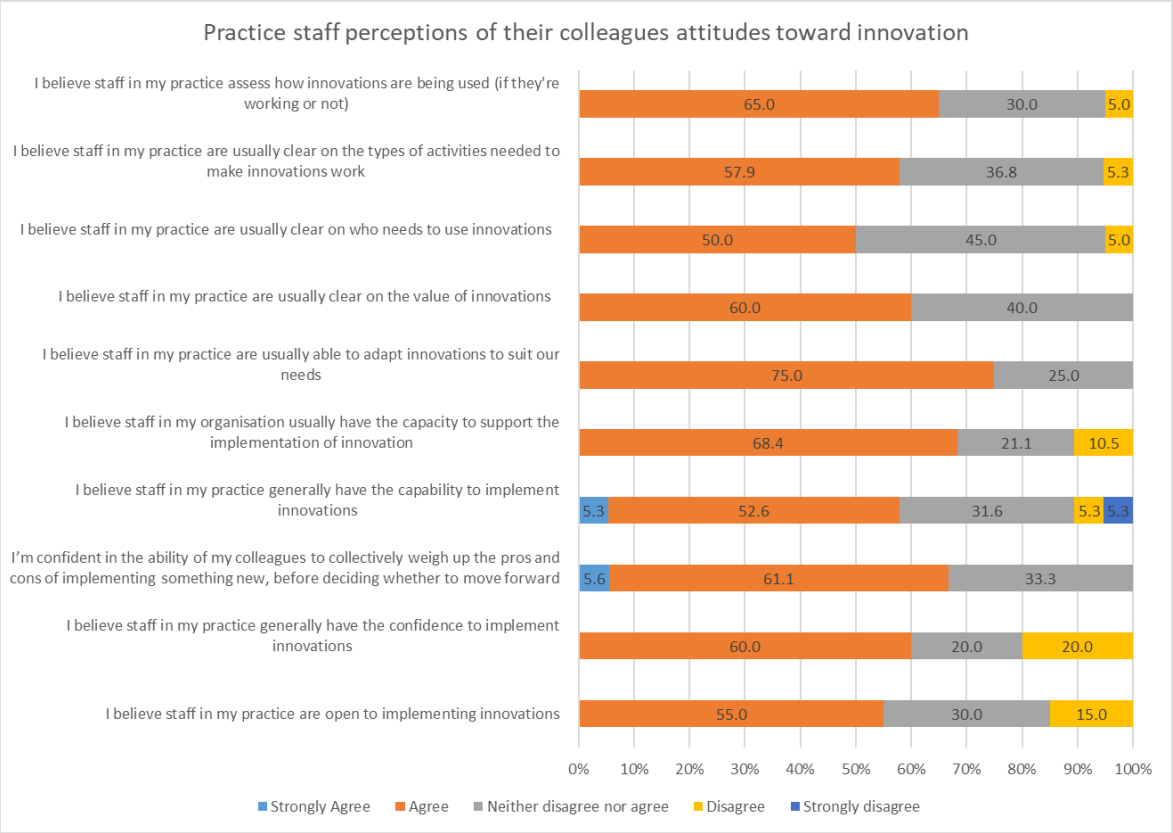
Figure 1: Practice staff personal attitudes toward innovation



As seen in Figure 2, there was less certainty from survey respondents about their practice colleagues' views toward innovation. By combining strongly agree and agree responses, only 55% of staff felt colleagues were open to new innovations, 65% of staff felt colleagues took time to determine if innovations were working or not, 57.9% were clear on the activities needed to make innovations work, 50% of colleagues usually clear on who should be involved, 60% clear on the value of innovations, 68.4% had capacity to use innovations, 57.9%

had the capability to use innovations, and 60% were confident to implement innovations. However, 75% of staff responding did think their colleagues were able to adapt to use innovations when required.

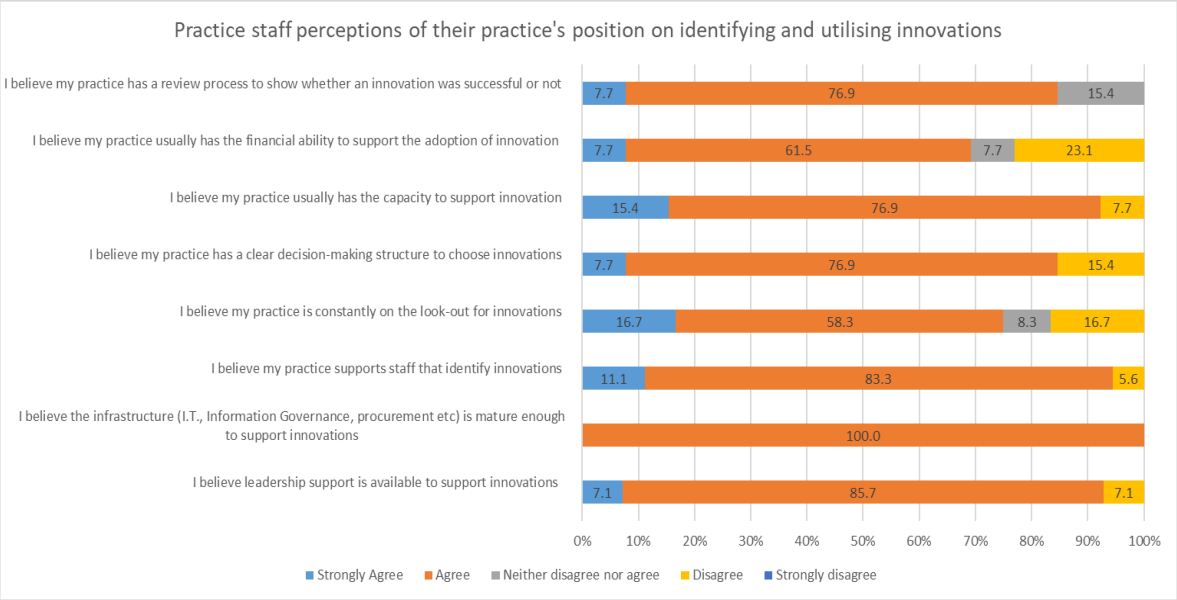
Figure 2: Practice staff perceptions of their colleagues' attitudes toward innovation



As seen in Figure 3 and by combining strongly agree and agree responses, 100% of staff respondents thought their practice I.T. infrastructure could support new innovations, 92.3% thought their practice had the capacity to support innovation, 92.8% had leadership support available to support innovations, 94.4% thought their practice supported staff that identify innovations, 84.6% had a clear decision-making process to select innovations, 84.6% had a clear review process about innovations, and 75% felt their practice was always searching for innovations. However, only 69.2% of staff respondents thought their practice had the financial ability to support innovations.

These contextual findings provide a basis upon which to understand the referrals data and qualitative findings on implementation, acceptability, and impact of the programme.

Figure 3: Practice staff perceptions of their practice's position on identifying and utilising innovations



4. FINDINGS - REFERRALS TO THE PROGRAMME

Each of the five participating practices routinely provided referral information through the lifecycle of the evaluation. Of note is the considerable effort required by the Wessex AHSN evaluation team and individual practices to disentangle referral data. This took several weeks as there was considerable SNOMED coding confusion at the practices, e.g., whereby the programme and other weight management intervention referrals were being recorded on the same code. This issue is further explored in section 5.

As seen in Tables 1 and 2, since the launch in July 2021 to the end of data collection for this evaluation, referrals to the programme were very limited at the demonstrator practices. Referrals to the programme were a small proportion of referrals generally to all available weight management interventions. For all the demonstrator practices, aside from Practice E, the small number of referrals appeared to have happened sporadically before the practices ceased to make any further referrals. Practice E was the practice with the slowest uptake of the programme, only beginning to refer to the programme in the last two months of the evaluation data collection period. Therefore, it is not possible to understand whether referrals from Practice E will continue or cease.

There were different referral models between practices. These referral models need to be considered to provide context and best understand the referral numbers. Although Practice E did not commence referring patients until the end of the evaluation data collection period, they adopted a proactive and planned referral strategy (sending out batch messages to eligible patients) as opposed to an opportunistic referral strategy (when a patient attends for an appointment). These strategies should be considered in the future to identify the optimal referral strategy for the practice context.

Lastly, it is important to note that of the two referrals made by Practice A, both patients contacted the clinician who made the referral due to issues or dissatisfaction with the programme. This feedback has been acknowledged here as this was likely a contributing factor in Practice A ceasing further referrals.

Table 1: Total referrals to the programme

Practice	Total referrals to all weight management innovations (the various options available to GPs between July 2021 and March 2022)	Total referrals to the specific NHS Digital Weight Management Programme (between July 2021 and March 2022)
Practice A	332	2 (0.6%)
Practice B	69	4 (5.8%)
Practice C	248	1 (0.4%)
Practice D	43	8 (18.6%)
Practice E	160	21 (13.1%)
Totals	852	36 (4.2%)

Table 2: Referrals to the programme over time

Practice	Referrals to NHS Digital Weight Management (from service launch)											
	July 21	Aug 21	Sept 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Total
Practice A	0	0	0	0	0	0	1	0	1	0	0	2
Practice B	0	0	0	0	0	0	1	1	2	0	0	4
Practice C	0	0	0	1	0	0	0	0	0	0	0	1
Practice D	0	0	0	0	0	6	2	0	0	0	0	8
Practice E*	0	0	0	0	0	0	0	0	0	21		21

**21 is the number of patients who consented for a referral to be made to the NHS Digital Weight Management Programme between April and May 2022 from a proactive recruitment strategy whereby messages were sent to patients who met the programme's criteria from their medical records. The exact date when the referral was completed by the practice is unknown.*

5. FINDINGS - UNDERSTANDING THE ADOPTION

Referrals by demonstrator practices to the programme were extremely low during the evaluation period. To understand why this is the case, the interviews with staff enquired about their experiences of the implementation of the programme, any challenges, and any perceived impacts of the implementation approach.

Seven staff from four demonstrator practices were interviewed about the programme. No staff members were available for interview from the fifth demonstrator practice. Four of the seven interview participants were part of Health & Wellbeing teams and female. These are teams comprised of non-clinical experienced health and lifestyle coaches. They cover various aspects of health, including sleep, wellbeing, physical activity, healthy eating, and lifestyle choices – aiming to encourage individuals to make positive and lasting changes to their health with a personalised approach. The remaining three participants were GPs and male. Written informed consent was obtained prior to the interviews and all were audio-recorded to support the analysis.

The reasons for low referrals were multi-factorial and complex, and most practices experienced these factors to a greater or lesser extent. Table 3 describes the themes identified from the staff interviews.

Table 3: Themes identified from practice staff interviews

Theme number	Theme and sub-themes
1	Limited clinician awareness about the content of the programme
2	Unknown triage processes and criteria
3	Mixed views from clinicians on their acceptability of the programme
4	Internal practice organisation to operationalise the programme 4a Different approaches 4b Throttling of access to the programme 4c Utilising Wessex AHSN implementation support
5	Considerations during the clinical encounter 5a Communicating the value of the programme to patients 5b Multiplicity of options 5c Patient preferences
6	Considerations after the clinical encounter 6a The referral process 6b The coding process 6c Absence of feedback 6d Significant delays reported in accessing provider support
7	Wider pressures in general practice

5.1 THEME 1: LIMITED CLINICIAN AWARENESS ABOUT THE CONTENT OF THE PROGRAMME

Across the interviews it was apparent there was limited awareness about the content of the programme, and each provider option within the programme. It was possible to know the provider names and which level of support they were linked to, e.g., 'Second Nature' was for Level 1 Digital Only and Level 3 Digital plus 100mins of human one-to-one coaching, and 'Xyla Healthcare' was available for all three levels of support – but it was not possible to know the specifics of what would happen to patients once they joined the provider's intervention. Many staff reported this was due to the complexity of the programme, access to information barriers, and limitations on their own time to understand the intervention options.

> *"I'm not hugely aware of it [*the programme*] to be honest, I know some details…my role [Health & Wellbeing team) isn't prescriptive, it's about helping patients to come to their own solutions and motivating them." 5*

> *"I think I would have had more impact if I'd been able to really explain to patients what the various options are and helped them make a decision tailored to their needs." 7*

Furthermore, attempts were made to investigate the programme but without success and these had an important impact on the ability to discuss it with patients.

> *"We did ask [programme commissioner] to see content material but didn't receive anything back. When we're talking to our patients and trying to describe what it involved, we can't really answer that...even a written summary would have been helpful to describe to patients on what they were work on over the 12 weeks. Also, I think patients expect that we would know more, and we couldn't help them." 3*

> *"I'm just hoping it [the programme] lives up to how I've sold it to patients. At the moment, I don't know." 7*

Linked to this was the general sense of a lot of weight management options available to general practice clinicians to discuss and refer to, e.g., the programme, ShapeUp4Life, Man Vs Fat, NHS Diabetes Prevention Programme, Better Health/NHS Choices/Change4Life, Solutions4Health, Weight Watchers, Slimming World. This abundance of options places a heavy informational burden on clinicians, which operated alongside a need for information about the programme and its providers in order to make decisions.

> *"I think health professionals are struggling to know what is available for weight management, so imagine what that's like for the patients." 5*

Despite these authors awareness of the informational resources provided by the national team, e.g. FAQs June 2021, clinicians interviewed were keen to see the literal process patients who go through, to feel confident to tailor suggestions to patients and/or help patients decide if needed.

5.2 THEME 2: UNKNOWN TRIAGE PROCESSES AND CRITERIA

Across the interviews, considerable confusion about the triaging process was reported. This had implications for clinician confidence in referring, managing patients' expectations, and whether patients continued with the programme, as described by this staff member:

> *"What are the triage criteria? How do they allocate patients to the levels? I just don't know, so it's hard to predict how patients will react in the future knowing some of their preferences at the start for personalised support…I don't know how the triaging system works and was surprised when a patient was not triaged to the personalised support level, as they had a BMI in the 40s, did no exercise, and had low knowledge of good eating habits etc…some patients didn't get triaged into the group for more personalised support, were disappointed, and went to the NHS Better Health Let's Do This App." 7*

The apparent challenge with a complex score-based triage system is how it stands against patient preferences (e.g., for personalised support) and the clinician-patient discussion at the point of referral. Patients triaged into the digital only option may react negatively due to their perceived need for personalised support. A review of the triage system, to include clinician input would potentially provide a more holistic equation for decision making.

5.3 THEME 3: MIXED VIEWS FROM CLINICIANS ON THEIR ACCEPTABILITY OF THE PROGRAMME

Clinicians reported mixed views about the programme, some stating they welcomed it as an additional weight management option for patients, but also that it was too soon to know about its impact.

> *"It's early days, but I think [the programme] can have a positive impact on our practice as it's another option for patients and as its digital it will appeal to a certain part of our population. The more diverse the range of tools the better, it's a good thing." 4*

> *"If you have a patient who is motivated and wants to do the programme, online and self-paced, then it's great, they've got 12 weeks to focus on, they're not in and out of the surgery, and achieve their goals." 5*

Due to implementation challenges, some staff were reticent about referring due to the complexity / bureaucracy needed to make a referral, the time pressures of a GP-patient consultation, and sustainability of the operationalisation of referrals via the Health and Wellbeing team.

> *"At the moment, as GPs in the practice, we're not often thinking about [the programme] as an option because of the e-RS (e-Referral System) referral step. What matters is speed, we have 600 seconds in a consultation, and this will likely be the last 30secs and its not enough time. We need something easy and simple to use whilst we've got the patient in front of us and we have the patient's attention. We can't end the conversation with 'you need to lose weight' and leave it there. We need to give the patient a mechanism to do something about it, but no detracting from the original reason they were in the consultation room." 2*

> *"It's another tool in the armoury but it increases workload to manage the referrals." 6*

> *"Unless we continue to take time away from the Health & Wellbeing coaches to have the discussions and organise referrals, I can't see us using it into the future." 2*

5.4 THEME 4: INTERNAL PRACTICE ORGANISATION TO OPERATIONALISE THE PROGRAMME

SUB-THEME - DIFFERENT APPROACHES

From the interviews it was apparent there were two approaches to organising referrals to the programme. Firstly, in an **ad hoc manner during routine GP consultations**. This was considered difficult to operationalise in

the limited consultation time and likely hampered by clinicians' limited awareness of the detailed content of the weight management options and providers.

> *"We've referred very much on an individual clinician basis, so opportunistically during any form of consult and check to see if they meet the criteria. I task my colleague to complete the referral form and then we leave it there, we don't follow the patient up after that." 6*

> *"What is an issue is the time involvement for practices…at the moment having to complete an e-referral is taking two members of staff. Somebody to send the text invite, have the conversation, and go to a second person to create the e-referral. So half of our onboarding to weight management services is ad hoc and based on Floreys we can do, sending them out whilst we're doing our repeat prescriptions…having to have verbal conversations and organising an e-referral is too much work to tag onto the end of a 10min consultation." 2*

In the case of GPs raising a discussion about the programme, it is a fast and limited discussion after which the onus is fully on the patient to research the available options and take the process forward themselves regardless of readiness levels.

The second approach was **proactive and via Health and Wellbeing teams**, as described by this staff member:

> *"We decided to do some patient searches and find people with hypertension or diabetes and there are so many patients that meet those criteria, so we've decided to focus on patients aged 65 and under. So we [Health & Wellbeing team] are ringing all those patients and offering the programme. We're sending a text message asking if they want to be automatically referred, if they say yes then they're referred and there's no telephone discussion. If they say nothing or no, we follow up with a text message asking if they'd like a call from the Health & Wellbeing team. If they agree, then we work from that list and call them." 3*

There appeared to be a different ethos within the Health & Wellbeing teams which affected the speed at which a referral was made. This was particularly true if the Health & Wellbeing coach perceived wider issues to deal with, e.g., confidence, prior to starting a weight management intervention.

> *"When I get patients referred to me and I start working with them, it's about being led by the patient, so they may have been referred to me by a GP about weight but they may not be the most important issue to deal with at that time, they may work up to that issue and have other stuff that is impacting on their ability to focus on weight management…most people know they need to lose weight, so its dealing with the barriers to dealing with it and building up their motivation. Its only at the point that the patient says 'can you refer me then' or if they really don't know what to do that I would say here are the options." 5*

In the case of Health & Wellbeing coaches raising a discussion about the programme, it is holistic and very conscious of patient preferences.

SUB-THEME - THROTTLING OF ACCESS TO THE PROGRAMME

It was apparent that due to the complexity of the referral process and the potential for many patients to be contacted from proactively generated lists, controls were in place to manage the volume of discussions about the programme and referral process. This makes sense from a practical point of view but also raises the question of exclusion from involvement in the programme.

Throttling (limiting) was seen firstly through delayed starting of referrals to the programme, as stated by this staff member:

> *"We were slow to get the programme going, there was a lot of to-ing and fro-ing in our PCN about how much involvement we wanted our Health & Wellbeing coaches to have, because potentially the numbers of patients that could go on it is high. It's a question of how much of Health & Wellbeing coaches time do we want to fill up? We could fill all of them up with the programme, so we've had to target patients, so it's not going to reach everyone. So that's why ShapeUp4Life is easier to provide, it's a standard referral form, two ticks and an email, and not having to go into the e-RS system." 2*

Secondly, through selective age restrictions, as described by this staff member:

"I don't know if we'll offer the programme to those aged over 65 [patient list generated by practice to call were for those under this age] and the likelihood is they won't have a phone or have the means or expertise to access the programme. I think there's a realistic age limit to reach for in this case." 3

Thirdly, the previous experience of patients on weight management interventions was important to judge, and thus could affect whether a referral to the programme is made, as described by this staff member:

"Should we use nudge theory? Patients may have declined a referral to a weight management intervention before, and if we offer them another service when they've declined similar things or the same things before, it's another prompt about weight loss and we have to decide if it's inappropriate or sensitive to do that." 4

SUB-THEME - UTILISING WESSEX AHSN IMPLEMENTATION SUPPORT

All practices reported a late start (referrals routinely being made in approximately January 2022) with the programme, in comparison to the mid-June announcement of the Enhanced Service and 1st July 2021 launch. As the primary care 'deployment team' at Wessex AHSN realised there was a gap in informational support for practices, several 'how to' guides and videos were created, including a comparison of digital solutions, and provided as training to practices participating in this evaluation, as described by this staff member:

"We were being guided by our PCN Clinical Director and the information [from NHS Digital Weight Management team] arriving to them. That person is a working GP of course so it's very easy for information to be lost and the weeks and months go by. I think the launching sessions with Wessex AHSN were helpful, as otherwise the programme may have easily sat in the background with everything else going on, especially as we were still dealing with COVID at the time." 3

"The slide presentation from Wessex AHSN was great and we've condensed that down and now provide that to patients, so they can make a more informed decision." 3

However, the training resources took time to develop and be deployed to practices. There was frustration from practice staff, generally with the national team and with the local deployment team, that this level of detailed support to understand the complexities of the programme was not provided sooner, as stated below:

"I was a bit disappointed that the training [Wessex AHSN organised in October 2021] came so much later than the launch of the programme [national launch July 2021] and thus we weren't talking to patients about it until early 2022. We were also concerned that the programme would only be available for a certain amount of time." 3

These reflections contribute to the wider issue of timeframes for implementation support, particularly for complex programmes like the NHS Digital Weight Management Programme, as reported by this staff member:

"If some detailed training had been available three months before the programme went live, it would have been smoother and more widely used and hit the ground running. You need that time for discussions at practice management meetings, referral processes to be put in place, for staff and GPs to be aware of it, and that can be a slow trickle down of information and slow process. If the information isn't on a small plate, it doesn't always get absorbed quickly. We want to feel competent in what we're doing and offering to patients." 3

5.5 THEME 5: CONSIDERATIONS DURING THE CLINICAL ENCOUNTER

SUB-THEME - COMMUNICATING THE VALUE TO PATIENTS

As previously stated, the lack of detailed information on the provider interventions within the programme and specifically what would happen to patients was a perceived problem for many practice staff. The subsequent challenge of passing enough information to patients for them to make informed decisions was also raised by practice staff:

"I only know about the referral criteria, I haven't been able to go into the programme system and see what is available for patients…it could do with a 'dummy patient' situation so we can go in and see is it modules etc. To be able to speak to a patient, you know, every patient is individual, some are 'what

is this and how does it work' and how am I going to look when I say there is this programme out there and all I know is the criteria. How do I encourage the patient that this is the right step for them?" 5

Often, the programme was compared to other weight management options, and helps explain the low referral rates to the programme, as described by this staff member:

"For ShapeUp4Life I can show the patients a website in my room, if onboarding them that way, but I can't do that for the Digital Weight Management Programme. So how to describe that to patients is quite difficult. There isn't an automated leaflet or information that goes to patients. It's hard to explain to patients what the digital aspects of it really means in practical terms." 2

SUB-THEME - MULTIPLICITY OF OPTIONS

Related to theme 1 on awareness of weight management options is the issue of how to choose and use interventions within a clinical consultation. Many staff reported confusion about which weight management option would be best for an individual patient, that referral criteria were complex to deal with in short consultations, that more support from practices to differentiate interventions would be welcome, and that clinicians display preferences toward weight management options – often related to time constraints. As described by these staff members:

"There are unfortunately quite a lot of weight management interventions out there, so it can get a bit confusing for myself and patients. I've mostly been referring to ShapeUp4Life, as I was under the impression that was the preference on our tier management system." 5

"The one thing I struggled with was the 'exercise on prescription', Tier 2 weight stuff like Slimming World and other weight management options, and now this programme – but that's only for diabetes and hypertension and there were a few I sent off [referred] that didn't meet the criteria and I thought 'oh no' and I must remember there are criteria for [NHS Digital Weight Management Programme]." 6

"If there are multi options for weight management then the practice should filter down that information and fill us [Health & Wellbeing coaches] in so we can factor that in when discussing options with patients. Otherwise, ShapeUp4Life does what it says on the tin so why would I choose anything else to refer patients to?" 5

"Exercise on prescription is a face-to-face programme and Tier 2 services can be online or face to face. I may talk about one or other weight management interventions more than the others just due to time constraints in the consultation…to decide you must make assumptions that someone is digitally literate, about trying to increase their activity levels or change eating habits." 6

SUB-THEME - PATIENT PREFERENCES

A clear influence on the uptake of the programme was practice staff reflections on patients' preferences for weight management interventions. In particular, the perceived value of the programme was the convenience provided by a digital innovation in addition to personalised support.

"It [NHS Digital Weight Management programme] stood out for some people as they heard about the potential for more personalised support, that's what drew patients in, and they wouldn't need to go to a village hall, and it would fit in with their life. Patients liked this." 7

However, the need for personalised support was often attached to the need for face-to-face support for weight management, which would suggest that not all patients are welcoming of a digital-only intervention. Clinicians are aware of this and respond accordingly, as described by these staff members:

I've spoken to two patients about it [NHS Digital Weight Management Programme] recently, one wanted to be support in groups and not a digital intervention, so I signposted them to ShapeUp4Life." 5

"Some of the feedback we've received is that patients are preferring face-to-face for weight management support." 2

"During a conversation, if a patient doesn't meet the criteria for [NHS Digital Weight Management Programme] then we talk about the ShapeUp4Life. However, if a patient meets the [NHS Digital

Weight Management Programme] criteria but doesn't want an online intervention then we'll offer something that have a face-to-face option like ShapeUp4Life." 3

"Having use of a solution [NHS Digital Weight Management Programme] that fits into people's lifestyle is reasonable but the proof is in the pudding on how many people have taken it up and benefited from it…I wonder how many people have said yes I'll have an app, download it, and then leave it on your phone and forget about it…how many apps do you have on your phone that you don't use and notifications that you ignore? [This is] versus exercise on prescription whereby you're having a session with a physical trainer to work out your levels and preferences, and you have to go somewhere and it's habit forming." 6

Furthermore, patients have preferences after they have chosen a programme provider. Interestingly, several patients were reported by practice staff to have requested a change in provider after their initial experience was not what they expected. However, there does not appear to be a mechanism to manage this change in treatment.

"There is no simple way to change provider, which I've had patients come to me about. Several have said it wasn't what they thought it would be." 7

5.6 THEME 6: CONSIDERATIONS AFTER THE CLINICAL ENCOUNTER

SUB-THEME - THE REFERRAL PROCESS

All staff interviewed agreed the referral process was complex and time consuming. At a minimum it took time for medical secretaries to manage the referral process and, in some cases, it took GP time to action the process. There was a clear preference for a self-referral mechanism like other weight management interventions, as described by the staff members below:

"We are really busy, so why do we need to go through the complicated referral process, why isn't there a way like with other [weight management] options to recommend to a patient this is what we advise and here is a link for you to contact yourselves. I wondered if there was a way the national team could organise that." 4

"We have the discussion with the patient and then task our medical secretaries to do the referral, but I do wonder is that a necessary step that we [the practice] do the referral. I think it's important that patients are motivated and proactive for this kind of intervention, that's part of any success they might see, and they make their own self-referral…I think it would be good for the national team to consider why it can't be a self-referral option." 4

"The thing about ShapeUP4Life is that there's a self-referral option, whereas with [NHS Digital Weight Management Programme] I have to do the referral myself." 5

SUB-THEME - THE CLINICAL CODING PROCESS

In the time-pressured environment of general practice, the additional problem of coding the referral was a demotivating factor for many staff. There was confusion and frustration with the situation whereby different weight management interventions were being coded to 'Referral to weight management service' (SNOMED code: 1326201000000101).

Confusion persisted due to several other available options for coding referrals to weight management interventions, e.g. 'Signposting to weight management service 1083431000000109', 'Refer to weight management programme 408289007', 'Referral to weight management service offered 767661000000105', 'Referral to weight management service declined 506171000000109'.

"The SNOMED code issue is you cannot code it as a digital offer, when looking back at referral data you cannot tell which is [NHS Digital Weight Management Programme] and which is another weight management offer." 4

"The referral code to the [NHS Digital Weight Management Programme] is used for other weight management options as well. That makes it tricky to understand who has been referred." 6

The problem this created was an inability to monitor referrals and robustly interrogate the practice's own data. This was also a significant challenge for the Wessex AHSN team conducting this evaluation.

There were also frustrations in finding appropriate referral routes in the NHS e-referral system (e-RS):

> *"A frustration with the enhanced service was it was clear that referrals to the national diabetes programme would be counted, but initially they didn't include any of the [SNOMED] codes, so organising referral coding was very open to interpretation. In the initial stages, I had to double code for a patient who'd been sent to a dietetics service, but I think that's been revised, but I've still had to go back and retrospectively unpick the referrals for our needs. It was frustrating that we had the service details and start date from NHS England but hadn't sorted out the coding yet." 2*

> *"When we first started using [NHS Digital Weight Management Programme], we were confused on how to do an e-RS referral because the [NHS Digital Weight Management Programme] isn't listed in the weight management area, it's in Dietetics. That is not a helpful place to put it."*

SUB-THEME - ABSENCE OF FEEDBACK

The referral and coding challenges meant that an inability to monitor referrals was demotivating and led to disengagement from practice staff. This was compounded by very limited feedback from patients and the national team leading the programme.

> *"I would not have clue [on who has taken part in NHS Digital Weight Management Programme], this is a big issue, if you don't get feedback on how many patients have accessed the [NHS Digital Weight Management Programme] intervention and how far they've got, you [GP] lose the drive to refer to it. I think that's what's happened, there was an initial drive and then a frustration with a lack of feedback. The only feedback I've had is from two frustrated patients who couldn't navigate the forms [referral hub information required]. I haven't received any feedback from the national programme highlighting its use." 6*

> *"I haven't any incoming documentation [from NHS Digital Weight Management Programme Referral Hub] about whether any patients have completed the course yet. I don't know what the success rate is yet." 2*

SUB-THEME - SIGNIFICANT DELAYS REPORTED IN ACCESSING PROVIDER SUPPORT

Many practice staff reported significant delays in accessing the provider support, particularly in relation to accessing the human-supported elements where applicable.

> *"After the conversation with me, the patients feel like this could be the first day of the rest of their life, but then the delay of not following through is devastating. The delay with, for example [provider named] for one patient, was about 6 to 7 weeks…the gap is far too long." 7*

5.7 THEME 7: WIDER PRESSURES IN GENERAL PRACTICE

General practice is under considerable pressure at present, with increased demands, a heavier workload, and increased complexity and intensity of activity. It was clear from the staff interviews wider pressures were a barrier to the engagement and operationalisation of the programme.

> *"Due to COVID and recent pressures on general practice, this [NHS Digital Weight Management Programme] hasn't been a priority for us to work out how to share the information with practice staff." 4*

> *"Although we've been receiving emails about [Digital Weight Management Programme] for quite a while, I haven't been able to look into it due to current pressures." 5*

> *"It was launched during a difficult period to be honest, in fact we're still under COVID procedures [interview in mid-April 2022], we're still triaging patients before we see them face-to-face. I think it was an odd time to launch it." 2*

6. FINDINGS - PERCEPTIONS OF IMPACT ON PATIENTS

The ability to judge the impact of the programme was severely limited by low referrals across the participating practices and the absence of any patients completing the intervention. Some views on patient impacts were shared via the staff interviews, some via ad hoc patient-to-clinician feedback provided by participating practices, and some captured as part of the one patient activation measure and patient acceptability survey completed.

Practice staff reported that it was too early to infer patient impacts, as described by this staff member:

> *"It's taken too long to get our processes set up, we're at the onboarding stage, we haven't received any discharge documents yet, so it's too early to know how this has impacted on patients." 2*

Some staff described negative feedback from the handful of patients who've initially been referred.

> *"For example, those who were triaged only just having the app, which they said was no different than having any other app…what they found disheartening was what was pinging through each week – rather than thinking someone was going to look into the situation properly – was looking at things via a photograph of a meal and saying things like "it's good to see you're having vegetables" and a bog-standard copy and paste text message…so they didn't feel that encouraged." 7*

> *"Each week the learning would be unlocked, like support, control, exercise or alcohol, but in the group chat they would paste some paragraph that would link to that learning but patients' personal queries were not addressed. They [intervention staff for the human-supported options] would login every few days and put the next paragraph in the group chat…but there was no set day or time they would come in, and it wasn't a two-way dialogue. There was just a comment on 'well done for having vegetables and keep it up'. It didn't feel any different from other apps...it didn't feel genuine." 7*

One patient consented to provide feedback on one of the provider options:

> *"I signed up for [provider named]. I didn't realise that it was a fully automated service. I thought we would be assigned into groups with somebody checking in on me. Although they have support, they only respond if you ask them a question and I did ask a question in community support but it was unanswered. Even when you sign up you are just left to look at the resources there is no clear pathway as to what to do. I don't think this app adds any value as you are left to your own devices which anybody could do on their own." (Patient linked to staff member 7)*

One patient, triaged to level 2 for digital intervention plus minimum of 50 minutes of human coaching, was sent a 'baseline' Patient Activation Measure (PAM) to complete at the time of referral to the programme. This was to understand whether the patient had the knowledge, skills, and confidence to manage their own health and care. This patient was female and aged 18 to 24 years old. Despite the patient having a self-reported high level of activation, scoring 84.80 and having an activation level of 4 on the PAM (defined as maintaining behaviours and pushing further), the patient did not attend their assessment with a coach from the provider team. As a result, this patient was not emailed a 'follow-up' PAM as this follow-up measure was intended to be finalised 'on completion' of the programme.

The same patient also completed the patient acceptability survey. In summary, they strongly disagreed with six key survey questions on whether they felt the programme: (1) would help manage their weight, (2) was an easy way to manage their weight, (3) offered reliable technical aspects, (4) fitted in with daily activities, and whether they felt (5) confident to use the programme, and (6) would use it again if needed.

7. FINDINGS - PERCEPTIONS OF IMPACT ON STAFF AND PRACTICES

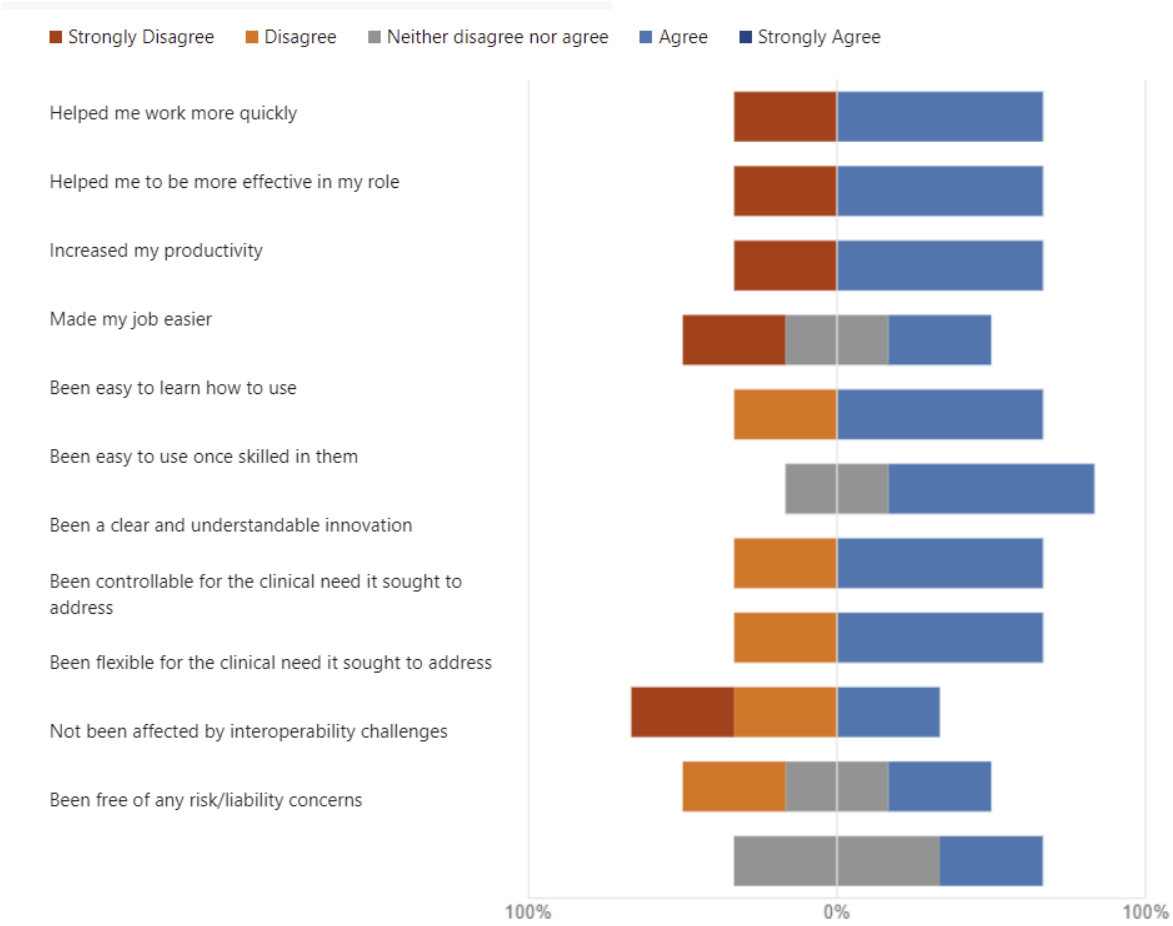
The ability to judge the impact of the programme was severely limited by low referrals across the participating practices and the absence of any patients completing the intervention. Some views on staff and practice impacts were shared via the staff interviews and some captured as part of the staff survey about the programme.

Practice staff discussed lots of challenges to the programme, however, they were optimistic that it could offer a valuable solution, as described by this staff member:

> *"It's early days, but I think [the programme] can have a positive impact on our practice as it's another option for patients and as its digital it will appeal to a certain part of our population. The more diverse the range of tools the better, it's a good thing." 4*

In an online survey to all practices, staff were asked about the programme specifically. Figure 4 below outlines the views of three practice staff – each from different practices. They were asked if they agreed or disagreed with the statements in Figure 4. Due to the low numbers, these findings can only be seen as early broad indications of impact. They are included for completeness but should be interpreted with caution.

Figure 4: Practice staff views on the programme



In the few instances where the programme has been used by clinicians, mixed views have been reported on a range of questions. Polarised views (strongly agree and strongly disagree) were seen on whether it helped staff to work quickly, made them more effective, increased productivity, and made their job easier. The programme was considered easy to use once staff are skilled in the processes needed to operationalise it but has been affected by interoperability challenges – it is assumed staff are referring to the human interoperability

challenges of referral processes, coding confusion, and organisation needed to share information between different team members (GPs, medical secretaries, Health & Wellbeing teams) to get referrals completed.

8. CONCLUSIONS

When considering the various data sources in this evaluation, a range of conclusions can be drawn.

At the clinician level:

1. **Practice staff had mixed views on their acceptability of the programme at this point in time.** Both the interviews and staff survey presented a range of challenges, notably, the complexity of operationalising the programme was reported by many and led to polarised views on whether the programme helped staff to work quickly, made them more effective, increased productivity, and made their job easier.

2. **Generally critical practice staff attitudes toward the programme led to low use.** Referrals were significantly lower than originally anticipated between July 2021 and March 2022. Across the five practices, only 36 referrals were made which represented only 4.2% of all/any type of weight management referrals during this period. This finding can be explained by a range of issues detailed below, due to both perceived implementation challenges related to the nature of the programme and to decisions made by clinicians in participating practices.

3. **Practice staff 'general attitudes toward innovation' did not appear to influence use.** Due to limited numbers, practice staff general attitudes toward innovation could not be compared between practices. As a group of responses, the clinicians involved had a positive personal outlook on using innovations in general. However, their views of their colleagues' attitudes toward innovation were less certain, for example, only 58% of staff believed their colleagues had the capability, 50% were clear on the who and how, and 55% were open to supporting the implementation of innovation at their practice. This contrasted with individuals' views of their practice's position on innovation, which were considered forward-looking and capable – although 23% of practice staff believed their practice did not have the financial ability to support innovation.

4. **Practice staff perceived many patients have preferences for personalised face-to-face weight management support.** Differing preferences of patients toward digital only support were described with some patients perceived to still want face-to-face personalised support. The low referral rate may have been affected by this preference and by patients who are automatically unable to be involved, i.e., those with low digital literacy or access to devices to support the intervention.

At the practice level:

5. **Practice digital readiness did not appear to influence use.** The practice profiles described Practice D as the least digitally mature and Practice C as the most digitally mature, based on the GPIT indicator metrics. However, this did not seem to influence the number of referrals to the programme, with Practice D referring second highest of the demonstrator practices. Practice C referred the least, only once, and this is better explained by the qualitative interview findings, with this practice providing detailed criticisms of an onerous referral process, coding challenges, and limited clinician acceptability.

6. **The programme is a complex to operationalise in busy general practice settings.** The complex nature of the programme, in terms of *operationalising referrals and having patient discussions*, was in tension with the reported preference of GPs for fast solutions whilst under the time and resource constraints of current general practice pandemic recovery conditions. Furthermore, coding complications and not receiving discharge summaries led to an inability to monitor or reflect on progress of patients and disengagement, in the face of a wide range of weight management alternatives that were easier to refer to and established.

7. **Practices took different approaches to referring**, either via GP routine consultations which were brief encounters or via Health & Wellbeing teams who worked from a list of identified patients and took time to work with patients to make choices based on their preferences. Due to low referral numbers, it was not possible to draw any conclusions about the value of either approach.

8. **Practice decisions to manage workload led to low use.** At practices, staff limited or 'throttled' access to the programme due to the burden of completing referrals, for example by only offering the intervention to patients under 65 years old who met the inclusion criteria. Also, practice staff showed preferences for easier-to-refer options such as ShapeUp4Life, which was 'two ticks, an email, and not having to go into the e-RS system'.

From the point of view of support/information sharing with practices:

9. **A lack of detailed provider intervention information led to low use.** Information about the programme and provider interventions was either unknown, inaccessible or overwhelming for general practice clinicians under pressure to deliver routine services. Clinicians reported limited knowledge (either not accessible or no time to access it) about the details of the providers and thus were unable to support clinical decisions/preferences of patients during clinical encounters. There are programme FAQs (June 2021), however, this was not "Clinician Ready Information", in a format for busy clinicians to pick up and immediately understand the programme and its nuances. Given the considerable pressures general practice are working under, the complexity of the programme, and general information overload in general practice – there is a great need for new programmes to have a wide range of support material in multiple accessible formats, e.g., videos to explain nuances of the programme, case studies describing/videos of patient referral 'discussions and decisions'. Wessex AHSN's deployment team attempted to fill this gap to support participating practices.

10. **Challenges at the national Referral Hub possibly contributed to low referrals.** Practice staff reported delays in patients accessing provider support, not receiving discharge summaries from the Hub, and an inability to obtain detailed intervention information from the Hub. Practice staff were unaware of the specific challenges at the Hub that led to this situation, only the resultant situation.

11. **The unknown triage process at the national Referral Hub presented challenges for clinicians** in terms of describing the programme to patients and predicting which level of support they would receive (e.g., digital only, or digital with human personalised support). It also has the potential to conflict with patient preferences, which cannot be circumvented, and this is likely one of the reasons for the disengagement reported and a lack of substantive throughput in the intervention.

When considering the wider context:

12. **The pressures on general practice due to COVID-19 contributed to low referrals**. All staff reported the challenges of COVID-19 work, e.g., vaccine programmes, and post-COVID backlog activity, and how that impacted their ability to engage with the programme to operationalise it in their practice

settings. Several highlighted that if training on the nuances of a complex intervention like this programme had occurred three months before the July 2021 live date, this may have resulted in more engagement – particularly in the context of COVID-19 related pressures.

Due to very limited data, it was not possible to meaningfully answer evaluation questions 2 (impact on patients), 4 (impact on practices), or 5 (how the impacts have occurred).

To address question 1 on the extent of use, clearly the programme is an under-utilised weight management intervention at present. This may not be due to the clinical value of the intervention/provider interventions, but the inability of referring practice staff to view the intervention detail and judge if there are fundamental value proposition problems. The extent of use was also affected by a multiplicity of weight management options and COVID-19 pressures on practices during the evaluation period.

To address question 3 on the acceptability and implementation of the programme, practice staff had mixed views on their acceptability of the programme at this point in time and this was strongly linked with their descriptions of implementation challenges. A wide range of challenges were reported, most notably, the complexity of operationalising the programme, multiplicity of weight management options, and GP preferences for fast solutions under time constraints such as simple or self-referral options.

To address question 6 on lessons learned, some of these came directly from the findings in this report. Other lessons were logged by the Wessex AHSN deployment and evaluation teams during the project. The lessons below are a hybrid list from these data sources.

9. SUGGESTED NEXT STEPS

The evaluation findings suggest that the following support would benefit the adoption of the programme:

9.1 INFORMATION SHARING CONSIDERATIONS

1. Make provider intervention materials and triage processes available to practice clinicians, so they can review the clinical acceptability and patient experience, in order to tailor their advice during clinical encounters.
2. Reduce the informational burden (managing information and the need for clinicians to seek information) by providing examples of referrals and case studies, potentially using short video format and other highly accessible media.

9.2 MANAGEMENT AND COMMUNICATION OF CHALLENGES

3. Provide clearer channels of communication regarding any challenges occurring at the practice level and at the Referral Hub (e.g., delays in allocating human-related support, in providing discharge summaries, coding confusion, e-referral location on e-RS). This should prevent disengagement from practice staff and automatically advocating other weight management options.

9.3 SUFFICIENT TIME FOR PRACTICE CLINICIANS TO EMBED COMPLEX NEW PROGRAMMES

4. As seen in the referrals data in Table 1, a great deal of time (five to six months) passed between the July 2021 launch and beginning to refer to the programme. Whilst the programme is a complex intervention with an informational burden and other challenges such a wider pandemic pressures, it would be helpful for practices to investigate national programmes, particularly when they seek to support priority areas of need, as they did in the participating practices with high rates of obesity. The referral levels to date cannot give the intervention a chance to be internally evaluated by practices.

5. Practices need time to prepare for and investigate complex national interventions. It was estimated that two to three months is needed to orientate, train staff, and set up practice level processes to manage the workload. It is suggested that launch dates for national programmes are preceded by several months of socialisation of information at the practice level, to give sufficient time to implement and evaluate the complex intervention.

9.4 MORE INVESTIGATION OF CONTEXT PRIOR TO STARTING A DEMONSTRATOR PROJECT

6. A fuller scoping of existing digital innovations at practices that expressed an interest may have led to different decisions about which innovation to offer and support. In addition, an understanding of interventions that permit self-referral compared to clinician led referrals, and the pros and cons of each, would mitigate the likely implementation challenge of 'clinician referral decisions based on ease of referral process'.
7. A fuller scoping of stakeholders would have helped deployment. Involving and gaining the views on the implications of deployment, from a wide range of staff during the expression of interest stage, would have been helpful to conversations with participating practices and secure timelines for implementing the innovation.
8. Practice engagement was highly variable; it would have been helpful to fully map out and routinely check practices were comfortable with and understood the different roles and level of input required for the deployment and evaluation activities.
9. Single one-hour launch events are not sufficient on their own to provide enough information for practices and clinicians to decide quickly / within the project timeframe about which innovation they would like to adopt as a demonstrator site. It cannot be assumed that busy practice clinicians have time to read lengthy pre-launch event materials, nor grapple with the implications of introducing an innovation within a short timeframe of a few weeks. Deciding on what and how to implement took two months for most participating practices.

9.5 MORE TIME FOR EVALUATION

10. One year was not enough time to deploy and evaluate a complex intervention that has a 12 week intervention timeframe. There were multiple risks to the timeframe, from: many months of delays due to varying levels of practice engagement (arguably predictable under COVID-19 pressures); once practices were engaged there were also delays making referrals; the volume of referrals would not be high due to the limited number of practices involved in the evaluation, and referrals do not all happen at the same time (e.g. hypothetically, patient 1 is referred in July and patient 50 is referred in December); and referrals only happen when they are clinically appropriate. With the need to allow the 12 week intervention to play out (for hypothetical patient 1 this would be January to March and patient 50 December to February), it was clear there would not have been enough time to collect and analyse quantitative and qualitive data on all patients to address the evaluation questions and write the final report. The demonstrator model would benefit from revisiting its structure and potentially using short one year demonstrator evaluations for simple interventions with a high turnover of use, and longer two year demonstrators for complex interventions like the NHS Digital Weight Management Programme.