

Beyond the 12-Week Model: A Co-design Study to Develop System Level Policy Recommendations for Long-Term Weight Maintenance in England

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Abstract

Background

Behavioural weight management programmes (BWMPs) can produce short-term weight loss; however, weight regain within one to three years is common. Provision in England is often funded for short periods, delivered through fixed 12-week models, and evaluated against short-term weight-based targets. Structural and system-level factors may influence long-term weight maintenance beyond individual behaviour change. This study sought to co-design and refine system-level policy and funding recommendations to strengthen long-term weight maintenance support within weight management services in England.

Methods

A multi-stage qualitative co-design study involved 16 weight management providers (WMP), 10 service users (SU), two carers, four referrers (R), and two funders (F). Of 34 stakeholders, five participated across all three data collection points. Findings from 96 prior interviews informed workshop content. Workshop 1 explored problems and potential solutions, informing draft policy guidance. This was reviewed through an asynchronous online workshop using Padlet and a further in-person co-design workshop. Data included written responses, rankings, audio-recorded small-group discussions, visual artefacts, and field notes. Reflective thematic analysis was inductive for Workshop 1 and deductive for Workshops 2 and 3, mapping stakeholder feedback onto policy themes. Iterative refinement resulted in 10 proposed policy guidance recommendations.

Results

Thirty-four stakeholders-informed and co-designed policy and funding recommendations that explicitly prioritise long-term weight maintenance. It identified convergent priorities across service users, providers, funders, and referrers, highlighting the need for longer funding cycles, flexible and tapered delivery, clearer referral infrastructure including a centralised “hub model”, and structured re-access pathways.

Conclusions

Improving long-term weight maintenance requires measurable shifts in funding duration, performance metrics, referral infrastructure, and continuity mechanisms. Policymakers should pilot five-year funding cycles with embedded review points, incorporate maintenance-focused key performance indicators, and test integrated referral hubs. Researchers should evaluate the implementation and cost-effectiveness of these system-level reforms across diverse local contexts.

Highlights

1. There is a lack of information about available weight management services and how to access them, resulting in missed opportunities for referral and support.
2. Unclear care pathways (i.e. which weight management support patients should be offered or available in the area) mean that patients with complex requirements may not receive additional support beyond behavioural programmes.

Policy Recommendations to improve weight loss maintenance include:

1. Establish a central hub serving as a single point of access for service users and professionals. This will enable ongoing follow-up and facilitate additional support for users as needed and streamlining referral pathways.
2. Develop transparent care pathways to make it easier for patients to access appropriate support, and empower health care professionals with the knowledge about how to refer patients effectively
3. Introduce funding longer funding cycles to weight management providers to ensure continuity of service provision.

Introduction

Obesity remains a major public health concern with approximately 30% of adults living with obesity [1]. Obesity is associated with increased risk of type 2 diabetes [2], cardiovascular disease [3], musculoskeletal conditions, and reduced sleep quality [4]. In England and several other countries, behavioural weight management programmes are commonly funded within community settings, and are a central component of weight management strategies [1]. A typical pathway for patients and services is referral by a general practitioner to a 12-week publicly funded behavioural programme. These programmes typically aim to achieve clinically meaningful weight loss (often $\geq 5\%$) through dietary change, increased physical activity, and behaviour change techniques delivered over a structured timeframe, usually 12 weeks [5]. While evidence indicates that such programmes can support short-term weight loss, longer-term maintenance remains a persistent challenge [6]. Not least, many programmes focus on weight loss rather than weight loss maintenance.

Weight regain following initial loss is common, with research suggesting that a substantial proportion of weight lost during structured interventions is regained within two years [7, 8]. Explanations for regain extend beyond individual adherence and include physiological (e.g., endocrine mechanisms) [9, 10], psychological factors (e.g., emotional eating, stress, tension), [11, 12] and financial and environmental constraints [13]. However, structural features of service delivery may also contribute i.e., programmes have short funding cycles, delivered over fixed 12-week models, and evaluated against short-term weight-based key performance indicators (KPIs). Such arrangements may prioritise short-term weight reduction over sustained behaviour change, and limit the opportunity for tapering support, relapse planning, or long-term follow-up.

Furthermore, evidence highlights fragmentation across referral pathways and variability in eligibility criteria (across regions), contributing to inequitable access and confusion among both healthcare professionals and patients [14]. This also attributes to what is called the 'postcode lottery', where individuals seeking support may have limited access to programmes and resources due to their location [15, 16]. Recent changes to service models in England such as the removal of the tiered care pathway

and the introduction of anti-obesity medications have increased uncertainty regarding appropriate referral routes and continuity of care.

Weight maintenance outcomes require attention not only to individual-level intervention content, but also to funding frameworks, service flexibility, system navigation, and ongoing support mechanisms. This project responds to these gaps by engaging stakeholders in the co-design of policy and funding recommendations intended to strengthen maintenance-oriented provision within behavioural weight management services.

Methods

Study Design

This study adopted a qualitative, participatory research design using co-design workshops to inform the development of policy and guidance for behavioural weight management services and funders. The first workshop was informed by a prior phase of 96 semi-structured interviews conducted with service users, funders, weight management providers, and referrers. These interviews explored experiences and perceptions of current services and identified priority areas to be explored during the workshop.

Researchers employed a three-stage approach to the co-designed guidelines, with the first workshop taking place in person, then an online engagement opportunity with an asynchronous format to provide flexibility and increased engagement, and the final workshop taking place in person (Figure 1). In between the workshops, the research team met with PPIE members and funders for critical feedback and insight on workshop agendas and emerging policy guidance recommendations.

Figure 1. Flow Chart of Research

Ethical Approval

Ethical approval for the study was granted by the Health Research Authority (24/WA/0348). All stakeholders provided informed consent prior to participation, including for audio recording and anonymised use of workshop artefacts.

Stakeholders

Stakeholders were purposively sampled to ensure a diverse range (by type of stakeholder, ethnicity and disability based on our equality impact assessment) of perspectives across the system. Eligible stakeholders included service users with recent or ongoing experience in behavioural weight management programmes, funders responsible for planning or funding weight management services, service providers, general practitioners (GPs) with experience referring patients to behavioural weight management services. Stakeholders were recruited through existing professional and community networks, direct outreach by the research team, snowball sampling, and reaching out to those that took part in the previous semi-structured interviews. Stakeholders received a £100 voucher for attending the in-person workshop and a £20 voucher for completing the online engagement.

In total, 34 stakeholders took part in the co-design study with 16 weight management providers (WMP), 10 service users (SU), two carers of service users, four referrers (R), and two funders (F). Of the 34 Stakeholders, five took part in all three data collection points (Table 1).

Table 1. Stakeholder Involvement in the Workshops

Data Collection

Data was collected and collated from the in-person workshops through audio recordings of small group discussions, photographs of artefacts (e.g., sticky notes, handwritten notes on large sheets of coloured paper), and field notes taken by facilitators and the research team. Artefacts were also transcribed to enable data analysis (see *Supplemental Materials*, p. 13). After the two in-person workshops, stakeholders were invited to provide their feedback anonymously about the workshop day, facilitators, and content.

Co-design WORKSHOP 1 – In-Person

Workshop 1 Objectives

- 1. Explore stakeholders’ experiences and perspectives on existing behavioural weight management services for weight loss maintenance.
- 2. Identify key barriers and enablers to effective weight loss maintenance.
- 3. Co-produce initial policy guidance recommendations.

Workshop 1 Structure

A one day co-design workshop was held in person at Loughborough University in June 2025. The session took place from 9:30am to 3:30pm, with breaks and refreshments provided (see *Supplemental Materials*). The workshop was facilitated by members of the research team with experience in participatory methods and public engagement. The workshop took place in a large room with five small tables, with each being facilitated by a member of the research team. When stakeholders arrived on the day, they chose which table they wanted to sit at, each table had a minimum of four stakeholders.

Co-design Online Engagement

Online Engagement Objectives

- 1. Gather feedback of the draft policy recommendations and guidance
- 2. Identify areas of the policy recommendations that required further refinement

Online Engagement Structure

As it was difficult to get referrers and funders of services to an all-day event, we conducted an online engagement exercise via Padlet.com This was open to participation from August 2025 to October 2025. Different stakeholders were invited to take part and a link emailed to them. From Workshop 1, 11 policy

recommendations were generated along with key questions about each recommendation. Stakeholders were presented with a Word document with the recommendations and corresponding questions. On Padlet, each recommendation was presented and summarised and stakeholders were asked to provide their response and feedback to the recommendations and questions from the researchers. Stakeholders were also asked to rank the three most important recommendations. Stakeholders were able to participate anonymously (via a generated username by Padlet) or with their name.

Co-design WORKSHOP 2 – In-Person

Workshop 2 Objectives

1. Co-produce final policy guidance recommendations with considerations for implementation
2. Present updated NICE guidance to stakeholders for feedback
2. Explore how policy guidance might be implemented and considerations around equity.

Workshop 2 Structure

A one day co-design workshop was held in person at a location in Birmingham in November 2025 as it was deemed more accessible by public transport. The session took place from 9:30am to 3:30pm, with breaks and refreshments provided (see *Supplemental Materials*). The workshop, facilitated by the same research team as Workshop 1, took place in two rooms, (i) a large room with four tables with a minimum of four people per table with a facilitator and (ii) one smaller room with one table with four people and a facilitator. The larger room was utilised for whole group discussions and research team presentations. The smaller room was used for small group activities to allow one stakeholder to attend virtually; this facilitated audio and minimised background noise. When stakeholders arrived, they were assigned a table to ensure a mix of professions and after lunch they were assigned a new table to facilitate interaction with different stakeholders. At the end of the day stakeholders completed an anonymous feedback form about the workshop and received a £100 voucher for their time.

Data Analysis

Audio recordings from each table were listened to by the facilitator (member of the research team) at the corresponding table and a summary of the conversations was produced. The summaries were analysed alongside visual artefacts and field notes using reflexive thematic analysis after the first workshop (Braun & Clarke, 2006). A hybrid approach was taken, combining inductive coding of stakeholder-generated content with deductive attention to policy-relevant domains (e.g., access, referral, funding, continuity of care).

To analyse the data from Workshop 1, the research team (CM, KS, MF, LMc, and CR) convened in July 2025 for two days. Transcripts and artefacts were initially reviewed and analysed separately by each member of the research team, and themes were then developed collaboratively through discussion and refinement. Discrepancies were resolved by consensus, and findings were mapped onto key policy domains for review and integration. From Workshop 1, 11 policy recommendations were proposed.

For the online engagement activity, data were exported from Padlet.com at the close of the engagement period, October 2025. Data comprised written participant responses to each of the 11 pre-developed policy recommendations and their associated guiding questions, alongside stakeholders ranked selection of the three recommendations they perceived as most important. As the 11 policy recommendations had already been developed from Workshop 1, the purpose of this stage of analysis was not to generate new themes, but to systematically examine stakeholder endorsement, critique, and suggested refinements to the proposed recommendations. Data were therefore analysed using a structured deductive framework, with each recommendation serving as an analytic category. Two members of the research team (CM & KS) independently reviewed the dataset to ensure immersion and familiarisation. Participant comments were organised under their corresponding recommendation and examined for: (1) level of agreement or support, (2) areas of concern or resistance, (3) suggested amendments or clarifications, and (4) perceived barriers and facilitators to implementation. Extracted feedback was synthesised to inform refinement of the policy recommendations prior to their presentation in the final workshop. Areas of strong convergence across stakeholder groups were noted as indicators of consensus, whereas points of divergence or implementation concern were retained for exploration and clarification during the final workshop stage.

Analysis of the final workshop focused on mapping participant contributions onto the existing policy framework rather than generating new themes. Data were therefore examined deductively against the established policy themes, with attention given to areas of endorsement, clarification, elaboration, or challenge. Where stakeholders introduced new nuances or implementation considerations, these were incorporated within the relevant policy theme.

The research team (CM, KS, MF, LM, and CR) convened in December 2025 for two days of collaborative analysis to further analyse the online engagement activity and Workshop 2 events following the same methods used for Workshop 1.

Rigour, Trustworthiness, and Reflexivity

To enhance trustworthiness, researchers asked PPIE members to review the agenda and design of the co-design day, triangulation across data types (audio, notes, and artefacts) and stakeholders (service users, service providers, referrers, and funders) [17, 18], reflexive discussions within the research team [19], an audit trail documenting coding decisions and theme development [20, 21], and a summary presented to an advisory board at different time points throughout the research project. The advisory board consisted of PPIE members, service providers, expert researchers, and individuals working for the Department of Health and Social Care.

Results

Findings are presented as policy guidance recommendations according to stakeholder groups (policy guidance, funders, and weight management providers) and available as a table in *Supplemental Materials*. Across the policy guidance, there was strong convergence around longer-term thinking in

funding, increased flexibility within service delivery, clearer system navigation, and a shift in emphasis from short-term weight loss to sustained weight maintenance and wellbeing.

System

Longer Funding Cycles

Stakeholders consistently emphasised that short-term funding cycles undermine service continuity, relationship building, and workforce stability. The WMPs described variability in funding arrangements, with some reporting one- to -two-year contracts, while others operated on two- or three-year cycles. One-year government funding allocations were viewed as particularly destabilising, limiting the capacity to establish partnerships, recruit and retain staff, and embed services within communities.

Stakeholders supported that longer funding cycles would enable services to develop sustained links with community assets and referral partners which service users could engage with, thereby strengthening weight loss maintenance support. Time for formative work and service co-design was identified as essential. Stakeholders reported that relationship-building and service set-up required several months before effective delivery could begin.

There was recognition that funders may require performance standards for quality control, however, a protected implementation period before formal performance review may allow for better programme integration into the local community. Overall, longer funding cycles were framed as foundational to system stability and maintenance-focused care.

Central Hub for Service Referral, Information, Navigation, and Follow-up

The concept of a centralised “Hub” was viewed positively across stakeholder groups and received strong endorsement in the asynchronous feedback, Workshop 2. Stakeholders described widespread uncertainty among both referrers and patients regarding available services, eligibility criteria, and referral processes, and this was particularly evident following changes to the tiered system and updated NICE guidelines.

The proposed Hub (Figure 2) was conceptualised as a single, accessible digital platform that would, provide clear, up-to-date information on available services (both digital and in-person), screen for eligibility and triage according to need, facilitate referral and re-referral, collect outcome data, and provide follow-up and redirect individuals requiring additional or alternative support (see *Supplemental Materials*).

Figure 2. Central Hub for Service Referral, Information, Navigation, and Follow-up

Stakeholders highlighted confusion where services were funded nationally and locally under different arrangements, reinforcing the need for a unified information source. There was also discussion regarding whether the Hub should focus specifically on weight management or adopt a broader wellness

remit. Questions remained regarding governance and funding responsibility for such a Hub. However, stakeholders perceived it as a mechanism to reduce GP burden, improve equitable access, strengthen continuity of care, and, therefore, support sustained, longer term weight management.

Clear Referral Pathways

Stakeholders described referral pathways as currently fragmented and constantly changing. Healthcare professionals were perceived to lack clarity regarding eligibility thresholds, available services, and appropriate onward referral routes. Simultaneously, WMPs were reported to receiving individuals with complex psychological or medical needs beyond their remit. Clearer referral pathways, potentially embedded within the proposed Hub, were viewed as critical to ensuring individuals access the right level and type of support. Stakeholders emphasised the need for system-wide clarity following structural changes to tiered provision.

Funders

Key Performance Indicators (KPI's) Focused on Longer-Term Outcomes

Funders discussions centred on the limitations of short-term weight-based KPIs, particularly the emphasis on achieving 5% weight loss within programme timeframes. WMPs reported that this target can create pressure on WMPs and SUs and inadvertently divert programme focus from sustainable, longer term behavioural change to short term weight loss outcomes. Stakeholders advocated for KPIs that reflect maintenance and broader health outcomes, including prevention of further weight gain, improvements in functional capacity (e.g., walking upstairs, ability to play with children/grandchildren, ability to tie shoes), reduced risk and prevention of comorbidities (e.g., Type 2 diabetes), and overall quality of life. There was debate regarding feasibility of long-term and diverse types of data collection, including who would collect and monitor such outcomes. A tension emerged between funding requirements for measurable weight outcomes and a broader wellness-oriented framing (e.g., improved mobility, daily functioning, and quality of life). Stakeholders acknowledged that future KPI models may need to balance both.

Extended Funding Cycles

Consistent with the policy-level recommendation, funders and WMPs endorsed funding cycles of approximately five years, with built-in review mechanisms. Stakeholders highlighted the need for initial protected development phases to establish workforce capacity and community partnerships.

Flexibility in Delivery and Tapered Support

Funding specifications were viewed as constraining service design. Stakeholders advocated for flexibility that would allow WMPs to tailor programme duration and modality according to local need and service model (e.g., group-based, digital, specialist male-focused programmes). Tapered support emerged as a key mechanism for improving maintenance outcomes. Extended contact beyond 12 weeks, with

gradually reduced intensity, was described as more aligned with behaviour change evidence and real-world implementation.

Re-access without Re-referral

Stakeholders discussed the importance of enabling service users to re-access support without requiring a full re-referral process. Current policies designed to prevent misuse were seen as inadvertently restricting legitimate access for individuals struggling with weight maintenance. The purpose of re-access was viewed less as “repeating” a programme and more as accessing targeted maintenance or alternative support. Stakeholders suggested that triage via the proposed Hub could determine whether individuals required renewed programme engagement, alternative modalities, or specialist input. Concerns regarding system misuse were acknowledged, with emphasis placed on understanding motivations for re-access and implementing proportionate safeguards.

Weight Management Service Providers

Spaced Sessions and Tapered Support

There was strong endorsement for spacing sessions over a longer timeframe and incorporating structured tapering. Examples of practice included monthly drop-ins and low-cost ongoing activity sessions. Tapered support was viewed as a mechanism for transitioning individuals towards independent self-management while maintaining connection to support. Stakeholders acknowledged potential financial and workforce implications but positioned tapering as an investment in long-term maintenance.

Explicit Weight Maintenance Components

Providers identified a gap in structured content addressing maintenance, disruptors, and emotional eating. Repeated re-access was attributed to insufficient preparation for life stressors and behavioural relapse. Stakeholders advocated integrating maintenance strategies earlier in programmes, including skills for managing disruptors, and individualising behavioural strategies. There was consensus that maintenance should not be treated as an “add-on” but embedded throughout programme design.

Facilitating Social Support

Social and peer support were identified as critical mechanisms for sustaining behaviour change beyond programme completion. Stakeholders described the importance of establishing peer networks early in delivery and preparing an exit or continuation strategy. Linkages with community services (e.g., walking groups, voluntary organisations) were viewed as valuable but dependent on local availability and participant confidence. Considerations included managing group dynamics and ensuring inclusivity.

Workshop feedback

Overall, stakeholders rated the workshops highly, commenting on the facilitation, timekeeping, and content being relevant and practical. Stakeholders also highlighted that they enjoyed hearing views from differing stakeholders and having the opportunity to be involved in research that has practical and real-world implications. Feedback from the first in-person workshop that impacted the second in-person workshop included stakeholders being seated with different backgrounds (SU, funder, referrer, or WMP) and mixing up the seating after lunch. The researchers responded to the feedback and created a seating chart for the second in-person workshop, focusing on each table having a stakeholder from each group, and then mixing up the tables after lunch. The feedback form is provided in *Supplemental Materials*.

Discussion

This study sought to co-design system-level, funding, and service-level policy recommendations to strengthen behavioural weight management provision, with a particular emphasis on long-term weight maintenance. The study was conducted in England, but many of the findings may be relevant to other countries with similar approaches to weight management. Findings highlighted a consistent shift in focus away from short-term weight loss targets, towards structural conditions that enable sustained behaviour change. Across stakeholder groups, there was convergence around four interrelated priorities: longer-term funding models, flexibility in service delivery, clearer system navigation, and continuity of support beyond weight loss programme completion. This emphasis aligns with growing recognition that obesity is a chronic, relapsing condition requiring sustained systems-level support over time, rather than time-limited intervention models [22].

The recommendation for extended funded cycles was identified as a key component of reform. Stakeholders identified that two- or three-year contracts, and particularly one-year funding allocations, limit the capacity to build community partnerships, embed services locally, and develop workforce stability. Longer funding cycles were positioned as foundational to building relationships with others who can help with maintenance of behaviours (e.g. walking groups). However, funders acknowledged a need for accountability mechanisms, in case WMPs were not performing.

The proposed central “Hub” emerged as a potential system-level solution to fragmented referral pathways and the lack of continued support [15]. The tiered system which offered increasing levels of support (depending on BMI and co-morbidities) was recently abolished. Thus, both healthcare professionals and SUs were perceived to lack clarity regarding available services, eligibility criteria, and onward referral routes. A centralised infrastructure for triage, information dissemination, and follow-up could reduce GP burden, improve equitable access, and facilitate appropriate re-access to support. Importantly, the Hub was conceptualised not solely as an informational repository, but as an active coordination mechanism capable of screening, data collection, and redirection where necessary.

Flexibility within funding specifications and programme delivery was repeatedly emphasised, with previous research citing rigid pathways as a barrier to improved care [16]. Fixed 12-week models and weight-centric KPIs were perceived to constrain WMPs’ ability to individualise care and integrate tapering

strategies. Evidence from behaviour change and weight maintenance research suggests that extended contact and ongoing support are associated with improved maintenance outcomes [23, 24]. Reframing KPIs to include longer-term maintenance, prevention of weight regain, and functional wellbeing outcomes may better reflect meaningful change and prevention of obesity and health conditions [25]. Although, stakeholders advocated for KPIs to be reframed and tailored to the individual, feasibility of long-term and individualised data collection remains a challenge.

Finally, facilitating structured re-access to weight management programmes without full re-referral was framed as critical for individuals navigating relapse or life disruptors. Rather than conceptualising re-engagement as failure, stakeholders advocated for a maintenance-oriented pathway that recognises weight management as iterative and dynamic.

Although the emphasis here was on behavioural weight management interventions, the same principles could apply to anti-obesity medications where there is rapid weight regain after cessation of the medications [26]. Continued support is needed to help people maintain weight loss and re-access may be required due to obesity being a chronic relapsing condition. Regardless of the intervention or approach used for weight management, helping users to maintain their weight loss must be a critical component of any intervention pathway.

Strengths and Limitations

This was a co-design study involving multiple stakeholder groups, including SUs, WMPs, funders, and GPs, enabling the integration of diverse perspectives and experiences. The approach emphasised genuine co-design beyond consultation, with stakeholders actively contributing to the generation, refinement, and prioritisation of policy guidance. The use of multiple workshops and a range of structured activities supported iterative engagement and depth of contribution, although the asynchronous format may have limited real-time deliberation. Transparency in the study design and analytic procedures enhances the trustworthiness of the findings and supports their potential transferability. However, participation was voluntary and may reflect the perspectives of those already engaged or invested in service development. Recommendations were developed within the English funding context and may not be directly transferable to alternative health systems. Finally, while stakeholders identified feasible directions for reform, economic modelling, addressing the wider obesogenic environment, and implementation testing were beyond the scope of this study.

Learnings for Co-Design

The co-design process yielded methodological insights. Iterative engagement across multiple workshops allowed early thematic findings to be progressively translated into policy-facing recommendations, enhancing transparency between data generation and recommendation development. Presenting pre-developed recommendations for refinement, rather than generating new themes at each stage, enabled focused critique and feedback. Diverse stakeholders facilitated constructive tension between strategic, operational, and lived-experience perspectives. Structured

prompts and explicit mapping of feedback onto policy themes supported analytic clarity and avoided drift from project objectives. Importantly, co-design extended beyond consultation, with stakeholder feedback directly shaping refinement and prioritisation of policy guidance. Overall, the process demonstrated that co-design can support policy reform in weight management services.

Conclusion

This study identified system-level, funding, and service reforms necessary to strengthen weight management provision and improve long-term weight maintenance. Stakeholders prioritised longer funding cycles, flexible and tapered delivery models, clearer referral pathways, and mechanisms supporting continuity and re-access. Findings suggest sustained behaviour change cannot be addressed solely at the individual level, but requires structural alignment across funding, service design, and system navigation. Through iterative co-design, experiential and operational insights were translated into actionable policy guidance. Embedding these recommendations within funding frameworks may enhance service stability, equity of access, and conditions required for durable weight maintenance.

Declarations

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Author contribution

statement: **Katelynn Slade:** methodology, investigation, analysis, writing – original draft, **Lorraine McSweeney:** conceptualisation, methodology, investigation, analysis, writing – review & editing, funding acquisition; **Charlotte Rothwell:** conceptualisation, methodology, investigation, analysis, writing – review & editing, funding acquisition; **Mackenzie Fong:** conceptualisation, methodology, investigation, analysis, writing – review & editing, funding acquisition; **Amanda Daley:** conceptualisation, writing – review & editing, supervision, funding acquisition; **Henrietta Graham:** conceptualisation, methodology, investigation, writing – review & editing, funding acquisition; **Alex Oni:** validation, writing – review & editing; **Claire Deborah Madigan:** conceptualisation, methodology, investigation, analysis, writing – review & editing, supervision, project administration, funding acquisition

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Table 1

Table 1. Stakeholder Involvement in the Workshops

Stakeholder	Workshop 1	Workshop 2 – Online	Workshop 3
WMP	X	X	
WMP	X		
WMP	X	X	X
WMP	X		
WMP	X		X
WMP	X		
WMP	X	X	
WMP	X	X	X
WMP	X	X	X
WMP	X		X
WMP		X	
WMP			X
WMP			X
WMP			X
WMP			X
WMP			X
SU	X	X	X
SU	X		
SU	X		
SU	X		
Carer to SU	X		
SU	X	X	
Carer to SU	X		
SU	X	X	
SU	X		X
SU		X	X
SU		X	X
SU			X

R			X
R	X	X	X
R	X		X
R			X
F	X		
F			X

Figures

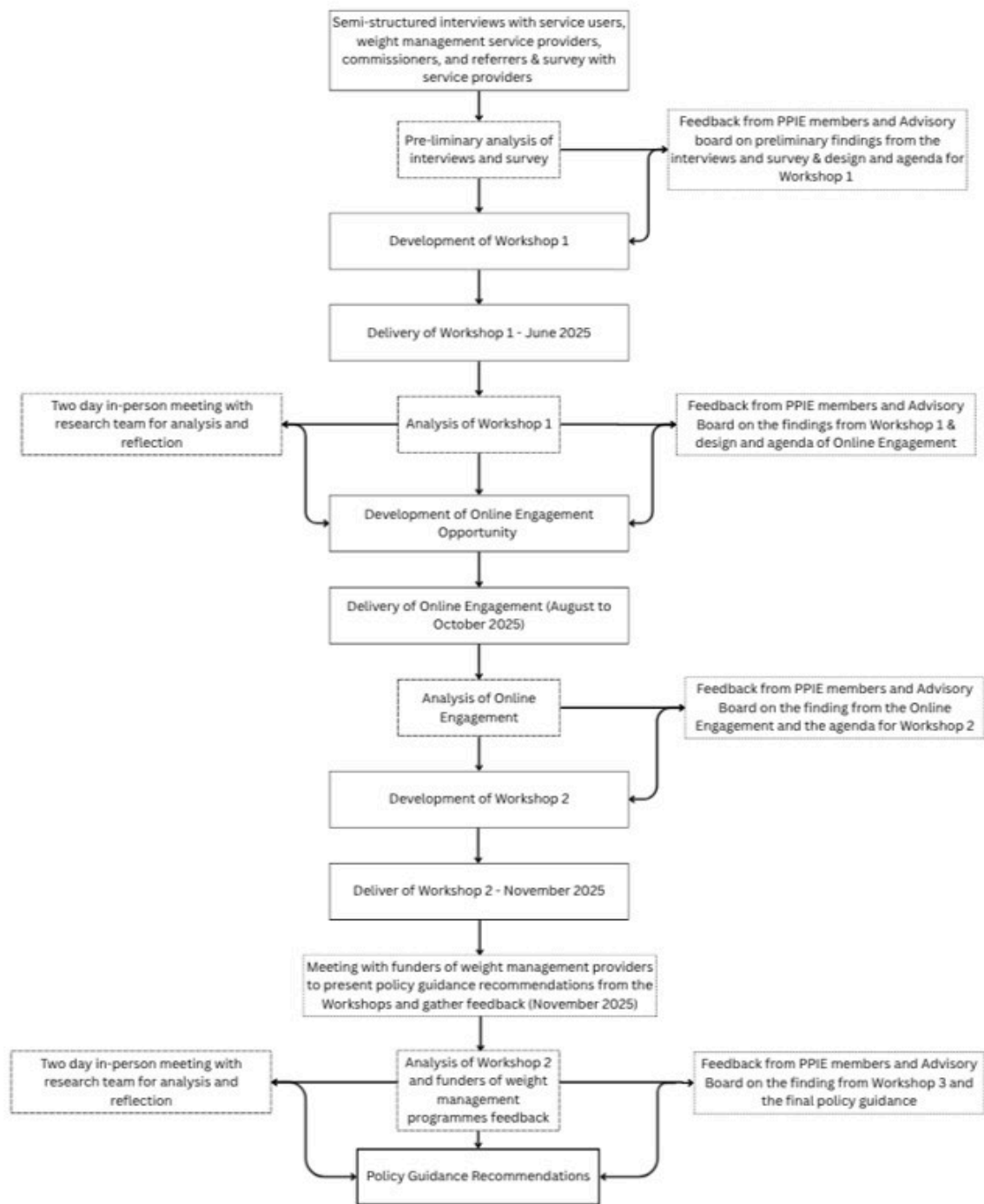


Figure 1

Flow Chart of Research

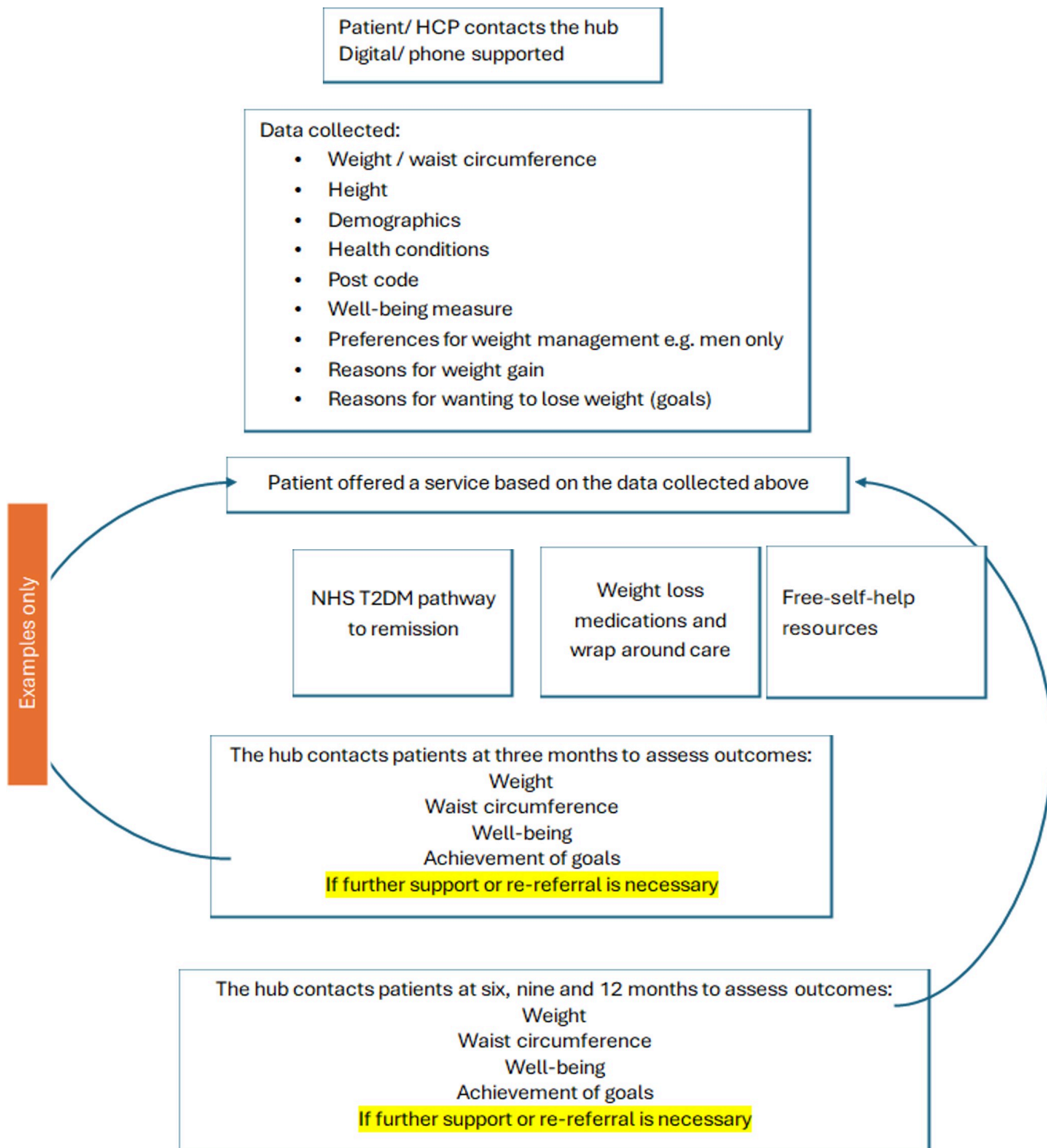


Figure 2

Central Hub for Service Referral, Information, Navigation, and Follow-up

Supplementary Files

This is a list of supplementary files associated with this preprint. Click to download.

- [WP3SupplementalMaterialPolicyGuidanceandRecommendationsIJOB.docx](#)
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