NIHR | Public Health Intervention Responsive Studies Teams

NIHR PHIRST Evaluation of

Southwark Council's Integrated Healthy Lifestyle Service

Final Report

April 2025

Supported by Southwark Council

PHIRST Elevate

THE UNIVERSITY of EDINBURGH

How to cite this report

Boath, A., Manner, J., Janac, S., Guo, J., Elliott, J., Williams, A., Murphy, M., Kelly, P. (2025). *Evaluation of Southwark Council's Integrated Healthy Lifestyle Service for exercise referral.* University of Edinburgh. doi: 10.7488/ERA/6185

Image credit: Everyone Health

Executive Summary

Southwark Council's Integrated Healthy Lifestyle Service (IHLS), provides accessible health improvement services that address various aspects of wellbeing, such as weight management, physical activity, and smoking cessation for residents and healthcare professionals in the Borough. It offers support and resources to diverse community members who may otherwise lack access to coordinated health services, promoting healthier lifestyles and long-term behaviour change.

The Healthy Lifestyle Hub (HLH) was incorporated into the IHLS in 2019. The HLH is a telephone-based service and single access point that coordinates referrals to various health services for Southwark residents. Its goal is to enhance triage and referral processes, and offer ongoing support, ultimately improving health outcomes by increasing access and reducing inequalities.

This evaluation focused on the integration of the HLH with two key services: Alive'n'Kicking (AnK) and Exercise on Referral (EoR), each offering 12-week programmes. All three services, commissioned by Southwark Council, are delivered by the third-party organisation, Everyone Health.

Our evaluation shows that:

- Some service users feel the HLH improves service accessibility;
- Service users experienced benefits including weight loss and improved fitness, improved mental health (EoR), and increased physical activity and healthier eating behaviours (AnK);
- The 12-week timeframe, however, was seen as insufficient for sustaining long-term behaviour change;
- Post-programme options from the HLH, AnK and EoR may not be sufficient and are not consistently well-advertised;
- There is uncertainty among service users around HLH's role in long term support;
- The HLH does not make a primary referral recommendation but can support the triage process;
- There was a misunderstanding by service users that EoR was a one-to-one service and confusion about roles within HLH and service teams, leading to unmet service user expectations;
- There is some inconsistency in HLH engagement with service users and access time to services;
- The HLH has more relevance to EoR delivery than AnK;
- There are inconsistencies in data collection between the HLH and EoR and AnK services;
- There is no system for linking referral, attendance, and outcome data for HLH and EoR and AnK services;
- There is no public involvement or community engagement to inform/support the running of the service.

Recommendations

The IHLS would benefit from extending post-programme support, enhancing communication with service users, clarifying referral processes, and strengthening reporting, governance, and data management for service delivery and feedback.

Individual recommendations include the following:

- Extend post-programme options (at little or no-cost to service users) and increase awareness of such options – involving local public health ambassadors could be one way of doing this
- Enhance data management (e.g. effective linkage between HLH and EoR data), including integration with post-service support (e.g. uptake and usage of leisure centres)
- Standardise data collection, particularly for long-term health metrics
- Set more accurate service user expectations by communicating programme details and wait times more clearly
- Streamline access times and clarify inclusion criteria for the HLH/EoR
- Clarify of the role of HLH in AnK referrals
- Introduce structured service user and stakeholder feedback mechanisms

Background

Community-level interventions

Community-level interventions provide an opportunity to address key modifiable health behaviours (e.g. physical inactivity and dietary behaviours) which tend to cluster within individuals, creating patterns that are influenced by socio-demographic factors (Meader et. al, 2018). Socio-economic factors substantially contribute to an individual's health, and such factors extend far beyond access to healthcare (e.g. deprivation) (NHS, 2019). A key example of wider determinants of health impacting disease prevalence is obesity. In 2021, 28% of adults in England were classified as having obesity and a further 36% were considered as having overweight (Stiebahl, 2025). Further, obesity rates are 36% in the most deprived areas compared to 22% in the least deprived areas, reflecting health inequalities (NHS Digital, 2024).

A contributor to obesity (and various other health conditions) is physical inactivity, with 25.7% of adults in England engaging in less than 30 minutes of physical activity per week (Sport England, 2023; Silveira et al, 2022). Physical inactivity is more prevalent among certain demographic groups, such as those from lower socio-economic backgrounds, older adults, individuals with disabilities, and women (Sport England, 2023). Therefore, targeted health interventions at the community level have the potential to address this complex interplay of risk behaviours among different populations, leading to more significant outcomes (Montgomery et. al, 2023).

The development of community-level integrated health and wellbeing services aim to provide comprehensive support (South, 2015). These services can address clinical and non-clinical needs, promote holistic care and improve access by reducing barriers, in turn, enhancing health outcomes through continuity of care (South, 2015). Such services have their root in acknowledging the multiple factors that contribute to an individual's sense of wellbeing and quality of life (Dahlgren & Whitehead, 1991). This approach allows for the identification and management of common underlying factors contributing to health issues, facilitating more effective behaviour change among community members (Montgomery et. al, 2023).

Additionally, interventions targeting multiple health risk behaviours at once are likely to reduce health care costs compared to interventions targeting single health risk behaviours (Prochaska, 2008). In his 2024 report, "Independent Investigation of the National Health Service in England," Lord Darzi emphasised the importance of shifting from hospital-centred model to a more community-based healthcare system (Darzi, 2024). Specifically, he recommended that services be integrated at the local level to improve accessibility and efficiency.

Integrated health and wellbeing services, based around a "hub" model, have been commissioned by many UK Local Governments (and the NHS) to move away from a siloed approach to the delivery of healthcare, to a more efficient and tailored service delivery (NHS Confederation, 2011). Hub models provide a centralised location or service that coordinates various health-related resources and support, facilitating easy access to multiple services in one place and performing triage to prioritise and direct individuals to appropriate healthcare interventions. They often offer an opportunity for both self-referral and referral by a healthcare professional (Figure 1). The hub model focuses on facilitating onward referral to a service, or range of local and national services. Services typically include weight management, smoking cessation, mental health services and diabetes care.

Addressing individuals' health needs via a hub has been shown to positively impact sense of wellbeing, and reduce hospital visits, reducing pressure at a systems level (Friedli et al., 2012; Dayson & Bashir, 2014). Furthermore, implementing health hubs at a local government level may allow for improved service capacity management and allow local governments to address specific health inequalities (NHS England, 2014; Marmot, 2013).

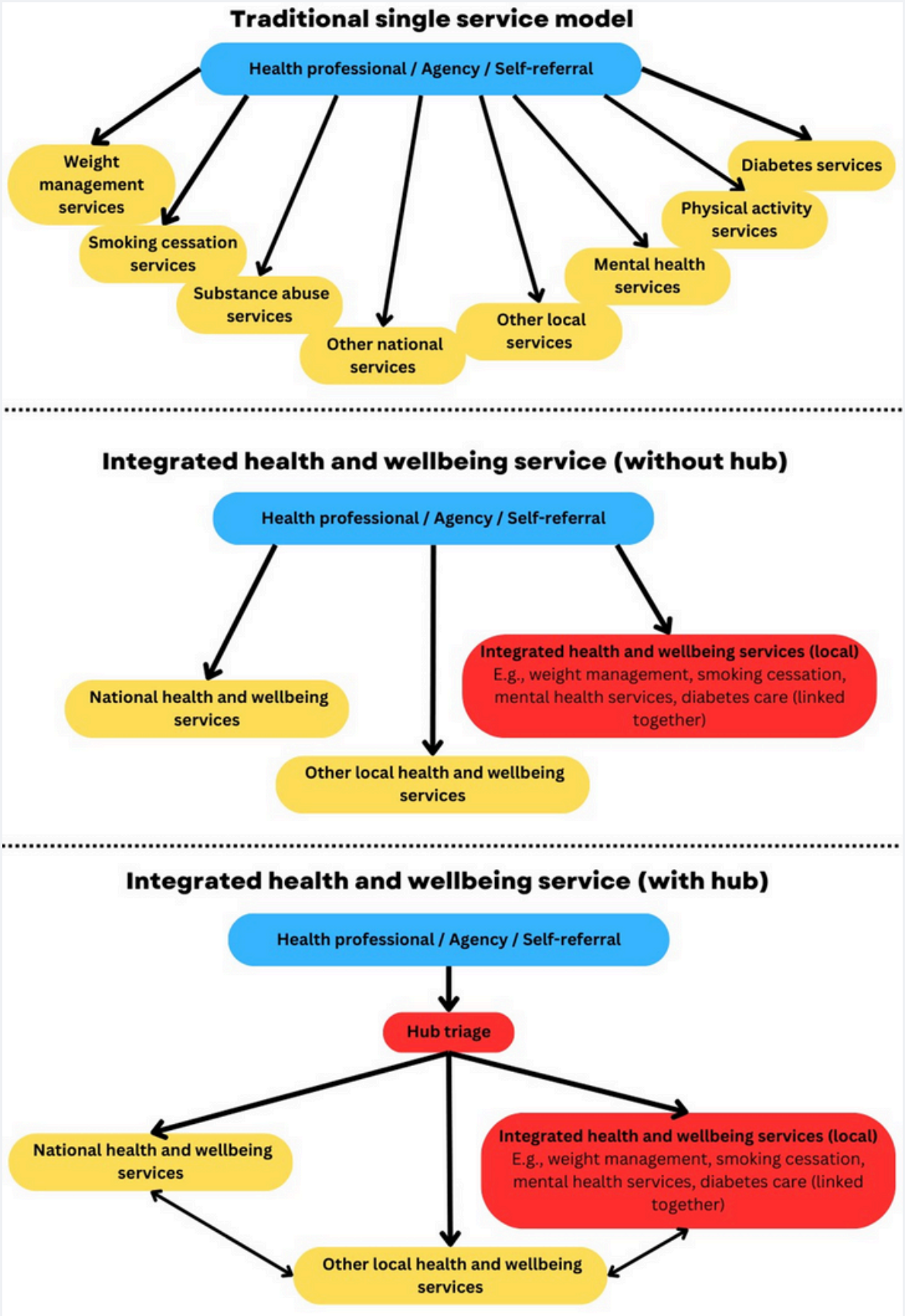


Figure 1. Hub vs non-hub models

Hub-based integrated health and wellbeing services in the UK

A targeted literature and web-based search was conducted, which aimed to identify relevant literature and emerging evidence on hub-based approaches to supporting behaviour change in the UK. A total of 28 council and/or NHS commissioned hub-based approaches were identified from this search.

Services offered: The hubs target various health behaviours, with 79% offering weight management services combining exercise and dietary interventions. Smoking cessation services are available at 71% of centres and mental health services are provided by 82% of centres.

Accessibility: Efforts to make services more accessible and increase reach include offering: free or low-cost services (89% of hubs); evening and weekend classes (79%); online resources, online booking and virtual consultations (85%); services in local venues such as libraries and leisure centres (36%), and; offering multiple services in a single physical location (25%). Additionally, 53% cater to specific groups, including older adults, individuals with disabilities, and ethnic minorities and 64% offer multilingual resources and culturally tailored programmes.

Referral routes: Referral routes involve self-referral, professional referral (e.g. healthcare professionals, social workers), and community referral (e.g. schools, charities, link workers) (Table 1). All 28 hubs provided self-referral options, making this the most universally available pathway for accessing services. Professional referrals, offered by 23 hubs (82%), rely on healthcare providers like GPs, nurses, and social workers to connect individuals to targeted programmes. Additionally, 18 hubs utilise community-based referrals, working with schools, charities, and link workers to reach underserved populations.

Referral type	Number of hubs	Strengths	Limitations
Self-Referral	28 (100%)	Enhances accessibility and autonomy. Reduces reliance on gatekeepers.	May exclude individuals without digital literacy or awareness of services.
Professional Referral	23 (82%)	Ensures medically guided, targeted interventions. Aligns with NHS systems for streamlined care.	May limit access for those without regular healthcare interactions.
Community-Based	18 (64%)	Engages hard-to-reach populations. Builds trust through local organisations.	Requires sustained partnerships and resources for effective implementation.

Table 1: Comparison of referral pathways

Southwark Council's Integrated Healthy Lifestyle Service (IHLS)

Southwark Council's Integrated Healthy Lifestyle Service (IHLS), established in 2013, aims to provide joined up health services for residents and healthcare professionals (HCPs) in the borough. As part of the IHLS, the Healthy Lifestyle Hub (HLH), a telephone-based, single point of access, triage service aims to facilitate referrals to the various health services available to Southwark residents. The HLH was established in 2019 to improve triage, referral, and ongoing support to specific programmes, in turn, improving health outcomes through facilitating access and reducing inequalities.

This evaluation focussed on the integration between the HLH and two key services; Alive'n'Kicking (AnK) and Exercise on Referral (EoR). Within the EoR service there are three programmes, depending on service user needs and programme intensity; KickStart, Active Boost and Cardiactive. The HLH, AnK, and EoR are commissioned by Southwark Council and delivered by a third-party organisation, Everyone Health.

Evaluation Aim:
To understand how the HLH influences health improvement services, including two local weight management services (AnK and EoR).

Evaluation Objectives:
1. Assess whether the HLH facilitates appropriate and equitable access to health improvement services (primarily AnK and EoR);
2. Assess whether referral from the HLH to AnK and EoR improves health behaviours and outcomes.

Methods

Overview of Methods

Based on the evaluability assessment and subsequent consultation with Southwark Council, both process and outcome evaluation components were included. The evaluation was mixed methods, using both quantitative and qualitative approaches across three work packages. The evaluation was supported by an **Embedded Researcher** from Southwark Council, who provided local knowledge of the Borough and the IHLS, contributing to key evaluation activities such as data collection and analysis, and public involvement initiatives.

Work package 1: Secondary analysis of data collected by Everyone Health on the HLH and EoR. Prior to analysis, data checking, cleaning and coding was conducted using Stata (Version 18). Differences in binary variables were calculated as frequency (%), continuous/categorical variables were derived as mean (+SD). Descriptive statistics were used to explore the agreed research questions.

Work package 2: An online survey (using Qualtrics) was developed and distributed via email by Everyone Health staff to all individuals who were in contact with HLH from establishment until 31/10/24. The survey was live for three months (23/10/24 – 23/01/25), with two reminders sent to prompt completion. At the end of this survey, eligible individuals (indicated that they contacted/were referred to the HLH but did not initiate services) had the opportunity to consent to be contacted by the research team to take part in WP3. Data preparation and analysis was conducted using Stata (version 18.0). Binary/categorical variables are presented as mean (SD) or frequency (%) for categorical variables.

Work package 3: Focus groups or interviews were held with: 1) Service users from AnK (parents) and EoR, 2) Everyone Health staff (from HLH, AnK and EoR), and 3) non-initiators. Non-initiators included participants from WP2 who indicated on the survey that they contacted/were referred to the HLH but did not initiate services and provided their email to be contacted for an online interview. All participants had to be at least 18 years of age.

A purposive sampling approach was used, and participants were recruited via email, text message, and in-person (during EoR and AnK programming). Focus groups and interviews were conducted by one of the Research Fellows and the Embedded Researcher between 30th October and 29th November 2024. These took place at one of Southwark's leisure centres, Southwark Council's Tooley Street building or online using Microsoft Teams. The sampling framework shown in Table 2 summarises recruitment aims and final totals for each participant group. Focus group and interview transcripts were analysed thematically by one of the Research Fellows and the Embedded Researcher to seek interpretive depth (Braun and Clarke, 2022).

Participant group	Subgroup	Recruitment Target	Number recruited
Service users	AnK and EoR service users (current and completers from 2022 onwards)	28-40	36 (8 AnK; 28 EoR)
Everyone Health staff	HLH, AnK and EoR	9-12	10 (2 HLH; 3 AnK; 4 EoR; 1 service manager)
Non-initiators	N/A	3-4*	*No responses from survey

Table 2: Interview and focus group recruitment

Public Involvement in the evaluation

Throughout the evaluation, we engaged with Southwark residents and service users in the following ways:

- One-off workshop with service users across AnK, HLH and EoR to consult on the evaluation protocol.
- 1:1 workshop with service user to inform the evaluation webpage.
- Setting up of a "Community Steering Group" consisting of Public Health Ambassadors, service users, the Embedded Researcher and the Knowledge Broker to meet regularly throughout the evaluation. The Community Steering Group helped contributed to the evaluation as follows:
  - Review interim and final evaluation findings, provide valuable context (e.g. for self-referrals)
  - Prioritising evaluation findings according to their perceived level of importance to the community
  - Support with use of language and terminology
  - Support with Knowledge Mobilisation (in progress)

Image credit: Everyone Health

Findings

Overview of data collected and received

Work package 1: Analysis of existing data
Data from individual clients who had used both the HLH and EoR services were linked based upon patient ID and approximate date of referral (Appendix 2). Data for the AnK intervention were not shared by Everyone Health in time for inclusion in report. Leisure centre data from Southwark Council were also not shared.

Work package 2: Survey of service users in Southwark
The survey data collection concluded on 24/01/25 with a total of 163 valid responses. In terms of identifying non-initiators, four eligible individuals were contacted via email to participate in a focus group or interview as part of work package 3, however none responded.

Work package 3: Focus groups and interviews
In total, 46 people took part in interviews and focus groups (36 service users and 10 delivery/HLH staff). Recruitment targets were met (except for non-initiators who did not respond to invitations). A breakdown of participants is shown in Table 2.

Southwark HLH Logic Model

Appendix 1 shows the logic model that was co-developed with members of Southwark Council during the Evaluability Assessment phase. It illustrates the shared assumptions about how the HLH impacts services in Southwark.

Objective 1: Assess whether the HLH facilitates appropriate and equitable access to health improvement services (primarily AnK and EoR)

1. Why have individuals who have been referred not initiated the service? [WP2]

The survey elicited 163 valid responses, with participant characteristics reported in Appendix 1. Of those who had been referred to AnK/EoR (n=107), 70 respondents had attended at least one session, 33 had not and 4 did not disclose. Of the 33 respondents who had not commenced AnK/EoR, 18 said they intended on starting and 15 said they did not intend on starting the programme.

Reasons for not intending to initiate EoR/AnK following referral included:

- Unsuitable time of day (n=2 EoR programme).
- Day of the week was unsuitable (n=1 EoR+other services).
- No longer interested (n=3 one EoR, one EoR+other services, one AnK)
- Other reasons included not feeling the EoR plan was suitable, taking up exercising at home, not being provided with a start date, and being told they were no longer eligible due to having a gym membership (n=6, 3 EoR and 3 EoR+other services).

2. How did the referrals (to EoR and AnK) from the HLH compare to those from other sources? [WP1]

Within EoR datasets (Active Boost, KickStart and Cardiactive) there is no variable which specifies the source of the referral. When data linking was performed between the HLH data sheets and EoR data sheets there was a high match rate (Figure 2), which suggests that the vast majority of EoR referrals (>90%) involved the HLH.

3. Have the quality of referrals increased since the HLH was introduced? (Overall and by demographic groups e.g. age, postcode ethnicity, gender) [WP1]

A key finding from the evaluation is that the pathway from HLH referral to uptake, adherence and completion is not recorded in a way that could be shared with the evaluation team. As such we were not able to answer this evaluation question. Based on this learning we have made recommendations on how this could be integrated in future services later in this report.

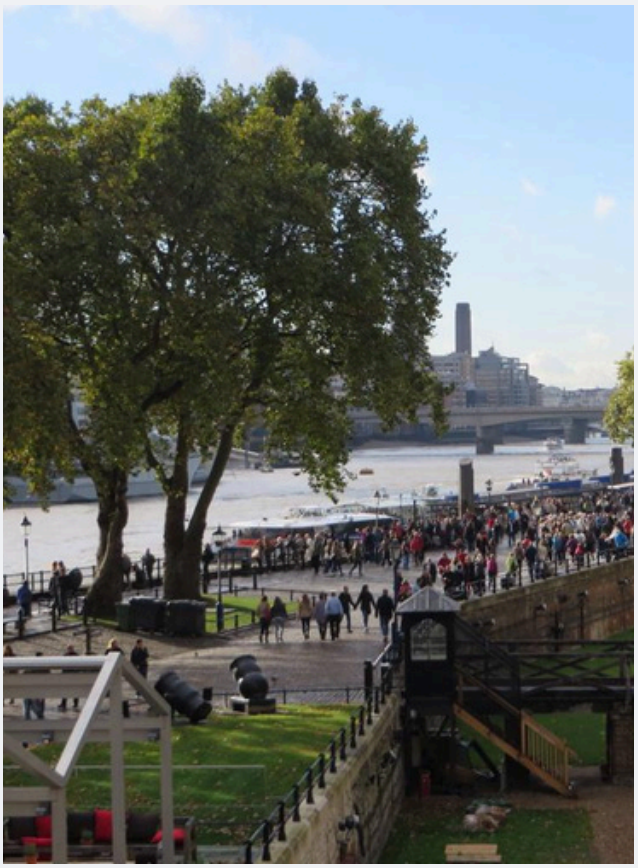
4. Who was referred compared to who took up the services? Have initiation and completion (adherence) rates increased since the HLH was introduced? [WP1]

Completion rates for all three EoR programmes are relatively consistent (Table 3). The completion rates noted within EoR are consistent with broader findings on exercise referral programmes, which have suggested a 40-59% for completion in observational studies of exercise referral schemes, and in an updated and expanded review reported an adherence range of 12-70% was reported (Pavey et al, 2012; Campbell et al, 2015).

Status	Active Boost N (%)	Kickstart N (%)	Cardiactive N (%)
Completed	430 (37.9%)	326 (31.3%)	144 (39.2%)
Left Early	598 (52.6%)	559 (53.6%)	157 (42.8%)
Not Participating	108 (9.5%)	3 (0.3%)	0
Participating	0	155 (14.9%)	66 (18.0%)

Table 3: Completion status of EoR programmes via HLH

However, these results must be interpreted with caution as when individuals were linked between the HLH data and EoR data the agreement between data held on individuals at the HLH level and programme level was low, meaning that the same individuals were classified as having a different completion status in the two data sets, for example, the agreement rate of completion status in those who participated in ActiveBoost wass 47.2%; even when accounting for unlinked individuals, this is low (Appendix 5).



5. How do HLH staff decide which services to refer people on to? Are there certain groups the HLH is targeting (e.g. certain demographics)?
and
6. How does the HLH support inappropriate referrals? e.g. do they refer on/link into to external services (wider impact)? [Both WP3]

According to HLH staff and EoR service users, HLH staff rarely make the primary referral (service) recommendation, as this is meant to come from the referrer (e.g. HCP) and normally outlined on the referral form. However, the HLH staff contact service users (and sometimes referrers) to clarify needs when the service or primary reason for referral (e.g. health condition) is unspecified or if they are unsure of the appropriateness of the service for the service user.

Additionally, in cases where Southwark-funded services are unsuitable and/or service users could benefit from additional services, HLH staff facilitate referrals to external support, such as smoking cessation or drug and alcohol services. This implies that there is **only a small positive impact on referral appropriateness from the HLH** and by extension likelihood of successful engagement with services. The HLH does not target specific demographic groups. However, part of the justification for the commissioning of the IHLS and HLH in Southwark was that it was an area of high deprivation and a high concentration of underserved minority groups (including ethnic minority groups).

Additionally, within the service agreement between Southwark Council and Everyone Health, **the inclusion and exclusion criteria for HLH and EoR participation differs slightly,** particularly in relation to referrals where there has been a diagnosis of osteoporosis. Additionally, there is no mention of eating disorder diagnoses in the inclusion or exclusion criteria for the HLH or EoR. This may increase the likelihood of inappropriate referrals and EoR programme registration for individuals with current or past diagnoses of osteoporosis and/or an eating disorder.

7. How do services users/Everyone Health staff perceive that the triage service supports their/service users' readiness to change their behaviour?
and
8. Does the referral recommendation from HLH on which services to join influence people's decisions?
and
9. Does the length of time between referral to a programme and programme start date impact completion? [All WP3]

Everyone Health (HLH and EoR) staff and service user **perceptions of the HLH's role in supporting behaviour change readiness, and programme initiation and completion are mixed and appear person dependent.** As mentioned previously, the HLH often does not make the primary referral decision, although they do contact service users and/or referrers to clarify needs when the service or primary reason for referral is unspecified and make additional recommendations.

Service access and response times varied significantly, with some users receiving quick support (within a week or two), while others waited months to years be booked onto EoR, with delays adversely impacting motivation. Structured programmes like Cardiactive generally had shorter wait times and more consistent engagement, whereas other programmes struggled with scheduling and support gaps. A number of external factors influencing wait times were reported by Everyone Health, but the impact and scale of these are unclear. Service users and staff noted variability in HLH engagement with service users, with less structured programmes (e.g. Kickstart) often receiving minimal HLH engagement, leading to challenges in people initiating services.

Although follow-up calls were valued for guiding users to additional services, not all service users recalled receiving them and they had varied effects on motivation and behaviour. Similarly, while HLH recommendations on services were appreciated for facilitating enrolment, users in less structured EoR programmes (e.g. Kickstart) faced difficulties, such as unclear communication and unmet expectations (e.g. that it was a one-to-one service), which impacted their engagement and motivation. These mixed perceptions and experiences of the HLH may impact its effectiveness in sustaining service user motivation and engagement with the services.

Both Everyone Health staff and service users acknowledged that behaviour change readiness, programme initiation, and completion were also person dependent. For example, as mentioned above, there were a number of reasons for non-initiation reported in the WP2 survey (e.g. time of day unsuitable, not interested). Everyone Health staff and service users also acknowledged that there were other reasons for non-engagement or limited engagement in services, which were unrelated to the HLH or programmes themselves (e.g. individual motivation, medical issues, not wanting to be in a gym environment).

10. What are service users experience of referral to EoR and AnK via the HLH? [WP3]

As discussed above our findings suggest that **the HLH has a varied impact on referral experience**. Additionally, there are challenges in managing user expectations. For example, service users often assume EoR is a more supervised service (one-to-one support), leading to unmet expectations. Confusion about roles within the HLH and EoR teams (e.g. who service users were being contacted by and why), lack of communication between the HLH, EoR and AnK, and logistical barriers, also detracted from the perceived service. According to Everyone Health staff and service users, there are also communication challenges between leisure centre staff, and Everyone Health staff and service users. This implies some communication gaps between the HLH, EoR, AnK, service users and leisure centre staff. During focus groups and interviews, few participants indicated they referred themselves or were aware of the HLH or EoR prior to HCP referral. This underscores the importance of HCP referral for this service as well as an opportunity to increase outreach within Southwark to increase awareness of self-referral.

11. How has the HLH facilitated access to services? [WP1, WP3]

Our evaluation indicates that the majority of EoR referrals are triaged via the HLH. At present, within EoR datasets, there is no variable to indicate if individuals entered the programme (EoR) without having first had contact from the HLH. Completion of matching the Hub data with the data from individual EoR sheets showed that a minimum of 70% of individuals were present at a hub level and programme level, which suggests that referrals all have contact with the HLH, thus suggesting the HLH is integrated with EoR. Generally, service users who engaged with the HLH felt that helped increase accessibility to EoR (e.g., by booking them onto a service and giving information about other services if appropriate).

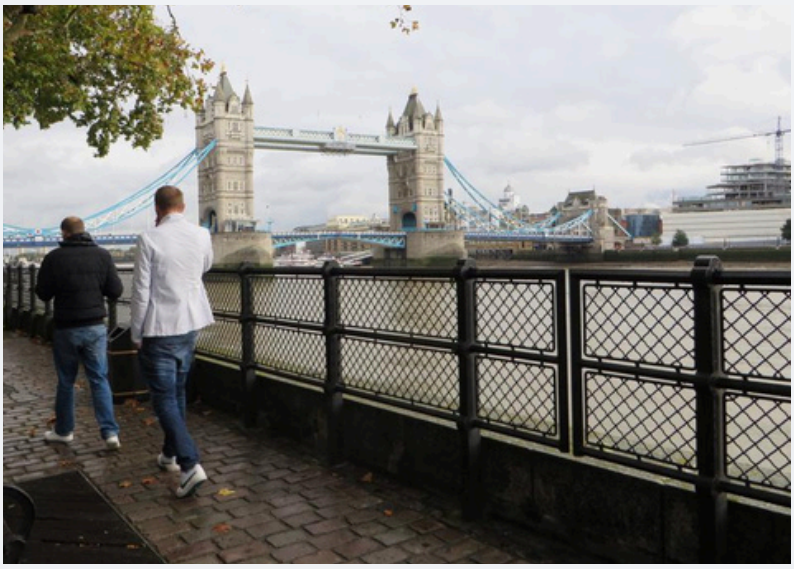
A few EoR participants who self-referred indicated that the HLH helped them decide which services were most appropriate for them. However, as most were referred by an HCP it was equally important that the HCP had knowledge of the specific service or programme (and who it was intended for) to make appropriate referrals. This suggests that the HLH serves a faciliatory function as opposed to supporting decision making Based on the qualitative and quantitative data analysed, the majority of AnK referrals come from the National Child Weight Management Programme and go directly to AnK staff. If the referral does come to the HLH, it is immediately passed onto AnK staff. As such, AnK service users (parents) do not have any direct contact with the HLH. In the data seen by the evaluation team, no AnK referrals were triaged by the HLH, suggesting this acts as a stand-alone service and is not “integrated” with the HLH. In focus groups and interviews, HLH staff indicated that they rarely see AnK referrals come through. Of the eight parents that participated in focus groups, one indicated that they self-referred their child into AnK.

Although it appears that AnK service users do not receive "triage" support from the HLH, a few parents reported that they participated in a virtual information session by AnK staff prior to programme initiation which was helpful in understanding the service and 12-week programme offering.

These findings suggests that the HLH has the potential to impact and enhance EoR as it receives a high number of referrals and has positive contact with some service users. However, they also suggest that at present the HLH is having negligible impact on the AnK service challenging a key assumption at the outset of this evaluation.

12. What services or support do service users access post-programme? [WP3]

Southwark commissioners indicated that post-programme support included options like free gym access, discounted memberships, and follow-on services (see Logic Model), yet from speaking to service users these appear not to be uniformly accessible or well-communicated. The HLH staff reported signposting to additional and external services post-programme, however some EoR and AnK staff were confused about the post-programme offer.

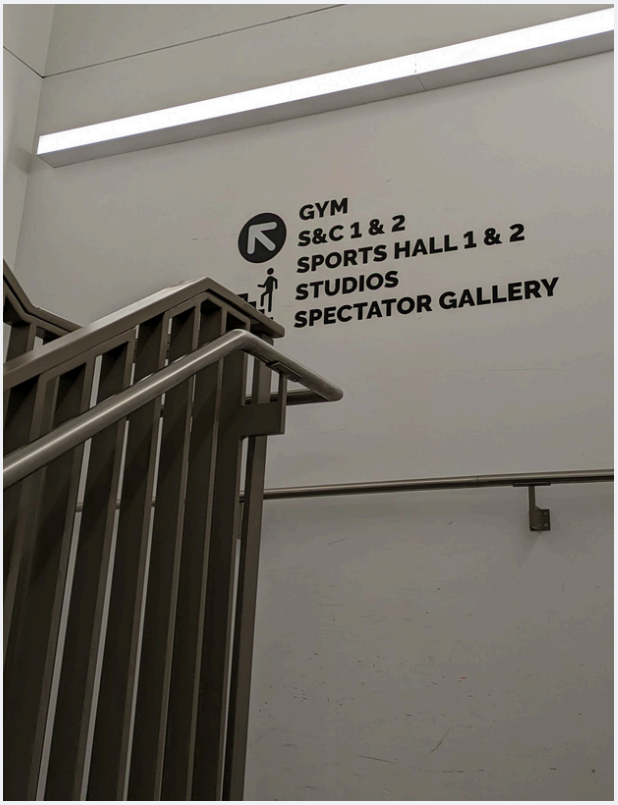


Additionally, service users from both EoR and AnK reported that they had repeated or planned to repeat their initial 12-week programmes. They cited several reasons for this, including the view that the 12-week timeframe was insufficient for sustaining health behaviour changes. This was particularly difficult for service users who missed sessions due to illness or injury as they were unable to make up for the weeks they missed. Additionally, many service users did not want to (and were possibly unable to) start paying for leisure centre use post-programme, even if this was discounted.

Objective 2: To assess whether referral from the HLH to AnK and EoR improves health behaviours and outcomes

1. Do programmes lead to changes in physical activity, sedentary behaviour and mental health at 3, 6 and 12 months? [WP1] Does EoR and AnK objectively change health markers (12-weeks)? [WP1]

Data relating to EoR demonstrated a high proportion of missing data (>90%) on objective health markers at 12-weeks in Kickstart and Active Boost (>80%). Within Cardiactive the proportion of missing data ranged from 70-100% depending on the variable (see Appendix 3). In addition, data sheets for HLH and individual EoR progammes also report different variables, for example, EoR sheets include the Rosenberg Self-Esteem scale, whereas the HLH does not. There is also disagreement between the degree of missing data between HLH data and data held for specific EoR programmes. It is unclear how these variables link, how they are being recorded and by who.



2. Do the follow-ups help support behaviour change? [WP3]

According to the Service Agreement, the HLH provides three follow-up consultations: a text message five weeks after the initial consultation to check on programme initiation, a 6-month review phone call to discuss progress and a final 12-month review phone call. Additionally, HLH staff indicated that service users can call the HLH out with these follow-ups for additional information and support. As mentioned above, focus groups and interviews have established that AnK acts as a standalone service with no follow-up from the HLH. For EoR, as mentioned above, service access and response times for the HLH and individual programmes varied significantly, and not all focus group participants recalled receiving follow-up calls. It was acknowledged by both staff and service users that one of the contributors to low engagement with HLH follow-ups was service users not answering calls or texts from an 'unknown' number and/or not knowing what the call was about. There was some confusion over roles within the HLH and EoR teams and service users did not always understand who was going to contact them, when and for what purpose. This implies some communication gaps between the HLH, EoR and service users. Additionally, service users were often not available for any of the attempted calls from the HLH or were simply not interested in a follow-up call.

Reactions from service users who did receive and engage with HLH follow-ups were very positive, particularly if they were offered and subsequently took up another service, such a smoking cessation programme. HLH staff felt that the follow-ups were particularly appreciated by, and beneficial for, service users who actively engage with the HLH (e.g. are more involved in conversations with HLH staff and proactively call in to ask questions and request support). It is unknown what proportion of HLH users are actively engaged in this way.

Within the EoR service itself, service users frequently reported not receiving a 12-week check-in where measurements are taken (e.g. weight and blood pressure), and if received the types of measurements taken appear to vary between clients. It has also been established that objective health measures are not collected at the 6-week time point, although commissioners assumed this was happening. These mixed user perceptions and experiences of follow-ups may impact its effectiveness in supporting and sustaining behaviour change and limits the HLH's ability to monitor and evidence programme outcomes.

3. Do service users report improved health? [WP3]

Users appreciated opportunities to maintain activity, though many found the 12-week timeframe insufficient for sustaining health behaviour changes. Reports of weight-loss, improved fitness, and enhanced mental health were common among EoR participants. AnK participants (parents) noted improvements to physical activity and eating behaviours among themselves and their children, often citing an increased interest in being physically active as well as eating healthier foods (particularly the ones provided by the AnK team during sessions). A few parents also noted that programme participation facilitated increased physical activity and healthy cooking/eating activities as a family, where members motivated each other and spent time together. However, the limited communication and accessibility of post-programme support options, despite their inclusion in the logic model, may impact the ability to maintain long-term health benefits for service users.

4. Why do people choose to take up memberships (or not) post-completion? [WP3]

Southwark commissioners believed that post-programme support included options like free gym access, discounted memberships, and follow-on services (see Logic Model), yet from speaking to service users these appear not to be uniformly accessible or well-communicated. Additionally, as discussed in response to question 12 above, many service users did not want to (or could not) pay for leisure centre use.

5. Do people feel an increased sense of community following participating in a HLH service? [WP3]

Generally, both EoR and AnK focus group participants did not report an increased sense of community post-programme. They noted a number of possible contributory factors including inconsistent attendance, limited opportunities for social interaction within individual sessions and living far away from the leisure centre and/or from other service users. Some participants from more structured EoR programmes (e.g. Cardiactive), mentioned that the regular interaction with others in their group enabled some social connections, particularly if group members continued to use the leisure centre regularly.

Image credit: Everyone Health

Recommendations

Based on the agreed upon evaluation objectives and research questions, and the evaluation findings, a number of recommendations have been made to inform re-commissioning decisions for 2025. **Overall, the IHLS would benefit from extending post-programme support, improving communication with service users, clarifying referral processes, and establishing additional reporting and governance structures for service delivery and service user feedback (including data collection and management).** These have been summarised into 10 key recommendations, which can be found below.

1. Expanded post-programme options

Focus group feedback indicated the 12-week programme may not be enough for lasting change and that many service users would like (or need) ongoing, no-cost support, as they may struggle to afford leisure centre access. Offering more free or low-cost options may help bridge the gap between initial involvement and long-term behaviour change. Involving existing community groups could help with signposting and raise awareness of post-programme support.

2. Consistent communication and post-programme support

Findings suggest that service users often lack awareness of post-programme options such as discounted leisure centre access and free gym and swim, impacting opportunities for long-term health maintenance and prompting some to repeat programmes. Improving communication around this support would ensure all participants can access these resources and provides another opportunity to involve existing community groups. Additionally, improving knowledge and communication between Everyone Health staff and leisure centre staff would improve efficiency and perceived service user experience during and post-programme.

3. Linked data collection

The current data architecture makes it challenging to link individuals between HLH and EoR accurately. Having one data storage point from initial referral to completion of programmes would mitigate this issue. Furthermore, this would allow for better tracking of individuals to establish if they are enrolling onto multiple services or the same service more than once.

4. More consistent data collection

Focus group participants reported inconsistencies in data collection, with significant gaps in tracking long-term health measures. This was also observed in the quantitative data, where a high degree of missing data was apparent at all follow-up time points, limiting the ability to assess service impact. Consistent data collection practices will enhance service evaluation and allow for more informed improvements. For example, if clients had contact from one practitioner for all data collected (e.g. designated health coach), this would assist in improved data collection and build rapport which could in turn facilitate increased engagement in data collection by service users. Reviewing data collection and follow-up processes would allow for appropriate refinements to be identified. Furthermore, a public involvement/community engagement group could help feedback on when and what data collection or follow-up might be most appropriate for service users.

5. Monitoring and integration of post-programme uptake

Monitoring the post-programme uptake and usage of those who have completed EoR or AnK would allow for ongoing monitoring and evaluation. Using a single identifier for individuals using EoR/AnK could be integrated into leisure centre recording, allowing for a longer-term view of physical activity behaviours. Additionally, it is recommended that the services be periodically evaluated internally.

6. Role of HLH in AnK services

The HLH has limited involvement in AnK referrals, often simply passing them directly to AnK staff. Ensuring HLH should have a more active role in AnK services, especially for self-referrals, could strengthen integrated service delivery and potentially improve user engagement.

7. Clear expectations and roles

Service users often misinterpret EoR as a more supervised service and there is confusion about the roles within the HLH and EoR and AnK teams and a lack of knowledge of such programmes by leisure centre staff. As such, clearer communication would set accurate expectations which could enhance service user satisfaction and engagement. More information could also be made available online for service users to read up on the programmes before. Again, a public involvement group could help prepare appropriate information and materials.

8. Clarification of inclusion/exclusion criteria

Ambiguities in referral criteria, particularly concerning conditions such as osteoporosis and eating disorders, may lead to inappropriate referrals. Clarifying these referral criteria will ensure participants are not enrolled into programmes which are unsuitable for them. This could be facilitated through the generation of a data collection template specifying such criteria.

9. Consistent access and response times

There is significant variability in programme access times, with some users waiting months, impacting motivation and engagement. Efforts to streamline this process and make access times more consistent and/or ensure service users have an accurate perception of wait times will help maintain service user motivation and improve adherence rates.

10. Participant involvement in programme development

The IHLS does not currently receive input or feedback from the community in a structured format at regular intervals (e.g. through a public involvement group, community steering group or service user engagement group etc.). Such a group could help reflect on certain programme areas (e.g. accessibility, referral pathways, service user journeys, data collection) and provide continual service feedback, overall aiding better connections between Southwark residents and the IHLS services. During our evaluation, we worked with the community and identified several interested and already established community groups who would be good candidates for continuous involvement within the IHLS (e.g. Public Health Ambassadors, Health and Wellbeing Coaches).

In particular, based on the recommendation above, a public involvement group could be engaged to help:

- Consult on the most appropriate means to contact service users for follow-up (as phone calls are often ignored)
- Consult on how to approach follow-ups, data collection and longer-term monitoring (e.g. timeframes, length of interaction, what data is collected)
- Raise awareness of self-referrals and post-programme support options
- Draft informational materials for websites or flyers, so people have more information of what to expect before attending various programmes (expectation management)
- Expand the referrer pool to include more social prescribers or health and wellbeing coaches – increasing uptake and widening the demographics

Summary

Image credit: Everyone Health

Image credit: Everyone Health

This evaluation of the IHLS aimed to understand the impact of the HLH on AnK and EoR. By employing mixed-methods across three work packages, it addressed questions identified by Southwark Council, PHIRST Elevate and other stakeholders, resulting in the development of key recommendations for service improvement.

Recommendations include: extending post-programme options (at little or no-cost) and increasing awareness of such options; enhancing data management (e.g. effective linkage between HLH and EoR data); standardising data collection, particularly for long-term health metrics; employing clearer communication to set accurate service user expectations and roles; streamlining access times and clarifying inclusion criteria for the HLH/EoR; clarifying the role of HLH in AnK referrals; employing integrated systems to monitor post-programme engagement, and; introducing structured service user and stakeholder feedback mechanisms.

It is expected that implementing these recommendations will improve programme accessibility, programme engagement, behaviour change and health outcomes, and importantly the ability to effectively evidence such changes.

References

Braun, V., & Clarke, V. (2021). Can I use TA? Should I use TA? Should I not use TA? Comparing reflexive thematic analysis and other pattern-based qualitative analytic approaches. Counselling and Psychotherapy Research, 21(1), 37-47. https://doi.org/10.1002/capr.12360

Campbell F, Holmes M, Everson-Hock E, Davis S, Woods HB, Anokye N, Tappenden P, Kaltenthaler E. A systematic review and economic evaluation of exercise referral schemes in primary care: a short report. Health technology assessment. 2015;19(60). https://eprints.whiterose.ac.uk/id/eprint/96814/1/Exercise%20referral%20schemes.pdf

Dayson, C., & Bashir, N. (2014). Evaluation of the Rotherham social prescribing pilot. https://www.shu.ac.uk/centre-regional-economic-social-research/projects/all-projects/evaluation-of-the-rotherham-social-prescribing-pilot

Dahlgren, G., & Whitehead, M. (1991). Policies and strategies to promote social equity in health. Background document to WHO – Strategy paper for Europe. https://core.ac.uk/download/pdf/6472456.pdf

Darzi, A. (2024). Independent investigation of the National Health Service in England. Crown copyright. https://assets.publishing.service.gov.uk/media/66f42ae630536cb92748271f/Lord-Darzi-Independent-Investigation-of-the-National-Health-Service-in-England-Updated-25-September.pdf

Friedli, L., Themessl-Huber, M., & Butchart, M. (2012). Evaluation of Dundee equally well sources of support: social prescribing in Maryfield. Evaluation report four.

National Health Service (NHS). (2019). The NHS long term plan (Version 1.2). https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf

NHS Confederation. (2011). From Illness to Wellness: Achieving efficiencies and improving outcomes. NHS Confederation. London, NHS Confederation, (224).

NHS Digital. (2024). Adult overweight and obesity: Health Survey for England 2022, Part 2. NHS Digital. https://digital.nhs.uk/data-and-information/publications/statistical/health-survey-for-england/2022-part-2/adult-overweight-and-obesity

NHS England. (2014). Five year forward view. Community Practitioner, 87(12)4.

Meader, N., King, K., Moe-Byrne, T. et al. A systematic review on the clustering and co-occurrence of multiple risk behaviours. BMC Public Health 16, 657 (2016). https://doi.org/10.1186/s12889-016-3373-6

Montgomery, S., McEwen, A., & Coleman-Haynes, T. (2023). Integrated health behaviour (lifestyle) services: A review of the evidence. National Centre for Smoking Cessation and Training. https://www.ncsct.co.uk

Office for Health Improvement and Disparities. (2025). Public health profiles (Physical Activity). https://fingertips.phe.org.uk/profile/physical-activity/data#page/4/gid/1938132899/pat/159/par/K02000001/ati/15/are/E92000001/iid/93015/age/298/sex/4/cat/-1/ctp/-1/yrr/1/cid/4/tbm/1

Pavey T, Taylor A, Hillsdon M, et al., Levels and predictors of exercise referral scheme uptake and adherence: a systematic review. J Epidemiol Community Health 2012;66:737-744. https://jech.bmj.com/content/jech/66/8/737.full.pdf?casa_token=LunN1S06WHUAAAAA:DzT1O0Q2B7cD7eVjBnjeHRqTAp1CNr7lYYtGc76P8Zq9rcmVc_x1jBiXSSZvHGLMFPUM3HE-8Ho

Prochaska JO. Multiple Health Behavior Research represents the future of preventive medicine. Prev Med. 2008;46(3):281–285. https://doi.org/10.1016/j.ypmed.2008.01.015

Silveira, E. A., Mendonça, C. R., Delpino, F. M., Souza, G. V. E., de Souza Rosa, L. P., de Oliveira, C., & Noll, M. (2022). Sedentary behavior, physical inactivity, abdominal obesity and obesity in adults and older adults: A systematic review and meta-analysis. Clinical nutrition ESPEN, 50, 63-73. https://doi.org/10.1016/j.clnesp.2022.06.001

South, J (2015) A guide to community-centred approaches for health and wellbeing. Project Report.Public Health England / NHS England. https://eprints.leedsbeckett.ac.uk/id/eprint/1229/11/A%20guide%20to%20community-centred%20approaches%20for%20health%20and%20wellbeing%20%28full%20report%29.pdf

Stiebahl, S. (2025). Obesity Statistics (Research Briefing No. 03336). House of Commons Library. https://researchbriefings.files.parliament.uk/documents/SN03336/SN03336.pdf

Sport England (2023). Active lives adult survey November 2022–23 Report. London (UK): Sport England. https://sportengland-production-files.s3.eu-west-2.amazonaws.com/s3fs-public/2024-04/Active%20Lives%20Adult%20Survey%20November%202022-23%20Report.pdf?VersionId=veYJTP_2n55UdOmX3PAXH7dJr1GA24vs

Contact

This report was prepared by PHIRST Elevate (NIHR160288). For any questions, please contact Phirst@ed.ac.uk

Report Authors

Dr A. Boath, Dr J. Manner, Ms S. Janac, Ms J. Guo, Ms J. Elliott, Dr A. Williams, Prof M. Murphy, Dr P. Kelly
University of Edinburgh

Acknowledgements

Esther Agyeman (Community Health Ambassador), Lisa Mitchell, Saran Sy Savane (Community Health Ambassador), Omotola Wonuola (Community Health Ambassador), Enduement Ruvon Adiohwo (Community Health Ambassador), Patricia Cuenca (Latin Ageing UK/Community Health Ambassador), Ese Anabui (Community Health Ambassador) and other members of the Community Steering Group

Dr Coral Hanson, Napier University

Maria Bujor, Southwark Council

Everyone Health

All individuals who participated in the evaluability assessment

Images

Images in this report were provided by members of PHIRST or Everyone Health. Everyone Health images were taken by members of Everyone Health staff in the Southwark Weight Management Team with consent provided by the families and those pictured at the start of the programme.

How to cite this report

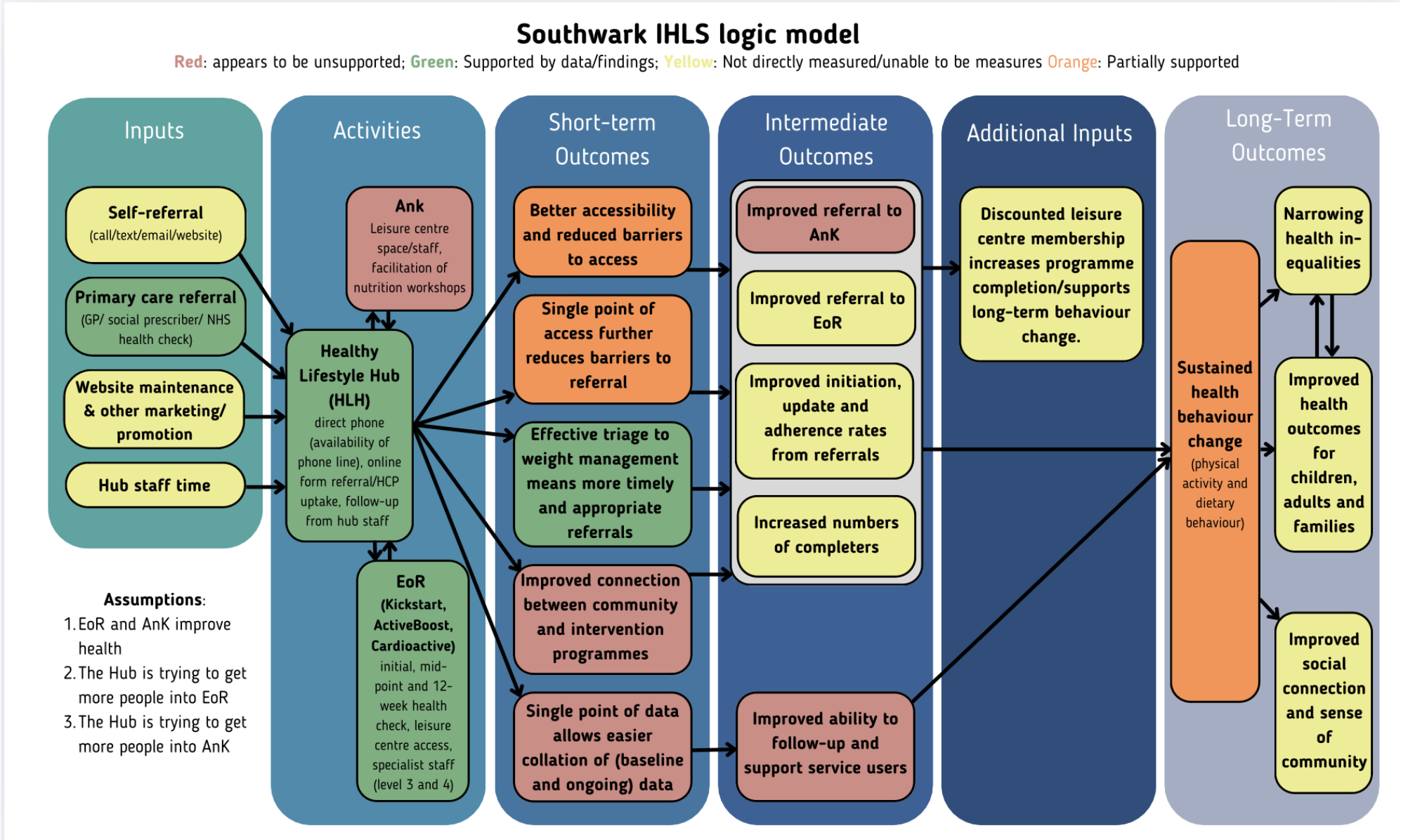
Boath, A., Manner, J., Janac, S., Guo, J., Elliott, J., Williams, A., Murphy, M., Kelly, P. (2025). *Evaluation of Southwark Council's Integrated Healthy Lifestyle Service for exercise referral.* University of Edinburgh. doi: 10.7488/ERA/6185.

This project was funded by the NIHR [Public Health Research programme (NIHR 166241)/PHIRST Elevate NIHR160288]. The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care.

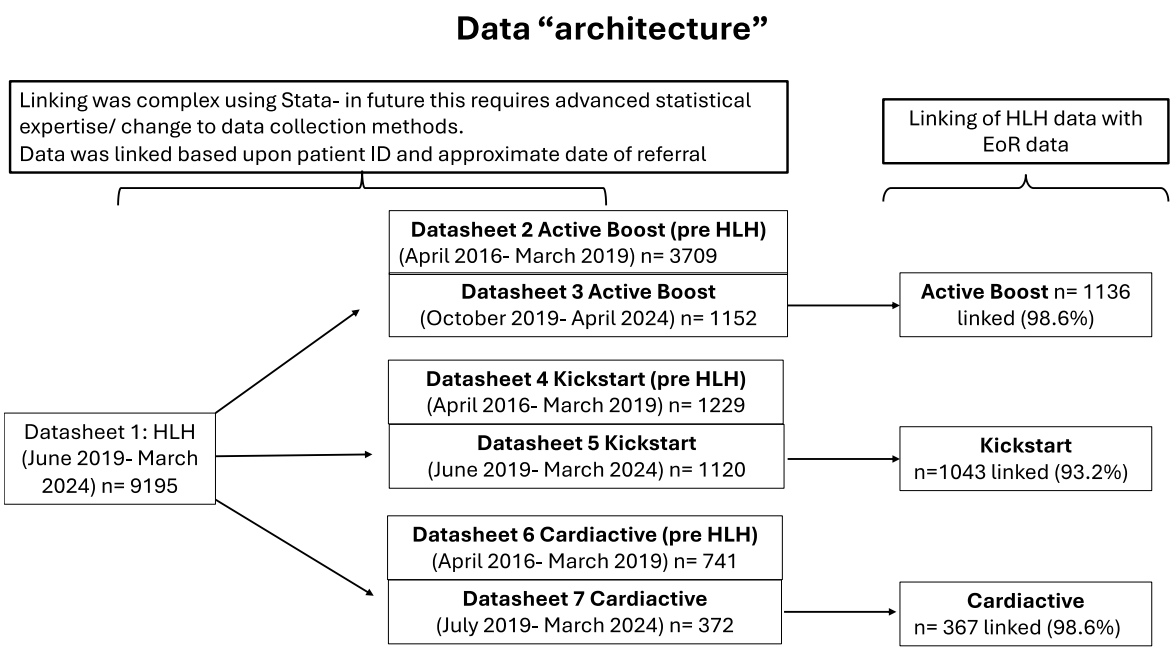
Appendices

- Appendix 1: Southwark IHLS logic model showing pre-evaluation shared assumptions on how the HLH impacts EoR and AnK Services
- Appendix 2: Data architecture
- Appendix 3: Missing data by time point
- Appendix 4: Survey Participant characteristics
- Appendix 5: Agreement in programme completion status between HLH data (data sheet 1) and EoR (data sheet 3)

Appendix 1: Southwark IHLS logic model showing pre-evaluation shared assumptions on how the HLH impacts EoR and AnK Services



Appendix 2: Data architecture



Appendix 3: Missing data by time point

	Programme	Kickstart Pre-HLH (n=1229)[1]	Kickstart HLH (n=1120)	Active Boost Pre-HLH[3] (n=3709)	Active Boost HLH (n=1152)	Cardiactive Pre-HLH [5] (n=741)	Cardiactive HLH (n=372)
3 months	Short Warwick Edinburgh Score	100%	79.6%	100%	82.4%	100%	68.9%
	IPAQ	N/A	N/A	N/A	N/A	N/A	N/A
	Rosenberg self-esteem	100%	55.5%	100%	87.1%	100%	74.6%
	BMI	100%	93.6%	100%	82.4%	100%	76.4%
	Waist circumference	100%	95.3%	100%	85.2%	100%	74.5%
	Hip circumference	100%	96.7%	100%	91.3%	100%	91.7%
	Waist to hip	100%	96.7%	100%	91.3%	100%	91.7%
	Body fat %	100%	100%	100%	100%	100%	100%
	Blood pressure	100%	93.4%	100%	80.1%	100%	70.3%
	Resting heart rate	100%	93.5%	100%	80.4%	100%	71.1%
6 months	Short Warwick Edinburgh Score	100%	100%	100%	100%	100%	100%
	IPAQ	N/A	N/A	N/A	N/A	N/A	N/A
	Rosenberg self-esteem	100%	100%	100%	100%	100%	100%
	BMI	100%	100%	100%	100%	100%	100%
	Waist circumference	100%	100%	100%	100%	100%	100%
	Hip circumference	100%	100%	100%	100%	100%	100%
	Waist to hip	100%	100%	100%	100%	100%	100%
	Body fat %	100%	100%	100%	100%	100%	100%
	Blood pressure	100%	100%	100%	100%	100%	100%
	Resting heart rate	100%	100%	100%	100%	100%	100%
12 months	Short Warwick Edinburgh Score	100%	100%	100%	100%	100%	100%
	IPAQ	N/A	N/A	N/A	N/A	N/A	N/A
	Rosenberg self-esteem	100%	100%	100%	100%	100%	100%
	BMI	100%	100%	100%	100%	100%	100%
	Waist circumference	100%	100%	100%	100%	100%	100%
	Hip circumference	100%	100%	100%	100%	100%	100%
	Waist to hip	100%	100%	100%	100%	100%	100%
	Body fat %	100%	100%	100%	100%	100%	100%
	Blood pressure	100%	100%	100%	100%	100%	100%
	Resting heart rate	100%	100%	100%	100%	100%	100%

Appendix 4: Survey Participant characteristics

Characteristics	N(%) / Mean (SD)
Sex (n= 163)	
Female	105 (64.4%)
Male	49 (30.1%)
Prefer not to say	3 (1.8%)
Not disclosed	6 (3.7%)
Index of Multiple Deprivation (n=163)	
Q1	24 (14.7%)
Q2	27 (16.6%)
Q3	28 (17.2%)
Q4	0
Q5	0
Not disclosed	84 (51.5%)
Age (n=138)	57.1 (12.3)
Ethnicity (n=163)	
White	77 (47.2%)
Black/Black British/Caribbean/African	57 (35.0%)
Mixed or multiple ethnic groups	10 (6.1%)
Prefer not to say	7 (4.3%)
Not disclosed	6 (3.7%)
Asian/Asian British	4 (2.5%)
Other	2 (1.2%)
Number of dependents (n=163)	
0	91 (55.8%)
1	32 (19.6%)
2	15 (9.2%)
3	8 (4.9%)
4	6 (3.8%)
5	1 (0.6%)
>5	1 (0.6%)
Prefer not to say	9 (5.5%)
Employment status (n=163)	
Employed (self or employee)	62 (38.0%)
Retired	42 (25.9%)
Long-term sick/disabled	18 (11.0%)
Unemployed	17 (10.4%)
Prefer not to say	17 (10.4%)
Looking after home or family	4 (2.5%)
Student	2 (1.2%)
Other	1 (0.6%)
Service referred to (n=163)	
EoR	72 (44.2%)
EoR + other service(s)	18 (11.0%)
AnK	8 (4.9%)
AnK+ other service(s)	1 (0.6%)
AnK + EoR	8 (4.9%)
Other service(s)	15 (9.2%)
Not referred to any service(s)	10 (6.2%)
Did not respond	31 (19.0%)

Appendix 5: Agreement in programme completion status between HLH data (data sheet 1) and EoR (data sheet 3)

Status: within programme	Completed	Left Early	Not Participating
Status: HLH			
Completed	**191 (16.8%)**	226	13
Left Early	227	**345 (30.4%)**	6
Participating	37	71	**0**