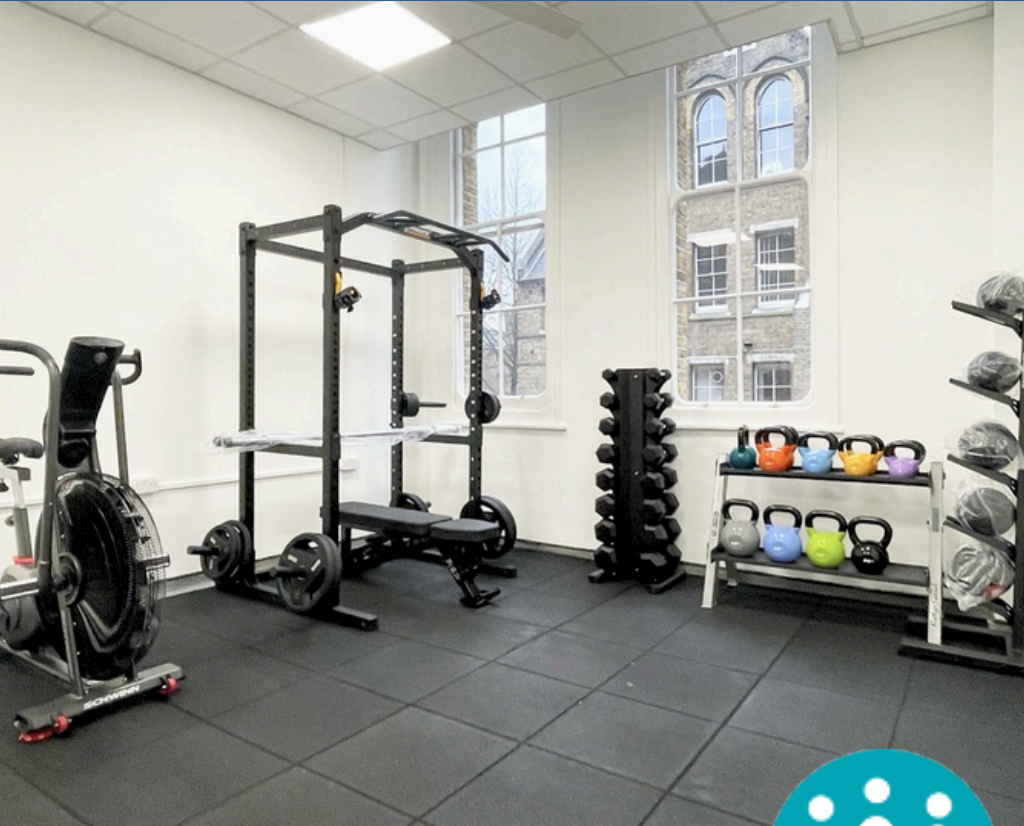


NHS COMMUNITY LIVING WELL

PHYSICAL ACTIVITY REFERRAL EVALUATION



PRELIMINARY FINDINGS

APRIL 2026



PARTNERSHIPS



Community
LivingWell

Working together for your wellbeing



NHS
Health
Charity



Noctor



**SPORT
ENGLAND**

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KEY FINDINGS

696

NUMBER OF GYM SESSIONS
SINCE SEPTEMBER 2023

102

NUMBER OF PARTICIPANTS
IN PHYSICAL ACTIVITY (PA)
PROGRAM

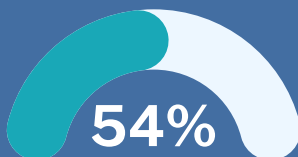
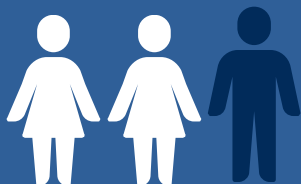
95

NUMBER OF LOCAL
ORGANISATIONS IN
SIGNPOSTING
DATABASE

402

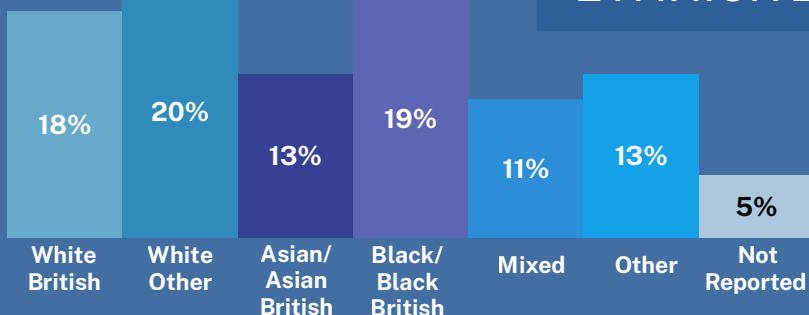
NUMBER OF REFERRALS
MADE INTO THE PA SERVICE

NEARLY
2 IN 3 ARE
FEMALE (64%)



MORE THAN HALF
REPORT A LONG-TERM
HEALTH CONDITION

**HIGH
ENGAGEMENT
ACROSS DIVERSE
ETHNICITIES**



BACKGROUND

NICE recommends physical activity (PA) as a treatment option for a range of mental health conditions. ^{1,2}

Between 2024 and 2025, NHS Talking Therapies received approximately 1.8 million referrals, with PA increasingly incorporated into treatment pathways.³

In 2023, Community Living Well (CLW) appointed a Physical Activity Coordinator to develop a PA service for individuals participating in Talking Therapies.⁴ PA sessions occur in a newly developed gym on-site at CLW, funded by CNWL NHS Health Charity, Sport England, and LiveMore.

“

*I loved the personalised training. **I was treated with respect and challenged at each session** which made me look forward to something I had lost interest in.*

”

SERVICE OVERVIEW

PA sessions at Community Living Well Gym

The program offers up to **12 personalised PA sessions** for individuals referred from **K&C Talking Therapies**, modeled on the **KBIM** Service in Sydney Health District.⁶ The gym facility is shared with the **Sport Therapy Team** at St. Charles Mental Health Unit four times a week.

Post-intervention support and alternatives



Participants receive **personalised community signposting** and **online resources**, tailored to their **health conditions**, from a database of over **95** organisations. Those who opt out of one-on-one training are still provided with signposting support.

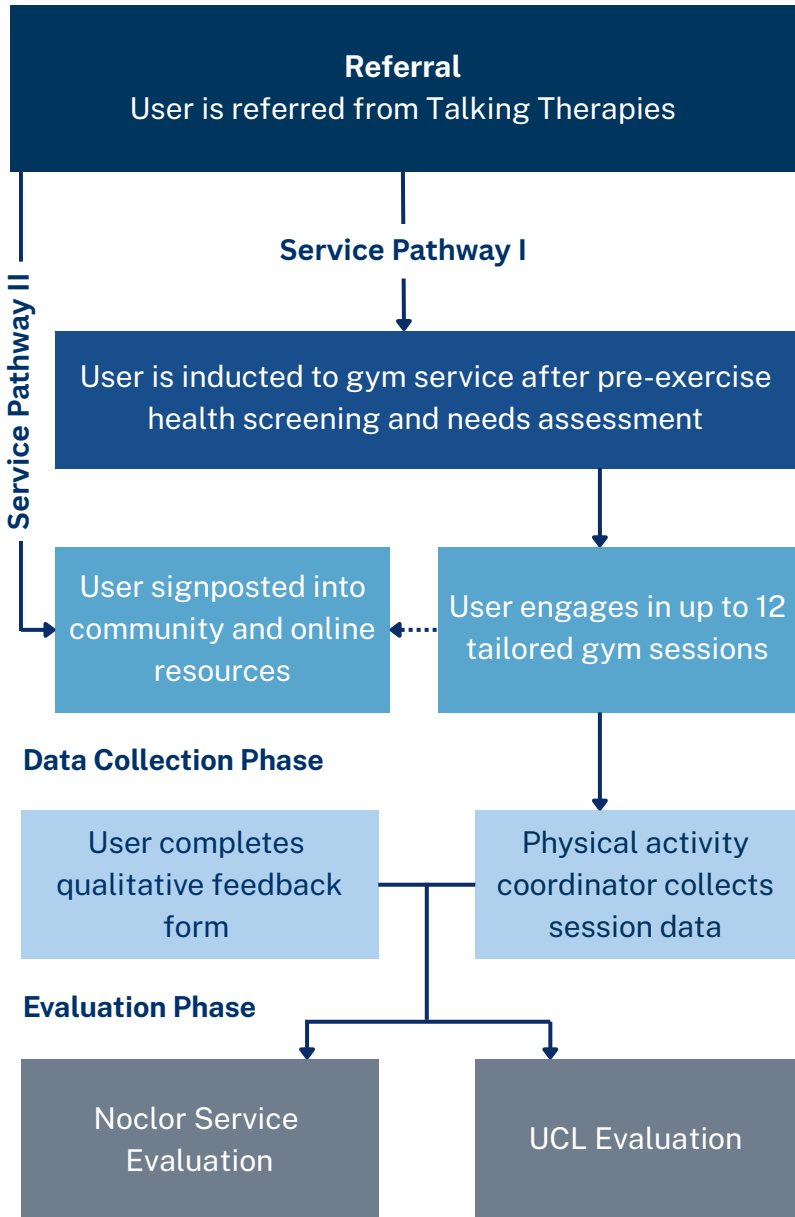
Feedback procedures and evaluation



After completing the program, participants are encouraged to provide **feedback** on the PA service. This information is used to inform **program improvements**.⁴

In this evaluation, quantitative changes in mean depression (PHQ-9) and anxiety (GAD-7) scores were compared between the intervention and non-intervention groups and are presented descriptively. Findings from **UCL** evaluations on the qualitative data are also presented.

SERVICE PATHWAYS



METHODS

1. Data Source & Identification of PA Referrals

- Data was extracted via electronic patient record system used by the NHS Talking Therapies (TT) service (IAPTus).
- The search strategy included patients with the following criteria:
 - PA labels*
 - Completed their treatment, and
 - Had anxiety and depression scores recorded at both baseline and end of TT treatment.
- The search was conducted for records since **September 2023**, approximating the Physical Activity Coordinator start date.
- From over 9,800 records, N=402 PA labels were identified. **102** participated in PA. Demographic data was analysed for all participants, of whom **55** met the criteria for GAD/PHQ analysis.

2. Sample Groups

- Records were organised by three groups, dependent on treatment exposure.**
- The dataset included demographic information and PHQ/GAD scores. Entries were cleaned and standardised for analysis.

3. Analysis & Variables Assessed

- PHQ-9 and GAD-7 scores for PA and non-PA groups were analysed descriptively, assessing the changes between baseline and final scores.
- Initial scoping of the data found that, on average, participants commenced PA **40 days** into TT treatment. To make the analysis comparable, **baseline** PHQ/GAD scores were recorded at this stage across the three groups.
- Data included demographic information, primary diagnosis, treatment dates, and whether PA, Signposting or No Intervention was provided.

Notes:

* PA labels are applied in IAPTus to individuals referred for PA treatment while receiving TT, allowing distinction between those offered PA and those who engage with the intervention.

**PHQ-9 and GAD-7 scores are taken at every TT session

***PA Participants who did not engage with the PA Coordinator until after their TT treatment had been completed were excluded (N=26)

PA Participants currently undergoing treatment without final PHQ-9 and GAD-7 scores were also excluded (N=21)

4. Findings & Reporting

- The current report outlines the preliminary findings of this evaluation, based on a descriptive analysis of the data.
- A second phase of evaluation will be undertaken to assess effect sizes. The results will be detailed in a subsequent report.

PARTICIPANT GROUPS

PA & Signposting (Group 1, N=55) Criteria:

- Assigned a PA label in IAPTus.
- Recorded PHQ-9 and GAD-7 scores at both baseline and end of TT treatment.**
- Engaged in PA whilst in TT Treatment.***
- Attended a minimum of one PA session.
- Provided resources on community and online PA information.
- Participants who did not commence PA until after TT Treatment was completed were excluded (word better) (N=47)

Signposting Only (Group 2, N=55) Criteria:

- Assigned a PA label in IAPTus.
- Recorded PHQ-9 and GAD-7 scores at both baseline and end of TT treatment.
- Signposted by PA coordinator whilst in TT Treatment.
- Provided resources on community and online physical activity information.
- NOT attended any PA session.

No PA Intervention (Group 3, N=42) Criteria:

- Assigned a PA label in IAPTus.
- Recorded PHQ-9 and GAD-7 scores at both baseline and end of treatment.
- NOT contacted by the PA coordinator during participation in TT Treatment.
- NOT provided resources on community and online physical activity information.
- NOT attended any PA session.
- The group size was **42** as this was the total number of people who received no intervention due to non-engagement.

***After treatment,
physical activity has
helped me build a
regular part of my
routine, providing a
structured and
positive outlet for
stress relief.***

SERVICE DATA

Between 2023 and 2025, nearly **700 physical activity sessions** were delivered from over **400 referrals**. Approximately **200 tailored signpostings** were overseen into community and online resources.

102

Total PA participants

402

Total PA referrals made by Talking Therapy professionals

696

Gym sessions completed by Physical Activity Coordinator

198

Total participants referred to community or online support resources only

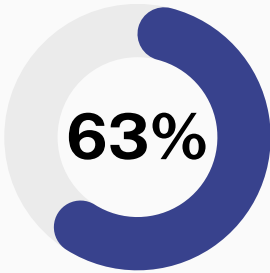
“

*It has enabled me to **feel more connected**. I feel more **confident and a lot stronger**.*

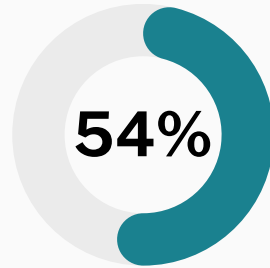
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WHO ENGAGED IN THE PHYSICAL ACTIVITY SERVICE?

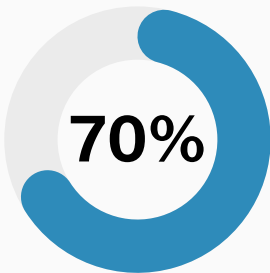
Two-thirds of the participants were female



More than half reported a disability or long-term health condition



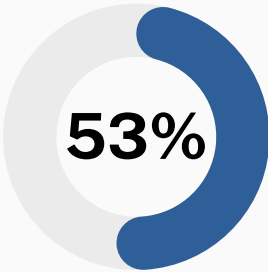
Most had depression as a primary diagnosis



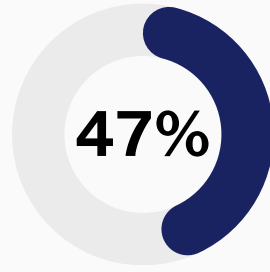
Just under 1 in 3 had anxiety as a primary diagnosis



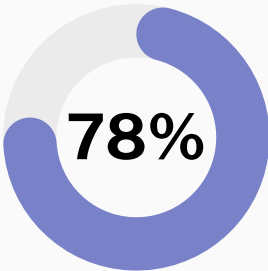
**Participants with
Step 2 Presentation
(Mild- Moderate)**



**Participants with
Step 3 Presentation
(Moderate-Severe)**



**3 in 4 attended
more than one
session once
referred**

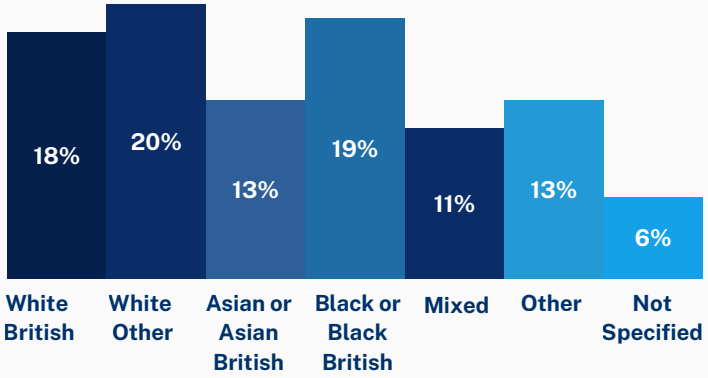


**Average duration
of engagement by
participants:**

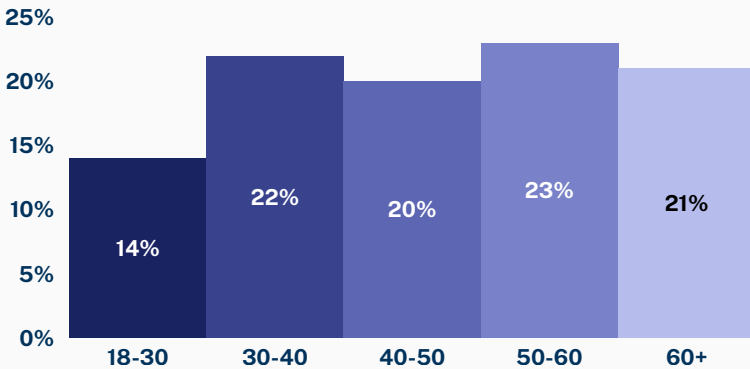


PA was widely engaged across ethnicities and ages, with an average age of 45

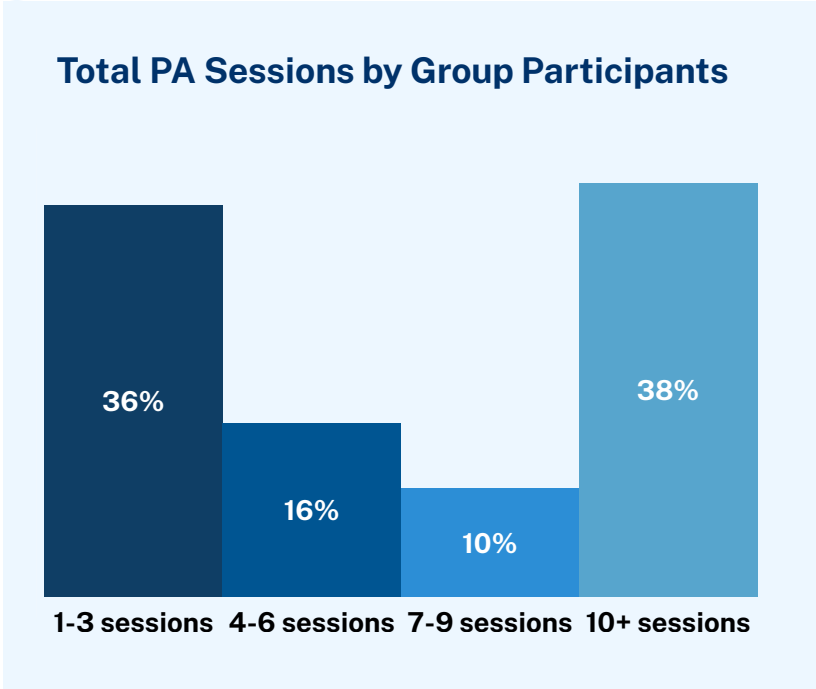
PA Participants - Ethnicity



PA Participants - Age



Over half of participants have **long term health conditions (LTCs)**, and maintained **engagement** for an average duration of **14 weeks**.



“Physical activity has **significantly improved my wellbeing** by boosting my mood, reducing anxiety, enhancing overall mental clarity and want to live.”

QUANTITATIVE DATA

Baseline and final PHQ-9 and GAD-7 scores were compared for all 3 groups. PA started on average 40 days into Talking Therapy treatment. Scores taken closest to this baseline were selected for comparison. The impact of PA looks promising, but further data collection and statistical testing is required.

Physical Activity Group 1 (N=55)

	Baseline	Final	Improvement
Mean PHQ-9	15.8	11.7	-4.1
Mean GAD-7	13.9	9.6	-4.4

Signposting Group 2 (N=55)

	Baseline	Final	Improvement
Mean PHQ-9	15.6	11.8	-3.8
Mean GAD-7	13.2	10.2	-3.0

No Physical Activity Group 3 (N=42)

	Baseline	Final	Improvement
Mean PHQ-9	15.2	11.6	-3.6
Mean GAD-7	13.7	10.4	-3.2

QUALITATIVE DATA

Qualitative evaluation conducted at **UCL** found PA participants reported benefits across multiple domains, including **confidence, access and social connectedness**. Inductive thematic analysis highlighted four key feedback themes.⁴



1

BARRIERS SUCH AS LONG-TERM CONDITIONS, CONFIDENCE & MOTIVATION

2

RESOURCE ACCESS AND AVAILABILITY

Participants discussed the impact of health conditions on their motivation and confidence to be physically active. Motivational challenges were compounded by difficulties accessing **affordable** training environments.

“

*Before this, physical activity was non-existent. I struggled to establish a **consistent routine** due to low motivation and depression.*

”

“

*I feel that I am doing something good for myself, I enjoy it so much, sometimes it's really hard to push myself to go to my session but **I know it will help me afterwards.***

”

3 ROLE OF THE PHYSICAL ACTIVITY COORDINATOR

4 IMPROVEMENTS IN MENTAL HEALTH

Participants highlighted the **important role** of the **Physical Activity Coordinator** in creating a **supportive** training environment, and the positive impact that **routine** sessions had on their mental health.

“*The trainer has a lot of innate kindness and humanity which really helps me to get the most out of our sessions. Amidst my depression it is **something I can trust.***”

“*Participating really gave me a sense of **routine** and reason to leave home as I suffer from depression, being able to **achieve something** made me feel a bit better. It gave me more confidence.*”

IMPLEMENTATION LEARNINGS

Deliver PA programs led by experienced professionals who are sensitive to the challenges people with mental health conditions can experience and create a positive environment.

Integrate PA professionals into the multi-disciplinary team (MDT) to prevent siloed working and strengthen referral pathways.

Collect impact data from the onset with a clear evaluation strategy so that effectiveness can be evaluated.

Demonstrate effectiveness by aligning data collection and evaluation strategies to clinical commissioning priorities.

Disseminate evaluation data and implementation learnings across professional networks.

Incorporate routine feedback and co-produce PA programs, aiming to incorporate peer pathways.

Person centred PA Programs integrate a range of evidence based training approaches that best meet individual clinical needs and preferences.

Develop a database of online and community resources so signposting information can be tailored to individual health conditions and cultural preferences.

Support PA routines that can protect against preventable health conditions, developing individual agency and confidence to move **'from sickness to prevention.'**⁸

LIMITATIONS

A key **limitation** of this evaluation is the challenge in establishing a **direct association** between the PA service and depression or anxiety scores.

WHAT DOES THIS MEAN?

Depression and anxiety scores were collected at separate Talking Therapy (TT) sessions, and not by the PA coordinator, resulting in an absence of data that aligns with PA sessions.

On average, PA sessions started **40 days** into TT treatment and continued for **18 days** after TT treatment was completed. The average duration in the PA program was **115 days**.

In response to this limitation, since January 2026, the **PA Coordinator** has been collecting depression and anxiety scores at first and final PA sessions. This will enable a more **accurate** assessment of mental health changes across the full program.

Further research and statistical analysis will be necessary to contextualise and interpret findings, with the goal of developing the PA program.

FUTURE RESEARCH

Depression

The evidence for PA in the treatment of mild to moderate depression is strong. NICE recommends further research on how to increase PA in minority ethnic groups that engage less with services. This PA program has demonstrated **wide acceptance** amongst **diverse populations**.

Anxiety

NICE state that whilst evidence for PA in the treatment of generalised anxiety is encouraging, **larger trials** are needed. 30% of participants in this PA program had an anxiety disorder.

ADHD

There is overlap between anxiety, depression and ADHD. **Long waiting lists** for assessments, and theoretical benefits of PA to ADHD symptoms can be explored in future research.

Health Economics

A randomised control trial in The Lancet (2025) showed that a community PA program was able to **offset future hospital costs** by €1,324 per person.⁷ Individuals receiving care for **severe mental illness** at St Charles Mental Health Unit have weekly access to the gym prior to discharge as part of a PA care plan. Sport England research shows that £1 of investment into community PA can generate £4.38 for the economy.⁵

***It is a real support to
me whilst I am
contending with
depression and trying
to emerge from it.***



CONTACTS

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