



Community Physical Activity & Digital Coaching

A solution to drive proactive neighbourhood health

End-of-Project Evaluation · for review

Partnership Community Wellness Services CIC & Holly Health

Funder Innovate UK - Contracts for Innovation: Scaling community initiatives in diet and exercise

Project period September 2025 - August 2026 (12 months)

Audience Innovate UK; ICS and Neighbourhood Health leads; commissioners; VCSE organisations

Total project value £250,000

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1. Executive summary

Between September 2025 and August 2026, Community Wellness Services CIC (CWS) and digital health coaching provider Holly Health tested a **hybrid model of community health** - combining trusted, in-person community exercise with adaptive digital coaching for people facing the greatest health inequalities in Sheffield. The project is in effect a working prototype of the direction health and care is moving in: **proactive, preventive, neighbourhood-based support** that reaches people conventional services struggle to hold, supporting people stay well in their own communities.

The case for this model is a system one. Sheffield's most deprived neighbourhoods carry the heaviest burden of inactivity, isolation and long-term conditions, and the lowest healthy life expectancy. Yet these are the people hardest to reach through clinical, appointment-based provision. A model that meets residents where they already are, through trusted community relationships and extends that trust into affordable digital support between sessions - offering a route to better wellbeing and lower avoidable demand at the same time. That is where this approach may fit in future neighbourhood-health provision.

What the project achieved

- **It exceeded its reach target** and more importantly, reached the right people - predominantly older adults managing multiple long-term conditions, the group that drives avoidable NHS demand.
- **The hybrid model proved out as the "gold standard."** Combining trusted classes with digital reinforcement produced the strongest engagement and the highest rate of lasting habit formation. Unusually for digital health, engagement actually rose amongst those with higher health complexity.
- **It delivered measured wellbeing gains**, particularly in mental wellbeing, alongside exceptional satisfaction with the face-to-face classes that anchor the model.
- **It was a catalyst for CWS as an organisation.** Over the funded year the charity more than doubled its class attendances, grew its earned income, and built durable digital and evaluation capability - positioning it well for future commissioning.
- **It built a credible route to continuation** - a community-prevention model that can be adapted to local clinical priorities and replicated in new areas, with strong early interest from system stakeholders.

The sections that follow set out what the project delivered, what the data shows, what the team learned, and how the approach can be sustained and scaled. The detailed delivery and outcome data - including the reach funnel - is presented in Sections 4 and 5.

"I have Parkinson's and sometimes fall. Prior to taking these classes, I could not get myself back up when I fell. I managed to get up unaided for the first time in about 2 years."

- Face-to-Face participant, class feedback survey

2. Introduction and context

2.1 The partners and the model

Community Wellness Services CIC (CWS) brings 20 years of community physical-activity delivery and social connection, working with people managing long-term conditions including cardiac, pulmonary, Parkinson's, cancer and musculoskeletal conditions. Classes run at affordable or free rates in accessible venues, led by Level 3/4 qualified instructors.

Holly Health is an NHS Innovation Accelerator backed SME, that provides a personalised digital coaching platform, supporting the public to build physical and mental health habits for improved health self-management. The platform also includes built-in outcomes tracking infrastructure which evaluates PROMs (patient reported outcomes measures) over time.

The project tested three flexible delivery pathways:

Face-to-Face Expert-led community rehabilitation and gentle exercise classes for the most vulnerable.	Digital-Only Scalable, self-paced wellbeing support with 24/7 access to automated health coaching.	Hybrid - "The Gold Standard" Blending human accountability with digital habit reinforcement between sessions.
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The Digital-Only route also enables scaled-up support across the wider South Yorkshire area, reaching people who cannot attend in person due to mobility, mental health, time or seasonal barriers.

2.2 Why this matters: the neighbourhood-health context

Sheffield's most deprived areas have physical-activity levels as low as **54.1%**, against **67.2%** citywide. Average healthy life expectancy in these communities is just **58.1 years**, well below the national 61.5-61.9. Nearly a quarter of adults (23.1%) do fewer than 30 minutes of activity a week. These are the communities where inactivity is highest and health inequalities starkest.

The project sits deliberately within the wider shift toward **neighbourhood health** - bringing NHS care closer to communities and taking a proactive, preventive, scalable approach. It integrates with MoveWell, Move More, Primary Care Networks and community charities, within the South Yorkshire Combined Mayoral Authority's focus on deprivation and prevention. It speaks directly to the NHS 10 Year Plan's community, digital and prevention agenda.

- It matters that there are accessible, inclusive and quality options for people at a local level.
- It matters that we provide truly patient-centred opportunities with quality - not just condition-specific or activity-specific. People need flexible, social, connected provision that is genuinely local and not clinical.

3. What we set out to do

The project was funded to test and scale a hybrid community exercise model, with clear objectives and nine SMART milestones tied to payment. The objectives were:

- **Extend reach:** support up to 1,000 adults at greatest risk, and increase CWS's delivery and reach by over 25%, with a focus on Sheffield's most deprived areas.
- **Deepen support:** give class attendees access to adaptive digital coaching, so people move seamlessly between in-person and digital support.
- **Reduce inequality:** prioritise people with chronic conditions, low confidence, digital exclusion and seldom-heard groups, using co-design.
- **Measure impact:** establish reliable outcomes and evaluation for the first time, to evidence value for commissioners.
- **Build for scale:** create the bespoke tooling, pathways and learning to enable replication across Sheffield, South Yorkshire and beyond.
- **Develop the partnership:** build a lasting partnership between CWS and Holly Health with the legacy of a bespoke digital tool, co-produced with the people who would benefit most.
- **Grow CWS as a business** - in activity, income and knowledge.

4. What we delivered

4.1 Listening first: market research and co-design

Before building anything, the project ran a multi-level engagement programme: a MoveWell focus group, 8 interviews with PCNs, community anchors, academic and voluntary-sector partners, plus 21 CWS participants across two focus groups, plus staff and instructor sessions. Four themes shaped the design:

- **Face-to-face is non-negotiable.** Participants described weekly classes as the highlight of their week, ranking social connection above exercise. Digital was therefore positioned firmly as a supplement, never a replacement.
- **Online sessions with familiar instructors were the participants' own idea** - short sessions between classes, featuring instructors they trust; now built and launched.
- **"App fatigue" is real.** Sheffield organisations had promoted digital tools before with disappointing results. The answer was a warm handoff through trusted CWS instructors, positioning the app as an extension of benefits already felt.
- **Design for economic vulnerability.** Phone memory, data costs and complexity are real barriers; the response included simplified sign-up, offline functionality and non-smartphone options (like a one-off online wellbeing check with habit suggestions).

4.2 The bespoke hybrid product

Holly Health built a suite of CWS-specific features: instructor-led videos at three difficulty levels, celebration-focused progress tracking (no guilt mechanics), CWS-specific nudges and notifications, and bespoke surveys. This content and tooling is now a durable, reusable asset owned by CWS beyond the funded period.

4.3 Adapting to different conditions and priorities

A key strength of the model is that it is **not fixed to a single condition or goal**. The digital platform's tracking and content can be configured to a commissioner's or community's **clinical priorities** - measuring the specific outcomes and clinical markers that matter most locally, whether cardiovascular, frailty, weight, cholesterol or diabetes-related. The same hybrid infrastructure - trusted classes plus personalised digital coaching and PROMs tracking - can therefore be pointed at whichever outcomes a place cares about. Reporting can be broken down by cohort so both NHS and charity partners see the distance travelled for their own populations. This adaptability is central to how the model aligns with local clinical needs and the CORE20PLUS5 priorities as it moves into new areas (Section 10).

4.4 Reach: 1,064 sign-ups across four channels

Recruitment ran through existing CWS classes (QR codes and instructor promotion), MoveWell navigator referrals, GP practices and PCN social-prescribing teams, and community partners. A major PCN partner (30,000 patients) sent SMS invitations to cohorts, which we tested and learned against the responses of before sending more batches.

Total sign-ups reached **1,064** (993 excluding external class surveys), against the 1,000 target. The project generated evidence at each stage of a transparent funnel – from reach, to baseline data, to measured outcomes - underpinned by strong in-app engagement.



The reach funnel: 1,064 reached → 742 onboarded with baseline data → 83 with 8-week outcome data (figures as at the May milestone).

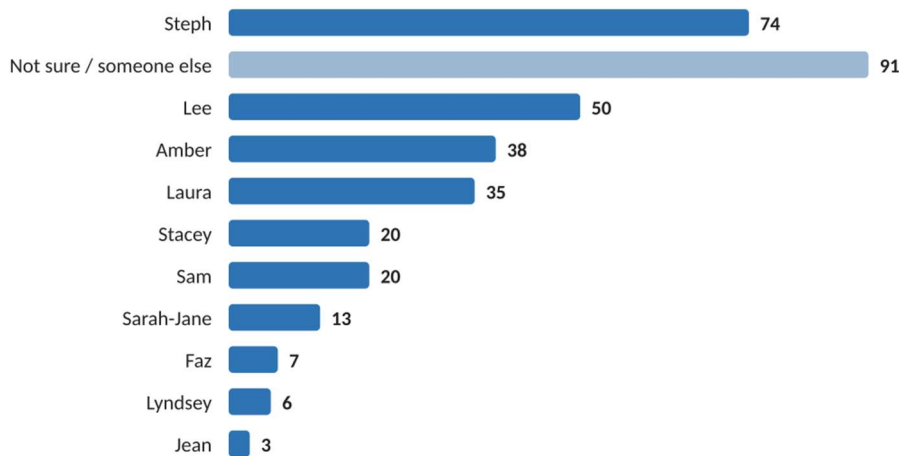
Pathway (sign-up route)	Signed up	Onboarded	8-week data
V1 - Digital-Only (early)	11	8	1
V2 - Hybrid (CWS members / class attendees)	450	367	57
V3 - Digital-Only (non-CWS: MoveWell, waitlist)	532	367*	25
External class feedback survey	71	-	-
Total	1,064	742	83

*Of the 367 onboarded V3 users, 161 opted in to be signposted to CWS classes (44% of those who signed up via the GP practice route) - evidence of the digital pathway feeding the in-person community service. Figures are reported as at the May milestone; a separate follow-up report on six-month survey insights will follow.

4.5 The trusted instructor as the front door

The co-design insight that a warm, personal handoff beats cold digital promotion is borne out in the data: 357 sign-ups came via the instructor route, within a matter of weeks, led by individual instructors with strong participant relationships.

Sign-ups attributed to each instructor (29 Jul 2026)



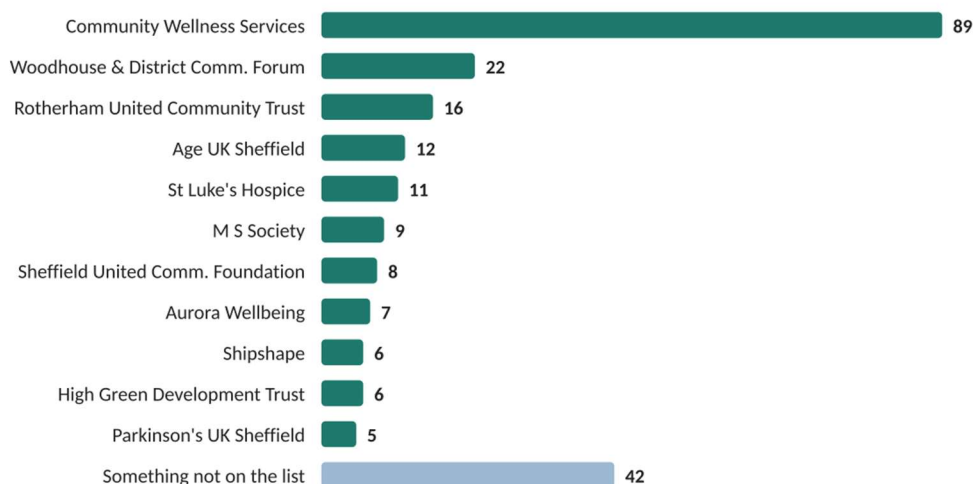
357 sign-ups came via the instructor route in total (266 named + 91 unnamed).

Instructor-attributed sign-ups. The trusted instructor relationship converts class attendees into digital users - the mechanism at the heart of the hybrid model.

4.6 A broad community network

Sign-ups also came through a wide network of trusted local partners - hospices, disease-specific charities, community forums and leisure organisations - not delivery in isolation. We supported these organisations with briefing meetings and a library of assets they could draw on to help promote the app (traditional and digital).

Sign-ups by community partner organisation (19 May 2026)



233 sign-ups carried a partner attribution — evidence of a broad, trusted community network.

Sign-ups by partner organisation. The spread across the voluntary and community sector underpins both reach and future sustainability.

4.7 Face-to-Face reach: the classes the funding made possible

The digital pathways generated rich automatic data, but they are only part of the story. The funding also sustained and expanded CWS's core in-person class programme - continuing classes that were running out of funding and enabling new ones - benefiting many people who attended but never signed up to the app. This Face-to-Face-only group is, by design, evidenced through attendance and reach data plus qualitative feedback (Section 6), rather than the digital outcome metrics.

CWS's own year-on-year figures show the scale of this enabling effect: comparing the funded year to the year before, **classes delivered rose 86.5% and attendances rose 107.5%** - more than doubling in-person reach.

Why this matters. These attendees are the funding's most tangible community impact and add materially to overall reach and value for money. That they cannot be counted through digital metrics is itself a lesson (Section 8): a future model should build lightweight in-person outcome capture into class delivery so this group is properly evidenced.

5. What the data tells us

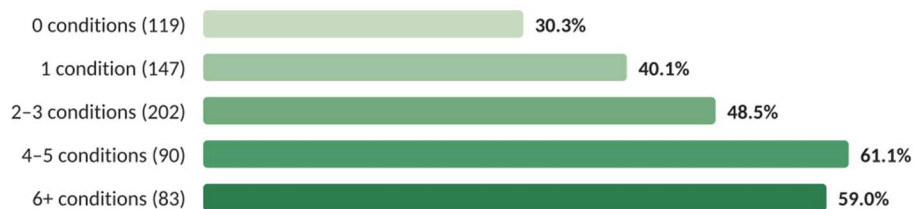
5.1 Who took part

Participants were predominantly older and female, concentrated in the 45-74 age brackets, with multiple long-term conditions (overall average of 3 LTCs, and 29% living with 4 or more) - only 18% had no medical conditions. The most common conditions were anxiety, hypertension, depression, arthritis and high cholesterol. Primary user goals were managing weight, improving relationship with food, and improving general health. This is precisely the underserved, complex-need population the project set out to reach.

5.2 The comorbidity-engagement gradient

A striking finding was that **digital app retention rose with health complexity**. Zooming in to the first four weeks of activity, retention climbed almost monotonically with the number of long-term conditions a user has.

Week-4 retention rises with number of long-term conditions



Both activity volume and week-4 survival climb with health complexity — the app's stickiest users are those managing complex needs.

The app's stickiest users are those managing complex, overlapping conditions - not casual fitness users. Users with 4+ conditions logged nearly three times the activity of those with none.

The same pattern appears by condition type: users managing serious or systemic conditions retained in the digital coaching longest (cancer 16.4 weeks, fatty liver 16.2, new anxiety diagnosis 15.8). This reframes the model's core value: it is most valuable as a sustained intervention for people with real, ongoing health challenges to manage.

5.3 Engagement: hybrid vs digital-only

The hybrid pathway does not just recruit better - it engages more deeply. Internal CWS (Hybrid) users averaged **24 in-app habit completions per onboarded user**, against **17** for the external GP (Digital-Only) group. In other words, pairing the app with a trusted in-person class produces materially more sustained digital engagement than digital referral alone - further evidence for the "gold standard" hybrid model.

Avg in-app habit completions per onboarded user



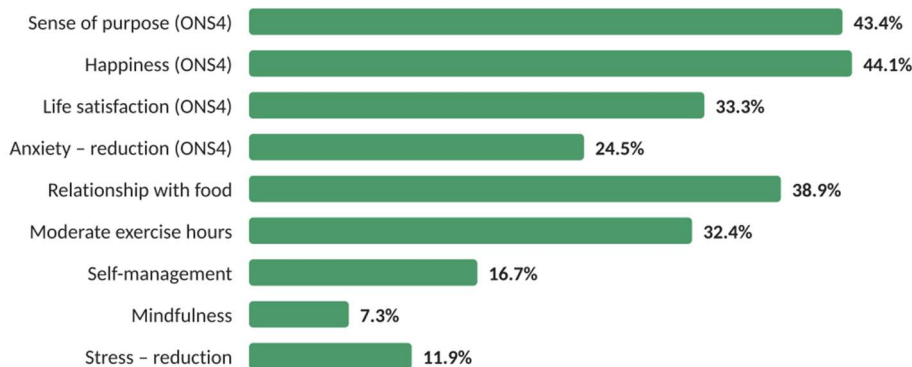
Hybrid (class + app) users engage more deeply than digital-only GP referrals.

Average in-app habit completions per onboarded user: hybrid (class + app) vs digital-only GP referral.

5.4 Measured outcomes

Participants who completed a follow-up survey (a self-selecting, voucher-incentivised subset) showed strong improvements against their own baseline, especially in mental wellbeing.

8-week change vs baseline — Hybrid pathway (V2)



Mean % improvement vs baseline. Self-selecting, voucher-incentivised follow-up sample (V2 n=50–57). Higher = better, incl. anxiety/stress shown as reduction.

Change vs baseline, Hybrid pathway (V2). Mental wellbeing gains are particularly strong. The follow-up sample is self-selecting - the tip of the funnel - so results are indicative, not population-wide.

Habit formation. 67% of the hybrid (V2) follow-up group and 53% of the digital-only (V3) group reported developing at least one new automatic health habit - the behavioural change the model is designed to produce. This is reinforced by the clearest behavioural signal in the data: users who log even a few habits early scale into longer retention, while those who log none are more likely to churn within 2 weeks.

“Developing new habits has been a helpful way of improving my health... it also made me acknowledge what I was already doing rather than focusing on the things that are not so good.”

- Digital-Only participant, follow-up feedback

5.5 Social connection - the community effect

An early, striking insight: CWS participants report far higher social-connection frequency than the average Holly Health user - evidence that community physical activity directly tackles the isolation linked to frailty, inactivity and cognitive decline.

Social connection: CWS participants vs UK average

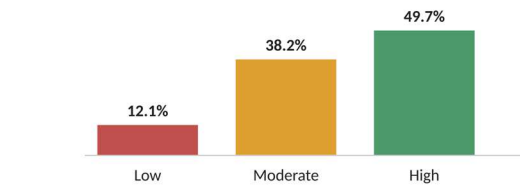


CWS participants report “often/very often” social connection at 62.6%, well above the 46.2% UK Holly Health average - the community effect the digital-only route cannot fully replicate.

5.6 Self-management and the baseline effect

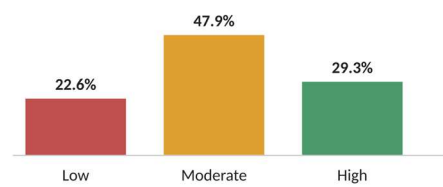
A question raised at the project showcase concerned self-management ability. The two cohorts tell an instructive story. The internal CWS (Hybrid) cohort shows notably higher self-management scores at baseline, while the external GP (Digital-Only) cohort tracks close to the typical Holly Health average.

Internal CWS (V2) — class attendees



Elevated by existing long-term attendance.

External GP (V3) — new sign-ups



Closely matches typical Holly Health baseline.

Self-management ability at baseline: internal CWS (Hybrid) vs external GP (Digital-Only).

Interpretation. The internal cohort's elevated scores are expected: these are established long-term class attendees whose self-management was already lifted by prior CWS participation, before Holly Health was introduced. The external cohort, closer to the Holly Health norm, is a truer picture of a fresh, untreated population. This baseline skew is important - it means the project's measured gains were achieved on people already on a reasonable footing, and points directly to the opportunity in taking the model to genuinely lower-activity communities, where the room to move the dial is greater.

6. The face-to-face pathway: satisfaction and human impact

The face-to-face classes remain the emotional and social anchor of the whole model. A survey of class participants returned exceptional results.



Class feedback survey (74 responses).

Across 74 responses, satisfaction averaged 9.6/10, the Net Promoter Score was +63 with zero detractors, and 94% reported improved mood. But the numbers only hint at what participants describe in their own words.

"It is a very friendly group led by an enthusiastic coach. I am so fortunate to have found this exercise class before, during and after my cancer treatment - long may it continue."

- Face-to-Face participant

"Enjoy my class every week - it gives me a bit of me-time as I am the main carer for my husband."

- Face-to-Face participant

"I felt very at ease, the atmosphere was friendly and welcoming and I didn't feel judged or uncomfortable like I have before in other exercise settings."

- Face-to-Face participant

7. What went well

- **Target exceeded, across three working pathways.** 1,064 sign-ups, with each pathway serving a genuinely different need.
- **The hybrid “gold standard” proved out.** The strongest retention and the highest habit formation came from combining trusted classes with digital reinforcement.
- **The warm-handoff model beat “app fatigue.”** 357 instructor-attributed sign-ups within a matter of weeks showed that a trusted human introduction is what makes digital take-up work in these communities.
- **It reached complex-need, underserved people - and held them.** Engagement rose with health complexity, exactly inverting the usual digital-health pattern.
- **Digital fed the community, not just the reverse.** 161 digital-only users opted into CWS class signposting (44% of the people that signed up via the GP practice route).
- **Digital confidence was higher than feared.** 87.6% of sign-ups were moderately-to-very confident using apps, easing digital-exclusion concerns - though the in-person route remains essential for those who are not.
- **Durable assets created.** Bespoke content, features and evaluation tooling now belong to CWS and can be reused and scaled without re-funding development.

“I’m in my 60s, I didn’t grow up with this technology in any shape or form - and I find it quite easy to use... the things the gym gives me are great, and this is a bit more specific to your own personal needs, so they go hand in hand.”

- Hybrid participant, user interview

8. What we learned

- **Early drop-off is the central challenge.** Up to a third of digital users leave in the first fortnight. Because early habit activation so strongly predicts retention, the first week is the highest-leverage point in the journey - structured onboarding and an early human check-in matter most.
- **Target by need, not by fitness.** Users whose main goal was “physical activity” retained least (7.8 weeks) - often already-active people who felt they needed less support - while those managing conditions retained longest. The model should be aimed where it demonstrably adds most value.
- **Face-to-face must be protected, not trimmed.** Many participants are explicit that the class and the instructor relationship are irreplaceable; digital works only as a companion to it.
- **Measurement is real work, with honest limits.** Standing up outcomes measurement for the first time was a genuine achievement, but the follow-up sample is small, self-selecting and incentivised; retention counts in-app actions only, and more than 10% of users act on notifications without logging in - so measured value understates real influence.
- **Value exchange drives partner engagement.** Community partners engage when the offer extends their existing work and gives them data on their own groups - not when it adds burden.

8.1 Reflections from the delivery team

The team behind the project - spanning CWS and Holly Health leadership, four frontline instructors, project support and consultancy - was invited to reflect candidly. The strongest shared theme was the value of joined-up partnership and the **warm human handover**: close collaboration between two prevention-focused organisations, milestones consistently met or surpassed, and the trusted instructor as the credible route into

digital take-up. Instructors valued the flexibility for participants to “click on at any time to suit them,” and familiar-face content as “a great selling point without being too pushy.” A recurring, slightly surprised recognition ran through the responses: the older cohort was more digitally capable and more loyal than expected once a tool earned its place - and two insights stood out, that **social connection, not exercise, was the real “glue”** of attendance, and that loyalty to instructors was strong enough to carry participants into the app.

On challenges, the team was candid. The **sign-up process was the single biggest friction point** - instructors a times helping nervous, less tech-confident participants install the app and overcome worries about sharing personal details. They noted that for some older participants it was not just difficulty but active resistance to technology. Beyond that: voluntary-sector recruitment was more variable than hoped, and the team’s clearest learning here is forward-looking: future projects need a co-designed approach to data reporting with charity partners from the outset, so tracking fits how each organisation already works; a hoped-for booking-system integration could not be completed in the window; delivery pressures left little time for wider commissioning outreach; and anticipated NHS commissioning opportunities tied to the Ten Year Plan did not materialise within the timeframe, though the groundwork is now laid.

Looking ahead, the team was united: make the app simpler for less tech-confident older users (a “basic” mode surfacing just habits, videos and a wellbeing section; more instructor-led videos), take the model into new areas of genuinely lower activity, convert built-up stakeholder interest into paid PCN-level deployments, deepen integration with delivery partners (Age UK, ShipShape, Rotherham United and others), and explore licensing or train-the-trainer replication elsewhere.

9. Organisational impact: what the fund built for CWS and Holly Health

Innovate UK’s interest extends beyond the project’s participants to the lasting capability it builds in the delivery organisations. For CWS, the fund was a genuine catalyst for growth and sustainability.

9.1 CWS growth (funded year vs prior year)

Measure	Change, July 2025 → July 2026
Classes delivered	+86.5%
Class attendances	+107.5%
Pay-as-you-go (non-commissioned) income	+39%

CWS delivery records; the fund enabled and contributed to this growth alongside CWS’s wider activity.

Beyond delivery volume, being an “Innovate UK grant winner” opened doors: it strengthened further grant applications (including Sport England and Healthy Heart awards secured with the help of citing the Holly Health digital integration) and has opened potential REACH funding and investment conversations.

9.2 Strategic capability (both partners)

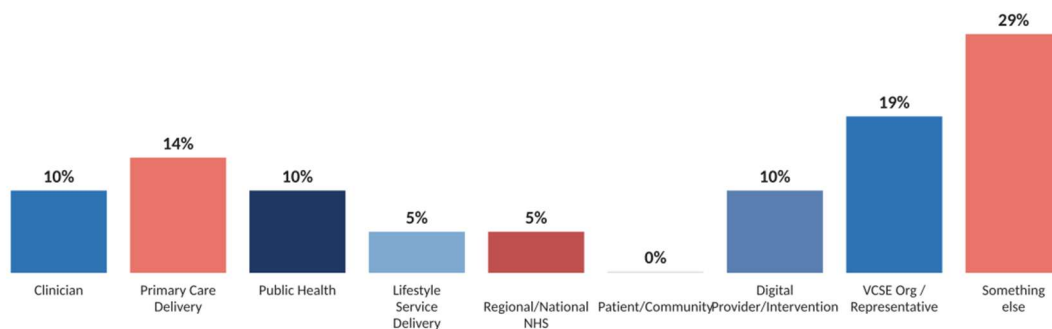
- **Neighbourhood-health positioning.** The fund let CWS invest in positioning for Neighbourhood Health and build relationships with Sport England and Active Partnerships - relationships likely to support future expansion.
- **Evidence and data capability.** CWS now holds outcomes and evaluation capability it did not have before, directly supporting future commissioning bids.
- **Durable digital assets.** The bespoke, CWS-branded content and app features are owned and reusable - a proven digital licensing capability CWS can take forward.

- **A renewed sense of direction.** The project expanded both partners' thinking on how in-person and digital delivery can work together and gave Holly Health a stepping stone into neighbourhood-health working alongside its established PCN-led approach.

9.3 Stakeholder engagement: the project showcase

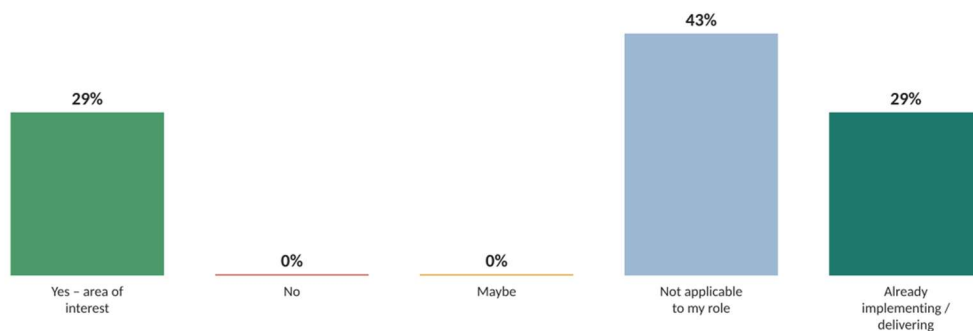
On 12 August 2026 the partnership held a showcase for around 31 stakeholders, presenting headline findings. Live polling captured both the make-up of the audience and their appetite for this kind of proactive, lifestyle-health provision.

Showcase attendees by role/area of work (n=31)



Showcase attendees spanned the commissioning-relevant system - primary care, public health, NHS, VCSE and digital providers.

Are you considering new proactive lifestyle-health support? (n=31)



Among stakeholders for whom it was role-relevant, interest was strong: 29% actively interested and 29% already delivering such support, with no negative responses. The 43% "not applicable" reflects the mixed-role audience.

Individual stakeholder responses reinforced the appetite. One system leader asked how the CWS/Holly Health model and its impact **"could be shared and realistically implemented further afield, including in London"**, alongside costs - a direct expression of replication interest.

"The hybrid option is exciting - it's good to see this coaching, holistic, habit-changing approach to support people who don't find traditional weight-management services work for them."

- Nutritionist, project showcase

The showcase presentation slides are included as an appendix.

10. A route to sustainability

10.1 The community-prevention model

The project has produced more than evidence - it has produced a repeatable **community-prevention model** that can sustain and extend the work beyond the funded period. The proposition is straightforward: CWS acts as the go-to community physical-activity and prevention partner for Primary Care Networks and GP practices, delivering trusted in-person classes with social connection, wrapped in personalised digital coaching and outcomes tracking. Holly Health provides the digital platform, access, reporting and clinical-safety (DTAC) compliance behind the scenes, while CWS owns the local relationships.

The offer is designed to flex to local need. It can run as a short trial or a full year-round programme; across one neighbourhood or several; and - as Section 4.3 describes - tuned to the clinical priorities that matter most in a given place, whether cardiovascular health and blood pressure, frailty, weight or diabetes. Reporting can be broken down by cohort or funder, so partners can see the distance travelled for their own populations. Positioned this way, the model aligns directly with the **Neighbourhood Health Framework** and CORE20PLUS5 priorities and offers a proactive-prevention capability at a fraction of the cost of additional clinical staffing.

This is the basis on which the partnership can move into new areas across Sheffield, Barnsley, Rotherham, Doncaster and beyond - a defined, deliverable model rather than a one-off pilot. (Indicative service tiers and pricing are available separately for interested commissioners.)

An indicative return. Based on initial estimates drawn from CWS's and Holly Health's prior data, the model is projected to return in the order of **£9 in health and social value for every £1 invested**, through reduced avoidable demand on NHS services and improved wellbeing. This is a high-level estimate offered to indicate the scale of potential value rather than a precise measured figure and would be refined against local data in any commissioned deployment.

10.2 Opportunities

- **A working prototype for neighbourhood health.** A live example of place-based, preventive, self-management-enabling care aligned to the NHS 10 Year Plan - a natural commissioning narrative.
- **A sharpened value proposition.** The evidence that the model holds complex-need users best aligns it with the cohorts that drive avoidable NHS demand.
- **Digital as the scale route.** The digital-only pathway extends reach across South Yorkshire and fills gaps MoveWell identified - mobility, mental health, caring responsibilities, seasonal barriers.
- **Transferability.** Deployments are being prepared with Active Partnerships teams in Sheffield, Tees Valley, Essex and Greater Manchester, with discussions underway with Greater Manchester's Prevention Demonstrator.
- **Reusable assets lower the cost of continuation.** Because bespoke content and tooling are built and owned, a continued service funds delivery, not development.

10.3 Challenges

- **Fragile unit economics.** Community delivery runs on thin margins; pricing must cover real cost while staying affordable to deprived populations (classes typically £5, or free when grant-funded).
- **Commissioning timelines.** ICB and local-authority contracting moves slowly relative to project cycles, risking a gap between pilot end and commissioned continuation.
- **Retaining the hardest-to-hold.** The early-drop-off group disproportionately includes the most disadvantaged users; sustaining them needs resource the current model only partly provides.

- **Digital exclusion persists for some.** Encouraging confidence data notwithstanding, a segment will always need the in-person core - which must be protected accordingly.

11. What we take forward

- **Redesign the first two weeks around habit activation** - structured onboarding, a supported first habit, and an early human touchpoint to convert sign-ups into retained users.
- **Target the model at managed-condition cohorts**, where engagement and value are demonstrably highest.
- **Protect and resource the face-to-face core** as the foundation the digital tool builds on.
- **Close the measurement gaps** - capture notification-driven value, extend tracking beyond the pilot window, and standardise outcome surveys for commissioner-grade evidence.
- **Pursue the neighbourhood-health commissioning case now**, using the complex-need finding and outcome evidence with ICS, PCN and social-prescribing partners while momentum is live.
- **Bridge the funding gap** with transitional or match funding to hold delivery together between pilot end and commissioned continuation.

In summary. The project exceeded its reach target, proved out a hybrid model in which digital coaching acts as a compassionate companion to trusted face-to-face delivery, and generated measured outcomes and a replicable, evidence-based approach to proactive neighbourhood health - delivered affordably and equitably in the communities that most need it.

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Appendix - Methodology and data notes

- Reach and funnel figures from the project sign-up tracker (V1/V2/V3 + external surveys); instructor attribution as at 29 Jul 2026; partner attribution as at 19 May 2026. Outcome data reported as at the May milestone (83 eight-week responses); a separate six-month report will follow.
- Baseline and outcome data from Holly Health's in-app "traffic-light" surveys, scored on Likert scales (1-5, or 1-10 for ONS4). Follow-up completion was voucher-incentivised; measures with 10 or fewer responses were excluded for reliability.
- Outcome samples are self-selecting (the tip of the reach funnel), so results are indicative rather than population-wide. The 8-week ONS4 percentages in Section 5.4 are reported as at the May milestone.
- Engagement figures: average habit completions per onboarded user of 24 (internal CWS / Hybrid) vs 17 (external GP / Digital-Only). Retention counts tangible in-app actions only; notification-driven engagement (estimated >10% of users) is not captured, so measured value understates real influence.
- Class feedback survey: 74 responses. User voices are drawn from class surveys, follow-up free-text, and a 1:1 participant interview (Feb 2026), minimally edited for anonymity and readability.
- Neighbourhood-health context figures as cited in the project's interim learnings report (Feb 2026), drawn from Sport England Active Lives and local public-health sources.