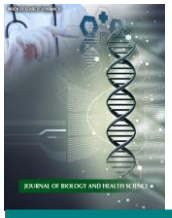

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Research Article

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Developing Health Professional Capacity Through Community Partnership: Evaluation of an Inclusive Exercise Program for Adults with Physical Disability in Longford, Ireland

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Abstract

Background: Adults with physical disability experience reduced access to structured physical activity and prolonged waiting times for rehabilitation services. Traditional one-to-one therapy models may not adequately address sustained physical activity needs while maintaining service quality and capacity. Community-integrated exercise pathways may offer a strategy to improve functional outcomes and alleviate system-level pressures.

Aim: To evaluate the functional and service-level impact of a community-based group exercise program implemented within an adult disability service.

Methods: A service evaluation was conducted of a community-based, group exercise program for adults with physical disability delivered in partnership between HSE adult disability services and community physical activity providers. Participants were referred through routine clinical pathways and screened for medical stability and suitability for group exercise. The intervention consisted of supervised exercise sessions delivered over an 8-week period. Outcome measures included the Five Times Sit-to-Stand Test (5TSTS), Berg balance scale, gait speed (10-metre walk test), 6-Minute Walk Test (6MWT) and self-reported health (VAS). Pre- and post-program assessments were completed by trained staff. Descriptive statistics were used to summarize outcomes, with paired analyses conducted using t-tests and Wilcoxon signed-rank tests as appropriate. Effect sizes (Cohen's d) and percentage change were calculated. Clinical significance was interpreted using established Minimal Clinically Important Difference (MCID) thresholds.

Results: The sample included 23 participants (14 female (60%), 9 male (40%) with a mean age of 51.3 years (SD=12.3), a median age of 55 years and an age range of 21-65 years. Participants demonstrated improvements in mobility, lower limb strength, balance and health-related quality of life, with a majority achieving clinically meaningful gains in gait speed and functional strength. At a service level, physiotherapy waiting list volume reduced by 93.9% (66-4 clients) and maximum waiting time decreased by 86.7% (30-4 weeks), indicating substantial improvement in service flow.

Conclusion: A community-based group exercise pathway embedded within an adult disability service achieved meaningful functional improvements while significantly reducing waiting list pressures. These findings suggest that redistributing appropriate signposting into structured community programs can enhance equity of access, preserve clinical capacity for complex cases and support sustainable service redesign.

Keywords: Physical disability; Community-based rehabilitation; Interprofessional education; Service evaluation; Exercise prescription; Partnership working

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Introduction

Adults with disability are less likely to participate in the recommended levels of physical activity (150-300 minutes of moderate-intensity aerobic activity plus muscle strengthening activities on two or more days per week) [1,2]. Evidence consistently demonstrates that adults with physical disability are less likely to meet recommended physical activity guidelines, contributing to increased risk of secondary health conditions, reduced functional independence and poorer quality of life [3,4].

Traditional service models within adult disability services frequently prioritize individual, impairment-focused therapy episodes. While clinically appropriate in some cases, such models are resource-intensive and may contribute to extended waiting lists and limited opportunities for sustained physical activity engagement [5,6].

There is growing recognition of the need for community-based, inclusive exercise programs that align with national and international physical activity guidelines and complement statutory health services [1,2]. Partnership working between health services and community providers has been identified as a key mechanism for improving sustainability and scalability within rehabilitation pathways [7,8].

This paper describes the design, delivery and evaluation of a community exercise program delivered through a partnership between the HSE adult disability service in Longford and Physical Activity for Health, Longford Sports Partnership.

Program Context and Partnership Model

Service need

Within the HSE adult disability community service in Longford, demand for physiotherapy and exercise-based interventions exceeded service capacity, resulting in prolonged waiting times. Extended waiting lists in public health systems are often indicative of structural mismatch between demand and pathway configuration rather than capacity alone [5].

Many service users require sustained, supported physical activity participation rather than short-term clinical intervention. Emerging rehabilitation models emphasize the importance of transitioning from episodic care toward long-term condition management and health promotion [3,9].

Partnership approach

The program was developed through collaboration between:

- HSE adult disability services (clinical governance, signposting pathways, outcome measurement);
- Physical Activity for Health Longford (program delivery, community integration) and;
- Longford Sports Partnership (facility access, physical activity promotion, sustainability).

Cross-sector partnerships have been recognized as essential for achieving integrated, community-based care aligned with contemporary health reform agendas [1,6]. Embedding structured exercise within community infrastructure supports continuity of care beyond time-limited clinical episodes [2].

Program Design

Exercise program structure

- **Duration:** 8-week blocks × 3 blocks;
- **Frequency:** 1 sessions/week;
- **Setting:** Community-based exercise facility;
- **Participants:** Adults with physical disability signposted from HSE adult disability services.

Exercise content

The program was designed in line with international physical activity guidelines for adults with disability [1,4]. It incorporated:

- Aerobic exercise;
- Progressive strength training;
- Balance and functional mobility training.

Progressive strength training and balance interventions are strongly supported in the literature as effective for improving functional mobility and reducing falls risk in adults with disability and older populations [10,11].

Methods

Study design

A prospective service evaluation using a repeated-measures pre-post design was conducted. The evaluation was embedded within routine service delivery and undertaken as part of quality improvement processes. Clinical responsiveness was interpreted using published Minimal Clinically Important Difference thresholds where available: ≥ 2.3 seconds for 5TSTS, ≥ 0.10 m/s for gait speed, ≥ 3 points for Berg Balance Scale and ≥ 8 points for EQ-VAS/health rating VAS. Because published 6MWT thresholds vary substantially by diagnosis, MCID interpretation for 6MWT was treated as exploratory only.

Setting

The program was delivered in a community-based exercise facility in County Longford, Ireland. Three consecutive 8-week blocks were delivered between March 2025 and January 2026 **(Figure 1)**.

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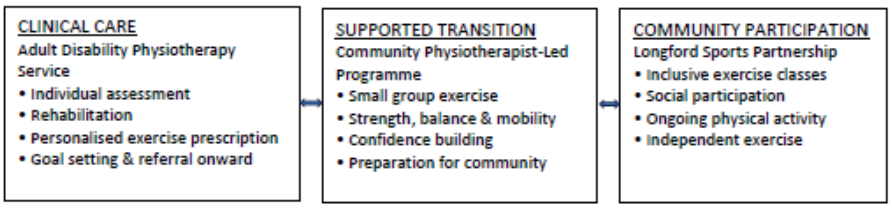

Figure 1: Integrated physical activity pathway for adults with disabilities, Longford.

Participants

Participants were adults (≥ 18 years) signposted through HSE Adult Disability Services Longford to physical activity for health community programs. Diagnoses included multiple sclerosis, Parkinson's disease, stroke, transverse myelitis, Chiari malformation, cerebral palsy, facioscapulohumeral muscular dystrophy, Becker muscular dystrophy and spinal cord injury.

The cohort represented a heterogeneous disability population presenting with mobility impairment, balance dysfunction, fatigue and reduced functional capacity typical of long-term neurological conditions managed in community settings. Participants were informed about the purpose of the service evaluation and provided consent for their anonymized data to be used for reporting and publication.

A control or comparison group was not included in this study because the work was undertaken as a service evaluation embedded within routine care, rather than as a controlled research trial. The primary purpose of the evaluation was to assess the outcomes of an existing community-based exercise program implemented within HSE Adult Disability Services and to inform service improvement and pathway development. As such, all individuals referred and deemed appropriate for participation were offered access to the program as part of usual service delivery.

Introducing a control group in which eligible participants were withheld from the program or delayed access to exercise opportunities would not have been consistent with the service's clinical priorities, particularly given the prolonged physiotherapy waiting times that the program was designed to address. The intervention functioned as a practical service response to unmet need for ongoing supported physical activity among adults with disability and withholding access to this pathway for research purposes was considered inappropriate in the context of routine care.

In addition, the evaluation was conducted within a real-world service environment, where program participation depended on referral patterns, clinical judgement and participant readiness to transition from physiotherapy rehabilitation to community-based exercise. These operational factors limited the feasibility of random allocation or the establishment of a parallel comparison group.

Instead, the study adopted a pre–post service evaluation design, using validated outcome measures and clinically meaningful change thresholds to assess functional outcomes and program impact. While this design limits causal inference, it allows meaningful assessment of participant-level improvements and provides pragmatic evidence relevant to service delivery and pathway redesign in community rehabilitation settings.

Eligibility criteria

Participants were recruited through routine referral pathways within HSE Adult Disability Services in Longford. Physiotherapists and multidisciplinary team members identified individuals transitioning from physiotherapy or requiring ongoing supported physical activity. Potential participants were screened for medical stability and suitability for group-based exercise.

Eligible individuals were informed about the program by their treating clinician and referred through established pathways for enrolment in the next available block. Prior to commencement, eligibility was confirmed, including the ability to safely participate in a 45-60-minute group session without continuous one-to-one assistance; use of mobility aids was permitted. Participants were informed that outcomes would be collected as part of routine service evaluation using anonymized data.

Recruitment was embedded within routine clinical practice, ensuring participants were clinically appropriate and aligned with the programs aim of supporting transition to community-based physical activity.

Inclusion criteria

Participants were eligible if they met the following criteria:

- Adults with a disability who had completed or were transitioning from physiotherapy rehabilitation.
- Medically stable and cleared to participate in moderate-intensity physical activity.
- Able to participate safely in a supervised 45-60-minute group exercise session.
- Able to engage in exercise without continuous one-to-one physical assistance.

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- Use of mobility aids permitted where appropriate.
- Demonstrated a goal or readiness to transition towards more independent physical activity.

Exclusion criteria

Participants were excluded from the program if they:

- Were medically unstable.
- Required intensive individualized rehabilitation.
- Demonstrated insufficient exercise tolerance for safe participation in a group exercise setting.
- Required complex one-to-one management for specific impairments (*e.g.,* upper limb rehabilitation or specialist postural management).

Eligibility decisions were made through physiotherapy referral and clinical judgement to ensure safe and appropriate participation within the group-based program.

Intervention

The intervention consisted of weekly supervised 60-minute sessions over 8 weeks. Sessions incorporated:

- Aerobic conditioning;
- Progressive resistance training;
- Balance training and;
- Functional mobility exercises.

Exercise intensity and progression were individualized within the group format based on tolerance and observed performance.

Outcome measures

The following validated measures were collected at baseline and program completion:

- **6-metre walk test:** Recognized as a reliable measure of functional mobility and predictor of health status [12].
- **Five times sit-to-stand test:** Reliable indicator of lower-limb strength and functional capacity [10].
- **Berg balance scale:** Validated tool for assessing balance and falls risk [13].
- **EQ-VAS:** Internationally validated measure of health-related quality of life [14].

The use of validated measures aligns with best practice recommendations for outcome-driven service evaluation in rehabilitation [8].

Data collection and analysis

Assessments were completed by trained staff. Descriptive statistics were used to summarize outcomes, with continuous variables reported as means and standard deviations and pre-post change scores calculated for each measure. Pre–post differences were analyzed using paired t-tests or Wilcoxon signed-rank tests as appropriate. Effect sizes (Cohen's d) were calculated to quantify the magnitude of change.

Clinical responsiveness was interpreted using established Minimal Clinically Important Difference (MCID) thresholds where available, allowing results to be evaluated in terms of meaningful functional benefit rather than statistical change alone. The proportion of participants achieving MCID thresholds was also calculated. This approach is particularly relevant in community-based rehabilitation and small-scale service evaluations, where improvements in strength, mobility or balance may translate into meaningful gains in independence, confidence and participation.

Service-level outcomes were evaluated through descriptive comparison of physiotherapy waiting list volume and maximum waiting time pre- and post-program implementation, with percentage reduction used to quantify changes in access. Given the service evaluation design and modest sample size, interpretation focused on the magnitude and clinical significance of change rather than formal hypothesis testing.

Results

The sample included 23 participants (14 female (60%), 9 male (40%) with a mean age of 51.3 years (SD=12.3), a median age of 55 years and an age range of 21-65 years. Across the three program periods, 29 individuals were invited to participate and 23 attended, representing a high uptake rate. Overall, participation rates were strong, with most non-attendance related to practical barriers such as work schedules or transport, rather than lack of interest. One participant who initially joined the program did not complete it due to the onset of dizziness and vertigo and was advised by their consultant to avoid exercise pending further medical investigation.

Across outcome domains, the program was associated with improvements in lower-limb functional strength, balance, gait speed and self-rated health **(Table 1 and 2)**. Five Times Sit-to-Stand performance improved significantly, with mean completion time decreasing by 3.67 seconds (paired t-test $p<0.001$; Wilcoxon $p<0.001$), representing a large effect size ($d=1.02$). Using a published clinically meaningful threshold of 2.3 seconds, two-thirds of participants achieved meaningful improvement.

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Table 1: Pre and post outcomes.

Outcome	n	Pre, mean (SD)	Post, mean (SD)	Mean change	Test statistic	P-value	Effect size	MCID threshold	Achieved MCID, n (%)
5TSTS (sec)	18	17.71	14.05	-3.67 sec	t(17) = 4.31; Wilcoxon W=14	<0.001	d=1.02	≥ 2.3 sec improvement	12/18 (66.7%)
Berg balance scale	20	47.8	50.1	+2.3 points	t(19) = 3.66; Wilcoxon W=18.5	0.002/ 0.003	d=0.82	≥ 3-point improvement	10/20 (50.0%)
6MWT (m)	8	300.1	200.8	-99.3 m	t(7) = -1.72; Wilcoxon W=8.0	0.128/ 0.180	d=0.61	≥ 14 m improvement *	2/8 (25.0%)
Gait speed (m/s)	11	0.65	1	+0.34 m/s	t(10) = 3.60; Wilcoxon W=1.0	0.005/ 0.004	d=1.08	≥ 0.10 m/s improvement	8/11 (72.7%)
Health rating VAS (%)	14	60	68.6	+8.6 points	t(13) = 2.14; Wilcoxon W=14.5	0.052/ 0.047	d=0.57	≥ 8-point improvement	10/14 (71.4%)

Table 2: Comparison waiting times and percentage improvement.

Metric	March 2025	Jan 2026	Improvement
Waiting list size	66	4	↓ 93.9%
Longest wait	30 weeks	4 weeks	↓ 86.7%

At a service level, physiotherapy waiting list volume reduced from 66-4 clients (93.9% reduction) and maximum waiting time decreased from 30-4 weeks (86.7% reduction) following implementation of the program pathway.

Balance also improved significantly, with Berg Balance Scale scores increasing by a mean of 2.3 points (paired t-test p=0.002; Wilcoxon p=0.003; d=0.82). Using a pragmatic threshold of 3 points for clinically important change in mixed rehabilitation samples, half of participants achieved meaningful improvement, although it should be noted that published Berg thresholds vary by diagnosis and setting.

Gait speed demonstrated the strongest mobility signal, improving by a mean of 0.34 m/s (paired t-test p=0.005; Wilcoxon p=0.004), with a large effect size (d=1.08). This exceeds the commonly cited lower bound of clinically meaningful change for gait speed (0.10 m/s) and 72.7% of participants surpassed this threshold.

Self-rated health improved by a mean of 8.6 points on the VAS. Although the paired t-test was borderline (p=0.052), the Wilcoxon signed-rank test indicated statistical significance (p=0.047), suggesting improvement in perceived health status. Using an 8-point threshold, 71.4% of participants achieved clinically meaningful improvement; notably, the same proportion also exceeded a 10-point threshold in this sample.

Six-minute walk distance was more variable and did not demonstrate a consistent improvement pattern. Given the small sample, heterogeneous diagnoses and the diagnosis-specific nature of 6MWT MCID estimates, these findings should be interpreted cautiously.

At the service level, the physiotherapy waiting list reduced from 66 clients in March 2025 to 4 clients in January 2026, representing a 93.9% reduction. Maximum waiting time decreased from 30 weeks to 4 weeks, an 86.7% reduction. These changes indicate substantial improvement in service flow and timeliness of access.

The program also provided a structured pathway for individuals awaiting or transitioning from physiotherapy, reducing reliance on individual therapy appointments **(Figure 1)**.

Participants demonstrated:

- Improved walking speed on the 6-minute walk test;
- Increased repetitions on the sit-to-stand test;
- Improved balance scores on the Berg balance scale and;
- Positive changes in EQ-VAS domains, indicating improved perceived health and wellbeing.

Discussion

This evaluation demonstrates that a structured community-based group exercise pathway can achieve dual impact within an adult disability service: Clinically meaningful functional improvement alongside substantial waiting list reduction. By embedding evidence-based exercise within a supervised community setting, the program addressed both individual-level rehabilitation needs and system-level service pressures. The findings reinforce the growing evidence that inclusive, community-delivered exercise can produce measurable gains in mobility, strength, balance and self-rated health while simultaneously improving service flow. This approach aligns with contemporary integrated, population-based health models that advocate partnership-based delivery beyond traditional episodic clinical care [1,6].

Furthermore, where specialist services are limited and workforce capacity is constrained, redistributing appropriate signposting into structured group pathways may enhance equity of access. The marked reduction in waiting list volume and maximum waiting time suggests a

transition from reactive backlog management toward proactive pathway configuration. Rather than expanding capacity through additional staffing alone, the program functioned as a parallel care pathway, enabling individuals requiring sustained, supported physical activity to engage in structured intervention while preserving one-to-one physiotherapy capacity for higher-complexity cases. Such redistribution aligns with health system improvement principles emphasizing redesign, stratified care and task-sharing [8,15].

Waiting list data indicate a substantial reconfiguration of service demand. Prior to implementation, 66 individuals were awaiting physiotherapy, with maximum waiting times of 30 weeks. By January 2026, this had reduced to four clients, with a maximum wait of four weeks, representing a 93.9% reduction in list size and an 86.7% reduction in longest wait time. These changes reflect not only increased throughput but a structural shift in demand management. Prolonged waiting lists in publicly funded systems often arise from pathway inefficiencies rather than absolute resource scarcity [5]. Within adult disability services, many signposting's relate to the need for ongoing supported activity rather than short-term impairment-focused treatment; default reliance on individualized therapy may therefore constrain overall capacity.

The reduction in physiotherapy waiting list numbers observed during the evaluation period should be interpreted with caution, as the study design does not allow a definitive causal relationship to be established between the exercise program and the observed service changes. The program was introduced as part of a broader effort to improve service flow and increase opportunities for supported physical activity among adults with disability and it likely contributed to the redistribution of appropriate referrals from individual therapy to group-based pathways. By providing an alternative, structured exercise option for individuals who had completed physiotherapy or required ongoing supported activity rather than intensive clinical intervention, the program may have reduced demand for repeated one-to-one physiotherapy sessions and supported more efficient prioritization of complex cases.

However, other service-level factors may also have influenced the observed reduction in waiting list numbers. During the evaluation period, changes in staffing levels, such as the appointment of additional basic grade physiotherapists or improved workforce stability, may have contributed to increased service capacity. In addition, routine fluctuations in referral patterns, seasonal variation in service demand or broader organizational changes within the service could have affected waiting list dynamics.

The waiting list comparison presented in this study reflects a snapshot of service data at two time points (March 2025 and January 2026). While this comparison demonstrates a substantial reduction in both waiting list volume and maximum waiting time during the period following program implementation, the absence of a controlled study design or longitudinal service data limits the ability to attribute these changes solely to the intervention.

Despite these limitations, the findings suggest that the program may have contributed to improved service flow by functioning as a complementary care pathway for individuals requiring ongoing supported exercise. The results therefore highlight the potential role of community-based exercise programs in supporting service efficiency within adult disability services, while recognizing that multiple contextual factors likely influenced the observed waiting list reductions.

The marked reduction in waiting list volume and maximum waiting time is best understood in the context of pathway redesign rather than simple demand fluctuation. The introduction of structured community-based group exercise classes created an alternative, clinically governed care pathway for individuals whose primary need was ongoing, supported physical activity rather than intensive one-to-one physiotherapy. Prior to implementation, many referrals entered a traditional individual treatment pathway by default. This model is resource-intensive and constrains throughput when a substantial proportion of service users require maintenance, strength, balance or general conditioning support rather than impairment-specific rehabilitation. By actively signposting appropriate low-to-moderate complexity referrals to supervised community exercise programs, the service redistributed demand across parallel pathways.

This redistribution had two immediate operational effects. First, it reduced the number of new referrals entering the one-to-one queue. Second, it transitioned suitable individuals already on the waiting list into a structured group environment, thereby preventing escalation of backlog. Because group sessions allow multiple participants to be managed simultaneously, clinician time per patient cohort was substantially reduced compared with individual appointments. The time released through group delivery increased capacity for higher-complexity, post-acute or high-risk cases requiring direct physiotherapy input.

In practical terms, group-based delivery improved throughput without requiring additional staffing. Freed clinical hours were reallocated to assessment, prioritization and targeted intervention for complex presentations. This shift from a single linear pathway to a stratified, blended model improved service flow, reduced bottlenecks and shortened maximum waiting times. The reduction from 66-4 individuals on the waiting list and from 30-4 weeks maximum wait, therefore, reflects improved demand management and capacity redistribution through structured signposting to community exercise, rather than simple variation in referral rates. From a systems perspective, the findings

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demonstrate how integrating community exercise within clinical governance frameworks can transform waiting list management from a reactive backlog issue to a proactive pathway design strategy.

The combination of statistical significance, effect size and MCID achievement strengthens the clinical interpretation of the findings. In particular, the large effects observed for 5TSTS and gait speed suggest that the program produced changes that were not only statistically detectable but also functionally meaningful. This is especially relevant in adults with physical disability, where relatively small gains in transfer ability, walking speed or balance may translate into better independence, improved community mobility and reduced fall risk.

The MCID analysis also adds translational value. In small service evaluations, reliance on p-values alone can be misleading because clinically worthwhile change may occur even when power is limited. By reporting the proportion of participants exceeding established thresholds, the findings become more interpretable for clinicians, service managers and commissioners. This is particularly valuable in community rehabilitation, where the central question is often whether an intervention produces enough benefit to justify continued delivery in real-world services.

Additionally, functional improvements observed across walking speed, lower limb strength, balance performance and health-related quality of life are consistent with evidence supporting progressive exercise interventions for adults with disability [2,11]. The use of validated outcome measures strengthened the credibility of findings and ensured alignment with best practice in rehabilitation and public health physical activity promotion. Importantly, the results demonstrate that clinical integrity can be maintained within a community-delivered model when appropriate screening, supervision and outcome monitoring are embedded.

The initiative also illustrates how partnership between statutory health services and community infrastructure can extend service reach without compromising governance. Embedding clear signposting criteria and validated outcome measurement maintained clinical oversight while enabling delivery outside traditional healthcare environments. This blended model addresses clinician concerns regarding loss of control when signposting to community providers and supports scalable, sustainable delivery without proportional increases in staffing [6,8].

From a physiotherapy service perspective, diverting appropriate low-complexity signposting into structured group pathways released clinician time for higher-risk and complex presentations, supporting improved equity and responsiveness. Earlier access to structured intervention may reduce the risk of musculoskeletal deterioration, deconditioning and progression to chronic disability. Although downstream utilization was not formally measured, reduced waiting times are likely to decrease clinical complexity associated with delayed management. Service modelling indicates that such redistribution can generate efficiency gains through reduced clinician hours per cohort compared with traditional one-to-one care.

The program also facilitated a shift in professional role identity. Health professionals transitioned from direct exercise delivery toward assessment, advisory and partnership functions, reflecting broader trends in workforce reform and integrated care [1,9]. Engagement in pathway redesign and outcome evaluation supported development of competencies in risk stratification, interprofessional collaboration and long-term condition management, consistent with experiential and adult learning principles [9,16].

Overall, these findings support a move toward blended clinical-community models for adult disability services. Formalized signposting pathways, outcome-driven accountability mechanisms and recognition of community providers as legitimate partners are central to sustainable implementation. By reframing waiting list management as an issue of pathway design rather than capacity alone, this model offers a pragmatic strategy for health systems seeking to improve access, enhance functional outcomes and strengthen service sustainability without reliance on additional staffing expansion.

Key messages for educators and service managers:

- **Waiting lists are a service design issue, not solely a capacity issue:** Community-based exercise programs can function as parallel care pathways for adults with physical disability, reducing reliance on one-to-one clinical input while maintaining safety and outcomes.
- **Partnership working develops workforce capability:** Collaborative delivery with community providers supports health professionals to develop competencies in signposting decision-making, risk stratification and long-term condition management.
- **Outcome measurement enables safe task-sharing:** The use of validated functional and quality-of-life measures provides accountability, reassures clinicians and supports evidence-informed delegation beyond traditional clinical settings.
- **Community programs can enhance continuity of care:** Embedding exercise within community infrastructure facilitates transition from episodic rehabilitation to sustained physical activity participation.
- **Practice-based service innovation is a powerful educational tool:** Involvement in waiting list–focused service redesign offers experiential learning opportunities aligned with contemporary health professions education priorities.

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Limitations

This evaluation used a pre-post design without a control group, limiting causal inference. The sample size was modest and longer-term follow-up data were not collected. Downstream healthcare utilization and formal cost-effectiveness analysis were not directly measured. Waiting list improvements may have been influenced by external service factors.

Future Research

Future research should incorporate controlled or quasi-experimental designs to strengthen causal inference. Multi-site studies would enhance generalizability and allow assessment of scalability. Formal cost-effectiveness analysis is warranted to quantify economic return relative to traditional care pathways. Longer-term follow-up studies are needed to assess maintenance of functional gains and sustained impact on service utilization.

Further investigation should also explore patient-reported experience measures, engagement beyond program completion and the integration of group-based pathways within interdisciplinary primary care and disability services. Implementation science methodologies may provide insight into contextual factors influencing uptake, fidelity and sustainability.

Conclusion

This service evaluation demonstrates that a community-based group exercise pathway embedded within an adult disability service can produce meaningful improvements in functional mobility, lower limb strength and perceived health status among adults with neurological and neuromuscular conditions. Clinically meaningful gains in gait speed and functional strength were observed in a substantial proportion of participants following the 8-week intervention. In addition to participant level improvements, the program was associated with a marked reduction in physiotherapy waiting list volume and waiting times, indicating a positive impact on service efficiency and flow. These findings suggest that structured, supervised community exercise programs can act as an effective adjunct to traditional rehabilitation services, enabling appropriate redistribution of care while preserving specialist clinical capacity for more complex cases. Embedding such pathways within community infrastructure may represent a sustainable model for improving access to physical activity and rehabilitation support. Further research with larger samples and longer follow-up is warranted to confirm long-term functional and service-level benefits.

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