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Article

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

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Abstract

Adults with physical disabilities living in rural areas often experience limited access to structured physical activity and prolonged waiting times for rehabilitation services. Traditional one-to-one therapy models may not adequately support sustained physical activity participation while maintaining service capacity. This study evaluated the functional and service-level impact of a community-based group exercise programme implemented within a rural adult disability service. A prospective service evaluation using a repeated-measures pre–post design was conducted in County Longford, Ireland. Adults with neurological and neuromuscular conditions were signposted through HSE Adult Disability Services to an 8-week supervised group exercise programme delivered in partnership with community infrastructure. Outcome measures included the 10-Metre Walk Test, 30-Second Sit-to-Stand Test, Berg Balance Scale, and EQ-5D health status scale. Changes in functional outcomes were interpreted using established minimal clinically important difference thresholds, while service-level impact was assessed through comparison of physiotherapy waiting list volume and maximum waiting times before and after implementation. Participants demonstrated improvements in mobility, lower limb strength, balance, and self-reported health status, with several achieving clinically meaningful gains in gait speed and functional strength. At a service level, physiotherapy waiting list volume reduced by 93.9% (66 to 4 clients) and maximum waiting time decreased by 86.7% (30 to 4 weeks). Embedding structured community-based exercise pathways within rural disability services may improve functional outcomes while alleviating pressure on rehabilitation services and supporting more sustainable models of care.

Keywords: physical disability; community-based rehabilitation; interprofessional education; service evaluation; exercise prescription; partnership working

1. 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, 15). 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 (5, 6).

Traditional service models within adult disability services frequently prioritise 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 (24,19).

There is growing recognition of the need for community-based, inclusive exercise programmes that align with national and international physical activity guidelines and complement statutory health services (1,15). Partnership working between health services and community providers has been identified as a key mechanism for improving sustainability and scalability within rehabilitation pathways (13, 18).

This paper describes the design, delivery, and evaluation of an community exercise programme delivered through a partnership between the HSE Adult Disability Service in Longford and Physical Activity for Health, Longford Sports Partnership.

2. Programme Context and Partnership Model

2.1. 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 (24).

Many service users require sustained, supported physical activity participation rather than short-term clinical intervention. Emerging rehabilitation models emphasise the importance of transitioning from episodic care toward long-term condition management and health promotion (21,5).

2.2. Partnership Approach

The programme was developed through collaboration between:

- HSE Adult Disability Services (clinical governance, signposting pathways, outcome measurement)
- Physical Activity for Health Longford (programme delivery, community integration)
- Longford Sports Partnership (facility access, physical activity promotion, sustainability)

Cross-sector partnerships have been recognised as essential for achieving integrated, community-based care aligned with contemporary health reform agendas (19,1). Embedding structured exercise within community infrastructure supports continuity of care beyond time-limited clinical episodes (15).

3. Programme Design

3.1. Programme Structure

- **Duration:** 8-week blocks x 4 blocks
- **Frequency:** 1 sessions/week
- **Setting:** Community-based exercise facility
- **Participants:** Adults with physical disability signposted from HSE Adult Disability Services

3.2. Exercise Content

The programme 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, 29).

4. Methods

4.1. 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.

4.2. Setting

The programme was delivered in a community-based exercise facility in rural County Longford, Ireland. Four consecutive 8-week blocks were delivered between March 2025 and January 2026.

4.3. Participants

Participants were adults (≥ 18 years) signposted through HSE Adult Disability Services Longford to Physical Activity for Health community programmes. 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 rural 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 anonymised data to be used for reporting and publication.

4.4. Eligibility Criteria

Participants were eligible if medically stable, cleared for moderate-intensity physical activity, and able to participate safely in a 45–60-minute supervised group session without continuous one-to-one physical assistance. Use of mobility aids was permitted.

Participants were excluded if medically unstable, requiring intensive individualised rehabilitation, demonstrating insufficient exercise tolerance for group participation, or requiring complex one-to-one upper limb or postural management.

Clinical suitability was determined through physiotherapy screening and signposting review.

4.5. Intervention

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

- Aerobic conditioning
- Progressive resistance training
- Balance training
- Functional mobility exercises

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

4.6. Outcome Measures

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

- **10-Metre Walk Test** – recognised as a reliable measure of functional mobility and predictor of health status (11).

- **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 (8).
- **EQ-5D** – internationally validated measure of health-related quality of life (12).

The use of validated measures aligns with best practice recommendations for outcome-driven service evaluation in rehabilitation (18).

4.7. Data Collection and Analysis

Assessments were completed by trained staff. Descriptive statistics were used to summarise changes in outcomes, consistent with audit methodology. Continuous variables were summarised using means and standard deviations. Pre–post change scores were calculated for each outcome. Clinical responsiveness was interpreted using established Minimal Clinically Important Difference thresholds where available.

Standardised effect sizes (Cohen’s d) were calculated to quantify magnitude of change. Percentage change from baseline was also reported to contextualise functional improvement.

Service-level impact was assessed through descriptive comparison of physiotherapy waiting list volume and maximum waiting time pre- and post-programme implementation. Percentage reduction was calculated to quantify change in access.

Given the service evaluation design and modest sample size, emphasis was placed on magnitude and clinical relevance rather than hypothesis testing.

5. Results

Participants demonstrated positive mean change across all functional outcomes. Improvements were observed in gait speed, lower-limb functional strength, balance performance, and self-reported health status. A majority achieved clinically meaningful improvements in gait speed and sit-to-stand performance, Table 1.

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 programme also provided a structured pathway for individuals awaiting or transitioning from physiotherapy, reducing reliance on individual therapy appointments.

Participants demonstrated:

- Improved walking speed on the 10-Metre Walk Test
- Increased repetitions on the Sit-to-Stand Test
- Improved balance scores on the Berg Balance Scale
- Positive changes in EQ-5D domains, indicating improved perceived health and wellbeing.

Table 1. Pre and Post Outcomes – one block of group exercise classes only.

Client	Attendance	5TSTS		10MWT		Berg		Health Rating VAS	
		Pre	Post	Pre	Post	Pre	Post	Pre-Post	Pre-Post
1.	5/8	23s	21s	0.58m/s	0.69m/s	31	36	45	45
2.	4/8	16.2s	14s	0.75m/s	0.75m/s	41	45	50	70
3.	3/8	14.7s	14s	0.25m/s	0.27m/s	48	49	60	70
4.	4/8	13.2s	10s	0.50m/s	0.66m/s	49	50	50	60
5.	8/8	18s	9s	0.59m/s	1.28m/s	52	52	50	80
6.	8/8	8.9s	6s	1.22m/s	1.58m/s	53	52	50	85
7.	8/8	15.9s	14s	0.50m/s	0.79m/s	44	47	80	70
8.	8/8	-	-	-	-	-	-	60	70

Of the eight participants in this block, four (50%) achieved 100% attendance across the programme.

In relation to clinical outcomes:

- 71% of participants exceeded the Minimal Clinically Important Difference (MCID) of 2–3 seconds on the Five Times Sit-to-Stand Test, indicating meaningful improvement in lower limb strength and functional mobility (Table 3).
- 57.1% demonstrated a clinically meaningful improvement in walking performance on the 10-Metre Walk Test, reflecting enhanced gait speed and functional ambulation (Table 3).
- Participants showed an overall 14.3% improvement in Berg Balance Scale scores, suggesting improved balance and reduced falls risk (Table 3).
- 62.5% of participants achieved a clinically meaningful improvement on the Health Rating Visual Analogue Scale (VAS), exceeding the MCID threshold of 8–10 points between pre- and post-intervention testing (Table 3).

Table 2. Mean Improvements.

Outcome Measure	Mean Pre	Mean Post	Mean Change
5TSTS (s)	15.7	12.6	–3.1 s
10MWT (m/s)	0.63	0.86	+0.23 m/s
Berg Balance Scale	45.4	47.3	+1.9 points
Health VAS	55.6	68.8	+13.1 points

Table 3. Participants Achieving MCID.

Outcome	Participants Meeting MCID	Percentage
5TSTS (≥2s improvement)	3 / 7	42.9%
10MWT (≥0.10 m/s)	4 / 7	57.1%
Berg Balance (≥5 points)	1 / 7	14.3%
Health VAS (≥10 points)	5 / 8	62.5%

In addition, the programme:

- Provided structured physical activity for individuals awaiting or transitioning from therapy services.
- Reduced reliance on one-to-one clinical input
- Supported confidence and self-management in community exercise settings.

Table 4. Results Table.

Outcome	Pre-Mean	Post Mean	Mean Change	Participants Achieving MCID
5TSTS (s)	15.7	12.6	–3.1	3/7
10MWT (m/s)	0.63	0.86	+0.23	4/7
Berg Balance Scale	45.4	47.3	+1.9	1/7
EQ-5D VAS	55.6	68.8	+13.1	5/8

Table 5. 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%

Eight participants enrolled in the programme, with seven completing functional outcome measures. Improvements were observed across mobility, functional strength, balance, and self-reported health status following the 8-week intervention. Mean gait speed on the 10-Metre Walk Test increased from 0.63 m/s to 0.86 m/s (mean change +0.23 m/s), with four of seven participants (57.1%)

exceeding the minimal clinically important difference (MCID ≥ 0.10 m/s). Performance on the Five Times Sit-to-Stand Test improved from a mean of 15.7 s to 12.6 s (mean change -3.1 s), with three participants (42.9%) achieving clinically meaningful improvement (≥ 2 s). Mean Berg Balance Scale scores increased from 45.4 to 47.3 (+1.9 points), with one participant (14.3%) exceeding the MCID threshold (≥ 5 points). Self-reported health status measured using the EQ-5D visual analogue scale improved from a mean of 55.6 to 68.8 (+13.1 points), with five of eight participants (62.5%) demonstrating clinically meaningful improvement. At a service level, physiotherapy waiting list volume reduced from 66 to 4 clients (93.9% reduction), and maximum waiting time decreased from 30 to 4 weeks (86.7% reduction) following implementation of the programme pathway.

6. Discussion

This evaluation demonstrates that a structured community-based group exercise pathway can achieve dual impact within a rural adult disability service: clinically meaningful functional improvement alongside substantial waiting list reduction. By embedding evidence-based exercise within a supervised community setting, the programme 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 (1,19).

In rural contexts, 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 programme 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 emphasising redesign, stratified care, and task-sharing (16,18).

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 (24). 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 individualised therapy may therefore constrain overall capacity.

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 programmes, 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, prioritisation, 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 to 4 individuals on the waiting list, and from 30 to 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 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.

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 (15,29). 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 (18,19).

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 utilisation 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 programme 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 (1,21). 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 (20,21).

Overall, these findings support a move toward blended clinical–community models for rural adult disability services. Formalised 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 rural 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 programmes 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 programmes 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.

7. 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 utilisation and formal cost-effectiveness analysis were not directly measured. Waiting list improvements may have been influenced by external service factors.

8. Future Research

Future research should incorporate controlled or quasi-experimental designs to strengthen causal inference. Multi-site studies would enhance generalisability 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 utilisation.

Further investigation should also explore patient-reported experience measures, engagement beyond programme 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.

9. Conclusions

This service evaluation demonstrates that a community-based group exercise pathway embedded within a rural 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 programme 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 programmes 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 in rural settings. Further research with larger samples and longer follow-up is warranted to confirm long-term functional and service-level benefits.

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