

Participant experiences of an exercise referral scheme in England: The importance of measuring social value

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Abstract

Background: Exercise referral schemes are widely perceived to generate health and wellbeing benefits for individuals with, or at risk of, health problems. Understanding the social value of exercise referral schemes – in terms of factors that influence service user engagement and experiences of attending an exercise referral scheme – is important to foster positive change and improve decision-making.

Methods: A social value approach was adopted to qualitatively explore experiences of engaging with an exercise referral scheme in one local authority in the North-West of England. Thirty-five service users (men = 21, women = 14) took part in focus groups ($n = 5$), paired interviews ($n = 1$) or individual interviews ($n = 5$). Data were thematically analysed to explore the perceived benefits (i.e. outcomes) of the exercise referral scheme when compared to the costs (i.e. barriers, inconveniences), and the extent to which participants attribute the benefits to the exercise referral scheme.

Results: Findings were explored through two key social value areas: outcomes – personal-emotional, physical and social outcomes (both positive and negative, intended and unintended); and attribution and maintenance of change. Participants reported improved physical, mental and social health and were motivated by a sense of community spirit and camaraderie. They expressed the desire to continue attending exercise referral scheme sessions and maintain the changes experienced.

Conclusion: The benefits of attending the exercise referral scheme were experienced beyond physical health to wellbeing on a personal-emotional and social level. Programmes should explore the inclusion of social value measurement in the longer term to provide services that are responsive to change, meet the needs of their communities and have tangible, measurable impacts.

Keywords

Behaviour change, community, outcomes, physical activity, social value, wellbeing

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Introduction

Exercise referral schemes (also known as physical activity [PA] referral), where individuals are referred to an exercise programme by a medical or health professional, are potentially effective in improving psychological and physical health outcomes and quality of life (Tomlinson-Perez et al., 2022). This is particularly the case for sedentary or inactive individuals with risk factors for ill-health and/or existing health conditions (Rowley et al., 2018). However, evaluating the usefulness of exercise referral schemes can be challenging due to the range of referral conditions and differing delivery and evaluation approaches (Henderson et al., 2018; National Institute for Health and Care Excellence [NICE], 2014; Oliver et al., 2021).

UK research highlights the use of clinical outcome measures such as blood pressure, lipid profiles and cardiorespiratory fitness to assess the effects of increased PA (e.g. Buckley et al., 2020; McGeechan et al., 2018). Many studies have focused on PA changes using randomised controlled trials to measure the effects of moderate to vigorous activity. In others, changes in outcomes such as quality of life have been assessed using tools such as the EQ (EuroQuol)-5D (Dimensions) (e.g. Taylor et al., 2020). Mixed-methods studies have added depth by exploring participant engagement, motivation and experiences using semi-structured interviews. These studies have examined perceptions of individual intervention components (Buckley et al., 2018); the role of social support, context and motivations in longer term adherence (Hanson et al., 2019; Martín-Borrás et al., 2018); and multilevel influences on engagement (Birtwistle et al., 2019; Buckley et al., 2020; Dodd-Reynolds et al., 2020).

While several studies demonstrate exercise referral scheme impacts on physical and mental health-related outcomes (e.g. Buckley et al., 2020; Dodd-Reynolds et al., 2020; Prior et al., 2019), community-based public health interventions require broader evaluation to capture individual and collective stories and accounts of change, the personal and social meanings of change and influencing factors. Those most in need of support often face barriers to engagement and adherence, thus increasing rather than diminishing health inequalities (Dodd-Reynolds et al., 2020). Context, barriers and facilitators, particularly in economically and socially disadvantaged areas, are crucial for understanding engagement (Dodd-Reynolds et al., 2020).

Social value measurement and a focus on the social return on investment have become increasingly prominent in health and social care research, particularly when evaluating community-based assets¹ in which PA and social participation are used to promote wellbeing (Baker et al., 2020). This approach requires data collection from a range of stakeholders, that is, those affected by an activity who contribute to and experience change, to quantify the social, environmental and ecological value of interventions beyond monetary outcomes (SVI, 2021). Such an approach recognises the wider, often unmeasured or unintended outcomes of health actions and programmes (NICE, 2014). The Public Services (Social Value) Act 2012 (HM Government, 2012) and its review (Cabinet Office, 2012) advocate for monitoring the wider social outcomes (i.e. the additional social, economic and environmental benefits that public service commissioning and procurement can generate beyond the direct delivery of services), and utilising social value-based commissioning and procurement to demonstrate positive change.

Identifying social value frequently involves the use of qualitative methods to document individual and group experiences of change (e.g. Arvidson et al., 2014). A focus on social value and the social return on investment is relatively new to the field of PA and sport, and more evidence is needed to understand the social value of exercise referral schemes to enable an understanding of its wider societal benefits, and to inform policy and investment (Gosselin et al., 2020).

Materials and methods

Study design and context

Studies highlighting the social value of exercise referral schemes are limited, partly due to the use of relatively inflexible evaluation methods unsuited for use in ‘real-world settings’ (Baker et al., 2020). Research exploring the social value of PA has found impacts on health, wellbeing, education and crime (UK Active Research Institute, 2017). Ritchie et al. (2024) examined social value framing across five domains (health, wellbeing, social, community and environmental) and social return on investment evidence in 45 EU policies referencing PA. Health benefits were the most cited and wellbeing benefits the least. They concluded that integrating a greater concern for social value in policy might enhance recognition of PA’s benefits when placed in a wider, system-level context.

This study adopted a social value approach to qualitatively explore individuals’ experiences of engaging with an exercise referral scheme in an urban area in the North-West of England. It addressed two research questions:

- What outcomes do individuals engaging with the exercise referral scheme experience and what do these changes mean to them?
- To what extent do the exercise referral scheme participants attribute the outcomes they have experienced to the community-based asset?

The exercise referral scheme in the area focused upon offers a variety of PA, weight management and wellbeing programmes for individuals aged 16+ with stable health conditions or risk factors. Referred through primary care and community routes, participants attended an initial 45-minute consultation followed by a free 12-week support programme. Sessions included condition-specific classes (e.g. cancer, cardiac, stroke) but were also targeted at those with broader medical conditions and risk factors (e.g. Type 2 diabetes, obesity and hypertension). Sessions were delivered in community venues with activities involving completion of a circuit of 10 to 12 exercises. Continued engagement beyond 12 weeks was available to participants for a small fee.

Between June 2016 and October 2018, 7,218 individuals engaged with the exercise referral scheme. Over half (52.8%) lived in the areas ranked as falling within the most deprived neighbourhoods in the borough, with 28.0% living in Index of Multiple Deprivation (IMD) quintile 1, the most socially and economically deprived quintile in England. The majority of participants were obese (71.7%), had existing health conditions (86.7%) and were physically inactive (93.6%, having not done any vigorous exercise in the last 7 days). Nearly two-thirds were women (63.9%), and their mean age was 54 years.

This study formed part of a larger pragmatic evaluation. The design was informed by a social value measurement framework, using participatory approaches (interviews and focus groups) to engage with stakeholders that are widely used in social value research. A number of key social value processes were followed: stakeholder involvement and engagement; understanding outcomes and what changes took place (positive and negative, intended/expected and unintended/unexpected); and attribution (not over-claiming) (SVI, 2021). This enabled the measurement and capture of outcomes and wider impacts of exercise referral scheme on the community. The authors of this paper (RH, EM, HT) have previously used this methodology in other studies evaluating community-based health interventions (see, for example, Harrison et al., 2018; Timpson and Harrison, 2022).

The exercise referral scheme

Participants and recruitment. Participants aged 18+ years were purposively identified by the exercise referral scheme staff. Session leaders, acting as gatekeepers, distributed participant information sheets and consent forms. Convenience sampling was then used, with gatekeepers informing potential participants of data collection procedures and dates. All participants provided informed consent.

Focus groups and interviews. In line with recommended social value methodology, both focus group and individual interviews were conducted to capture personal and collective stories and accounts of change. Data were collected between October and November 2017 by RH and five researchers involved in the wider evaluation. Participants had engaged with the exercise referral scheme for varied periods of time varying from 2 weeks to 3 years.

All the researchers were familiarised with the interview schedule and accompanying prompts to ensure consistency in data collection and approach. Participants were given multiple options for how to engage with the evaluation, depending on their preference, for example, face-to-face one-to-one interview, focus group interview or over the telephone.

A discussion guide informed by prior research and social value principles (SVI, 2021) aimed to encourage participants to describe their expectations, motivations, barriers, facilitators, attribution and maintenance of change. The same guide was used for all the focus groups and interviews (a copy of the guide may be obtained from the corresponding author of this paper).

Focus groups lasted for a mean of 36.88 minutes, and paired face-to-face interviews lasted for an average of 40.14 minutes; all took place in community settings. Telephone interviews with participants ranged from 14.04 to 32.23 minutes in length ($M = 23.02$).

Data analysis

Focus groups and individual interviews were audio recorded and transcribed verbatim to capture individual/group perspectives (Kidd and Parshall, 2000) together with group norms/areas of consensus (Kitzinger, 1994). Transcripts were analysed thematically in NVivo Enterprise by the first author (RH). A deductive approach, informed by a focus on implementation and social value, guided theme development, followed by the inductive analysis of subthemes (Clarke and Braun, 2013). Analysis involved a process of reading and re-reading the transcripts, with codes being refined throughout the analysis process. To enhance trustworthiness and inter-rater reliability (Campbell et al., 2013), themes were then discussed and agreed between the authors RH, EM and HT, with authors LP and PMW as ‘critical friends’ (Smith and McGannon, 2017).

Results

Thirty-five individuals (including two carers) consented to participate. Table 1 shows participant numbers by data collection method, exercise referral scheme type and gender. The sample size enabled data saturation to be achieved.

Findings are presented across two areas: (1) outcomes (or changes) experienced – personal-emotional, physical and social, and (2) attribution and maintenance of change, explored through a social value lens. Illustrative quotes are provided to support the narrative.

Figure 1 outlines the key exercise referral scheme activities and outcomes. While long-term impacts on health inequalities are difficult to measure, sustained behaviour change may contribute

Table 1. Participant numbers by data collection method, type of exercise referral scheme, place and gender.^a

Focus group (FG)/interview (I)	Gender		Total
	Man	Woman	
FG 1 – Cardiac rehabilitation (medical centre)	3	3	6
FG 2 – Chronic Obstructive Pulmonary Disease (COPD) rehab (medical centre)	4	3	7
FG 3 – COPD rehab (sports/leisure centre)	2	1	3
FG 4 – Cancer rehab (sports/leisure centre)	4	3 (including one carer)	7
FG 5 – Stroke rehab (sports/leisure centre)	2	3 (including one carer)	5
One paired interview (PI) – cardiac rehab (sports/leisure centre)	2		2
Individual interviews (I1 to I5) (telephone interview whilst participant was at home)	4	1	5
Total	21	14	35

^aFor those attending focus groups and taking part in interviews, we did not directly ask about sex assigned at birth/ participants' current self-identification, but assigned participants gender based on observation.

to wider system impacts (e.g. reduced disease prevalence, reduced adult health and social care costs, improved quality of life).

The outcome categories of personal-emotional benefits and social support, while distinct in their focus and function of the support being described (e.g. subjective versus interpersonal/collective experiences), are interlinked. For example, individual wellbeing can enhance social interaction, which in turn may reinforce wellbeing. This highlights the complex, layered nature of exercise referral scheme outcomes as shown in Figure 2.

Outcomes

Personal-emotional benefits of the exercise referral scheme

Motivation and support. Taking part in organised activity was a motivating factor for engaging with exercise referral scheme sessions, as was participants wanting to improve their levels of physical fitness and weight loss. Participants also spoke of the need for 'self-motivation':

... I did want to continue with some of them because obviously it's difficult to do things on your own, it's worse. If somethings organised it's much easier to keep involved with. (I2, man)

One of the advantages of the groups was that they were considered to be non-judgemental, providing support to 'push you along', for example, when individuals found some of the equipment difficult or did not 'necessarily want to be there'. The sessions were also seen as a place to have a 'laugh':

We know people who may struggle a bit on certain types of equipment, and some aren't as fit as others so we can keep an eye on them. ... this is a friendly group and we send people round in twos. ... (FG2, man)

Participants spoke about not necessarily setting tightly defined goals but monitored their progress using report cards and recording how they felt after carrying out the exercises. They felt supported by the exercise referral scheme trainers who not only helped them use the equipment but

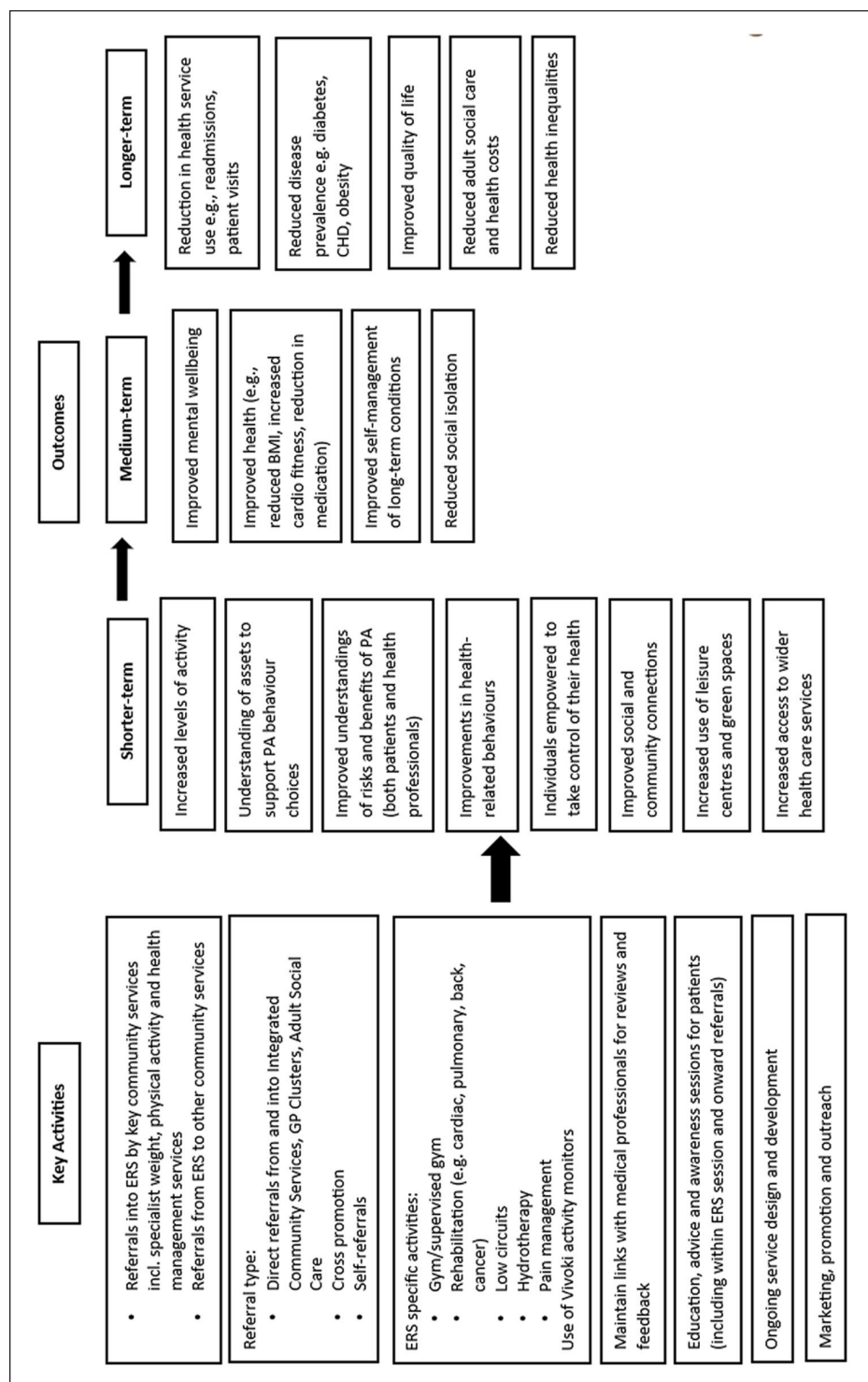


Figure 1. Activities and outcomes of the exercise referral scheme.

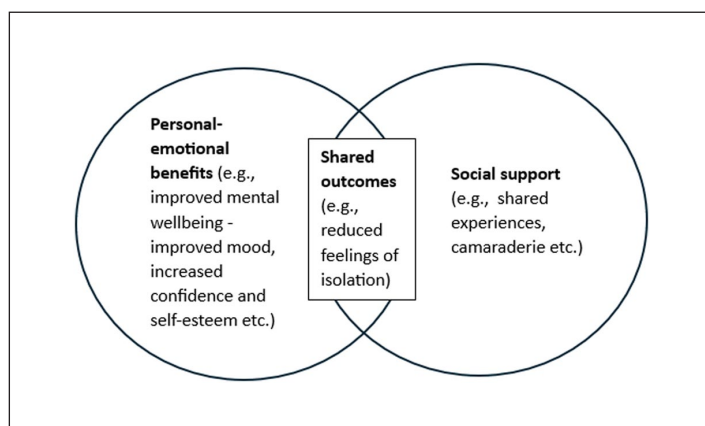


Figure 2. Example of how personal-emotional and social support outcome may overlap within the exercise referral scheme.

were also aware of the individual needs and requirements of those who were attending, and were ‘very accommodating’ in terms of what people were able to achieve:

... there’s no right, you’ve been here for 3 months now, don’t you think it’s time you started doing a bit more. . . it’s probably the opposite you know ‘how are you today. . . Just do what you can’, there’s no physical and no psychological pressure. I think they do have an understanding and appreciate it and embrace the fact that we’re all different we’re all at different levels. But the majority have struggled to get here – but we are here – and I think they’ve embraced that. (FG2, man)

Improved mental wellbeing. Participants described having mixed emotions when first referred to the exercise referral scheme, including feeling ‘happy’ as well as being ‘totally terrified’. The mental health benefits of attending the exercise referral scheme were, however, very evident, with some describing the exercise referral scheme as a ‘lifeline’ that they did not want anybody to take away. Participants spoke about the positive impact on their mental wellbeing that came from being able to speak with others who were in a similar situation. The exercise referral scheme was seen as enabling people to develop friendships with others and gain a sense of fellowship, purpose and routine:

When you’ve been you do feel so much better that you’ve done this, and you’ve done that, and you’ve come out feeling good so yeah it’s an absolute part of well-being feelings, if you like really. (I2, man)

Participants described experiencing positive change in their level of confidence. This confidence was seen in different areas, such as ‘getting out of the house’ and meeting people in a group setting, as well as the ability to undertake the different aspects of activity:

It’s been a year now, I started off in slow steps, coming along here . . . and I started to get confidence, in coming here and actually getting out of the house. I thoroughly enjoyed it. It’s been amazing for me [as] it’s brought me out my shell. The fact that I’m even speaking like this [is evidence of the fact]. (FG1, woman)

Physical benefits of the exercise referral scheme

Improved health. Many participants felt that active living was important in older adulthood and perceived this as especially important for those leading a more sedentary lifestyle while also highlighting that it was never too late to become physically active. The exercise referral scheme was seen as offering a good introduction/re-introduction to exercise that individuals found less intimidating than, for example, attending a gym, and which also encouraged them to undertake other activity:

Without the facility, the majority of people would still feel daunted by saying you've not been well for this reason or the other, you need to go and sign up at a gym, they would never go. . . The good thing even if people do this for 12 weeks and then they go and buy a bike or something, then it's done some good. (FG2, man)

Participants spoke about 'steadily getting fitter' with slow but steady improvements in their physical health such as weight loss, improved strength and stamina, improved breathing (e.g. being less out of breath), improvements in joint pain linked to arthritis and better balance and coordination. This was seen by some as the 'most important aspect'. One participant commented they had experienced a reduction in their cholesterol levels that meant they did not need to take statins anymore, while another spoke of reducing the level of another medication they were taking:

. . . my sense of balance has improved quite dramatically over the months that we've been doing the exercises. . . I've got emphysema and the last time that I had a lung test my result had gone up one point rather than dropped from the previous year. I've got measurable benefits coming from it, which to me is great. So, I will carry on doing it. (FG2, man)

I went to [name of country] to see my son and he lives in [state] and it's hilly and he had me walking round everywhere. . . he was impressed that I could do it. If I hadn't have been coming here, I wouldn't have been able to do all that. . . It's taken that apprehension out the way that what you think you can't do you can do if you give yourself a chance. . . (PI, man)

The importance of being physically active, and how this type of structured exercise helped with long-term recuperation after illness, a stroke or an operation, was also discussed, along with encouraging others to take up activity:

. . . these things are essential or vital for people like myself . . . you get involved with this at an early stage after the, after your operation then and recovery, the fact that you can get involved with it does become part of your, in my situation, long term recuperation . . . if it wasn't available then there's a large number of us I don't think we'd do any sort of you know, structured exercise. (I2, man)

. . . our daughter started swimming . . . encouraged by the fact us old fogies started exercising. (FG2, man)

Social benefits. All participants highlighted the social aspects of the exercise referral scheme and felt that this was an important characteristic that should 'not to be underestimated'. Some participants spoke about meeting others in similar situations who might be isolated. Others described developing a sense of 'community spirit' and attendance being 'like a community more than a class' with a strong sense of 'camaraderie'. Participating in the exercise referral scheme was seen to help pass the time, and an opportunity to talk about common interests such as sport. These friendships extended outside of the exercise referral scheme groups:

I don't see anybody . . . So yes myself like [name], we enjoy the social side of it you know a good old chat like I say for older isolated people. (I4, woman)

You have a laugh, you have a chat . . . But the very nature of getting up and coming and doing even if it's only for an hour, the health benefits might not be humongous in the scheme of things but to somebody who's done no exercise and is generally feeling crap psychologically and physically it's a big deal. (FG2, woman)

A lot of people have made social contacts, myself included. . . it's not just the physical aspect it's getting out and having a social side to it as well. (I2, man)

One participant did, however, highlight their initial concern about attending the group and the challenge of developing relationships with other people who had been attending the exercise referral scheme for a longer time. This participant spoke about the importance of making sure new people felt welcome when they first started with the group:

. . . initially, I didn't like it . . . some people have been going five years or more and they were very cliquey. . . I always make a point now if I see any new people coming in, I try and go and talk to them because of the way I felt. (I1, man)

Attending the exercise referral scheme gave participants a sense of purpose and routine, and for one person, their experience of attending the sessions led them becoming an exercise referral scheme volunteer:

I tend to mark on the calendar Tuesday mornings at gym, and you know try and build the week around that so that I miss as few as possible. Because if I didn't do that then I doubt that I and myself and other people would do any at all, and it's sort of vital to people who are our age to keep as active as possible. (I2, man)

Attribution and maintenance of change

The theme attribution and maintenance of change explored the degree to which outcomes were experienced as a direct result of attending the exercise referral scheme, and whether perceived changes could be maintained. Participants were asked whether the outcomes they described would have happened without the exercise referral scheme. Many felt that PA and attendance at exercise classes was daunting but being part of the scheme broke down the barriers to accessing a gym or a leisure centre. People described how, previously, they would not have undertaken any exercise but now had confidence to do so:

If it [the exercise referral scheme] hadn't been there in the first place, I'm not sure where I would be now. But I certainly wouldn't be as fit and healthy as I am and perhaps not as positive because its helping with the lifestyle if you like that you think well I did this yesterday perhaps we ought to go for a walk today rather than just watching the TV or something. So, it's the spinoffs that make you think about doing other things as well. (I2, man)

A number of participants said that it was the other exercise they took outside the exercise referral scheme sessions that helped maintain the changes they first experienced after attending the exercise referral scheme. This included being members of walking groups, swimming, going to/joining the gym, attending Pilates classes, gardening and so on. Participants also spoke about weight loss by attending groups such as Slimming World.

When asked whether they would maintain the changes they had experienced, participants spoke about hoping they would be able to keep attending the exercise referral scheme for as long as they could. They described the importance of continuing to be active, many mentioning lifestyle changes as a result of attending the group; acknowledging that taking up more exercise to keep fit and improve/maintain their level of health was something they would never have done without the exercise referral scheme:

... it's the lifestyle changes that I've made because of it [the exercise referral scheme]. I'll certainly keep on with those definitely. (I2, man)

With respect to the maintenance of change, most participants found the sessions easy to access. Some, however, spoke about potential challenges if attending by public transport. The cost of sessions emerged as a possible barrier to attendance (especially for those who were in receipt of benefits). Generally, however, participants felt that paying £2-£3 for a session was less than they would pay, for example, to attend a gym session, and it was worth it because of the benefits experienced:

I'm breathing [better] now and I'm walking quick, so I'm made up with all of this. I'm just wondering whether I can afford to keep it up. I have a car at the moment but ... I need the car to get here. No buses come here. (FG5, man)

I joined the gym for 12-months and got my lifestyles card and any of these classes are free with that. It runs out [next month], but I won't be renewing the gym membership, but I'll still pay my £3 and come here. (FG3, man)

Discussion

This study used a social value approach to explore experiences of engaging with an exercise referral scheme in an economically and socially deprived borough in England. Despite differences among participants, all experienced psychosocial benefits, including personal-emotional, physical, and social improvements. These were driven and impacted by prior activity experiences, motivation and support (Birtwistle et al., 2019). A strong sense of 'camaraderie' and 'fun' was evident, with participants encouraging each other, which motivated individuals to sustain engagement and increase their PA, and this in turn encouraged them to engage with new/additional activities (Verplanken and Orbell, 2019). Overall, the exercise referral scheme acted as a catalyst for behavioural change, promoting regular exercise through intentional and consistent engagement in a familiar setting (Verplanken and Orbell, 2019). These findings have broader social value implications: sustained improvements in health could reduce long-term pressure on health and social care, and while such outcomes may be harder to quantify, they represent meaningful, lasting change.

In this study, applying a social value framework enabled an exploration of individual and collective accounts of change and influencing social factors (SVI, 2021). The approach facilitated the development of insights at whole-system level (individual, family/community, organisational, societal), emphasising the benefits to communities and society (including social justice) as well as the individuals concerned (Thomas, 2021). Participation in the exercise referral scheme, and associated PA, improved physical health, mental wellbeing and social functioning (Marques et al., 2016; Pentecost and Taket, 2011). Charting these outcomes reveals

the potential of social value methodologies to demonstrate meaningful, accountable and systemic impact in health and social care contexts. Importantly, exercise referral scheme participation provided participants with a routine and sense of purpose. The social value approach enabled attribution of outcomes to the intervention by capturing broader, non-clinical impacts that are often overlooked, thereby deepening understanding of change beyond traditional metrics (Gosselin et al., 2020; NICE, 2014).

With respect to the maintenance of behaviour change, most participants continued exercise referral scheme attendance well beyond the initial 12 weeks engagement (some for at least 3 years). Sustained participation supports habit formation and long-term behaviour change (Beeken et al., 2017; Gardner and Rebar, 2019). While exercise referral scheme programmes can have high attrition rates and re-referral rates (Tomlinson-Perez et al., 2022), engagement of 20+ weeks has been shown to enhance adherence and outcomes (Rowley et al., 2018). All participants expressed the intention to continue with the exercise referral scheme unless factors such as the groups becoming too big or there no longer being enough space occurred. Exercise referral schemes are typically funded to provide a time-limited period of support however, but this exercise referral scheme employed a maintenance strategy,² which enabled people to access support beyond 12 weeks. This approach supported the camaraderie and friendships to be sustained while accommodating new participants, highlighting the value of extended support.

While evaluating exercise referral scheme impact remains challenging (Morgan et al., 2016), applying a social value lens evidenced positive outcomes across different exercise referral scheme groups (cardiac rehabilitation, cancer, chronic obstructive pulmonary disease [COPD], and stroke rehabilitation). Further research is needed, however, to assess the longer term outcomes and sustainability of such programmes. Social value can be assessed in many ways, including through the use of structured frameworks; performance indicators aligned with stakeholder value; robust mixed-methods data collection; stakeholder engagement to ensure relevance and explore attribution; and regular evaluation and reporting, for example (B-Lab, 2016). The use of these strategies enhances the ability to measure and communicate the wider impacts of exercise referral scheme, supporting more informed decision-making and accountability in health and community-based interventions.

It is critical to continue to develop evidence concerning the social value of PA more widely and use this to inform policy to further promote benefits and impacts, not only at the individual level, but also at the community and system levels, of PA (Ritchie et al., 2024).

Limitations and strengths

It is important to recognise that the sample in this study did not reflect the broader exercise referral scheme demographic, with women being over-represented in the group. This is likely the result of convenience sampling and participant availability at the time of data collection. The sample was, however, deemed inclusive enough to capture general perceptions of the exercise referral scheme and its impacts. The study also did not include individuals who disengaged from the programme, limiting insight into barriers to sustained participation. In addition, it was not possible to compare responses based on duration of engagement, as not all participants disclosed how long they had attended. This restricted analysis of potential differences between short- and long-term participants.

A particular strength of the research, however, was the use of peer-based focus groups. Those taking part had attended groups together for a number of weeks, had made connections and developed friendships and were used to describing their experiences of the exercise referral scheme with their peers (Kidd and Parshall, 2000). The inclusion of interviews/focus groups with exercise

referral scheme facilitators would likely have enriched the findings of the study and would have allowed a degree of triangulation between participant perspectives. Future research should address these limitations to enhance understanding of engagement dynamics and the broader implementation context of exercise referral scheme programmes.

Conclusions

This study explored the work and achievements of an exercise referral scheme using a social value lens to show how social participation and PA were key to promoting health and wellbeing. The findings described in this paper contribute to a developing body of evidence in the area of PA, sports and social value demonstrating the effectiveness of exercise referral scheme in supporting communities to address health-related issues. They will be of use to service commissioners and providers who want to understand the broader psychological and social benefits of exercise referral scheme. The ongoing measurement of outcomes and impacts from exercise referral scheme such as the one focused on here should be promoted to help develop future provision and ensure it meets the needs of those referred to a service. Programmes such as this should explore building a clearer focus on social value into their long-term plans so as to continue to develop services that have a tangible, measurable and positive impact upon communities in which they take place.

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Use of AI

No generative AI tools were used in the analysis, writing and editing of this manuscript.

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Supplemental material

Supplemental material for this article is available online.

Notes

1. Community-based assets are the strengths, resources and relationships within a community, such as local organisations, projects and interventions, social networks and cultural knowledge, that can be mobilised to support health, wellbeing and social change.
2. Within this context, a maintenance strategy provided support to help participants maintain PA beyond the initial 12-week programme, such as continued access to sessions, progress monitoring (by staff), and peer support.

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