Where next for the design, delivery and evaluation of community-based physical activity prescription? Emerging lessons from the United Kingdom.

EJ Oliver,[1] B Buckley,[2] CJ Dodd-Reynolds,[3] J Downey,[4] C Hanson, [5] H Henderson,[6] J Hawkins,[7] J Steele,[8] M Wade,[9] & PM Watson.[10]

[1] Corresponding author. Department of Sport and Exercise Sciences, Durham University, UK. Emily.oliver@durham.ac.uk +44(0)191 https://orcid.org/0000-0002-1795-8448

[2] Liverpool Centre for Cardiovascular Science and the Institute of Life Course and Medical Sciences, University of Liverpool and Liverpool Heart & Chest Hospital, Liverpool, UK. https://orcid.org/0000-0002-1479-8872

[3] Department of Sport and Exercise Sciences, Durham University, UK. Durham Research Methods Centre, Durham University, UK. https://orcid.org/0000-0003-0670-8264

[4] Sport, Health, and Wellbeing, Plymouth Marjon University, UK. https://orcid.org/0000-0001-8534-2437

[5] School of Health and Social Care, Edinburgh Napier University, Edinburgh, UK.

[6] School of Sport and Exercise Science, University of Lincoln, UK. https://orcid.org/0000-0002-2742-4909

[7] DECIPHer, School of Social Sciences, Cardiff University, UK. https://orcid.org/0000-0002-1998-9547

[8] Faculty of Sport, Health, and Social Sciences, Solent University, Southampton, UK; ukactive Research Institute, ukactive, London, UK. https://orcid.org/0000-0002-8003-0757

[9] ukactive Research Institute, London, UK. https://orcid.org/0000-0002-9217-1493

[10] Physical Activity Exchange, Research Institute for Sport and Exercise Sciences, Liverpool John Moores University, UK 0000-0003-1575-246X

Word Count (inc. abstract, ex. references): 1992

Abstract

Despite widespread use, community-based physical activity prescription is controversial. Data limitations have resulted in a lack of clarity about what works, under what circumstances, and for whom, reflected in conservative policy recommendations. In this commentary we challenge a predominantly negative discourse, using contemporary research to highlight promising findings and 'lessons learnt' for design, delivery, and evaluation. In doing so, we argue for the importance of a more nuanced approach to future commissioning and evaluation.

Community-based physical activity prescription, most commonly known as exercise referral, is widespread globally. Such schemes typically involve referral via primary care and are targeted at those who are inactive and have, or are at risk of, chronic health conditions. First introduced in the 1990s, exercise referral schemes expanded internationally, initially without a substantial evidence base.[1] Subsequent policy has attempted to enhance practice; for example, in the UK a national quality assurance framework[2] and national clinical guidance;[3, 4] however, implementation has been challenging. Emerging from a symposium considering the future of exercise referral within the UK, this piece amalgamates reflections from researchers working on physical activity prescription within that context. We hope that this learning may stimulate reflection on and comparison with practices in international systems.

Common to other health interventions which vary across service providers, there have been challenges in terms of conducting rigorous yet ecologically-valid evaluations. Data sharing to compare schemes has been particularly problematic. As a result, policy for exercise referral schemes has been ambiguous.[5] Evidence reviews [6-9] have had to synthesise findings from schemes employing heterogenous practices which are often not underpinned by evidence-based designs, behaviour change theory, nor include long-term follow up. Consequently, there remains outstanding questions regarding what works, for whom, in what circumstances and why. Recent policy reflects this; for example, the UK's National Institute of Clinical Excellence's 2018 guidance review reiterated the paucity of the evidence base and consequently made only conservative recommendations for ongoing commissioning.

One would be forgiven for thinking that exercise referral-based research had stagnated. Here, we argue this is not the case. Localisation of health policy and funding in the UK has enabled research and practice-based innovation, that addresses some of the more complex challenges of design, implementation, and evaluation within this field. There is growing evidence to suggest that exercise referral schemes work better for some groups than others,[10,11] and tailored behaviour change approaches can promote more holistic physical activity engagement than is typical through gym-based exercise prescription.[12] Where psychosocial constructs are augmented (i.e., through either explicit or implicit use of behaviour change strategies), adherence is supported.[10] Here, we collate learning from exemplar case studies and emerging research to demonstrate how understanding of community-based physical activity prescription is advancing. In doing so, we highlight both promising findings and areas of contention, deliberately showcasing diverging perspectives to invite debate concerning future approaches. Given the expansion of exercise referral internationally, and social prescribing in the UK, this is a pertinent and timely issue.

1. Design

A key advancement for provision and research has been moving from seeking system-wide standardisation ("top down") towards a "bottom up" approach involving intervention design with local stakeholders. For example, the Co-PARS programme,[12, 13, 14] was a three-year process of iterative coproduction, refinement and evaluation of an exercise referral scheme in Liverpool. Two key learning points emerged. First, collaborative relationships between multiple interdependent stakeholders (e.g.,

commissioners, providers, users) can be fostered through "levelling" power and promoting a sense of shared intervention ownership.[15] Buckley et al. [12, 13, 14] facilitated this through weighting practitioner and participant experience equally to academic knowledge; using a non-specialist, impartial facilitator; and separating stakeholder groups for discussion of sensitive issues (e.g., funding and resources). Second, the design benefitted from being an iterative cyclical process, allowing ongoing intervention refinements.[16] Buckley et al.'s engagement with stakeholders went beyond the formal "co-production" phase, allowing practitioners to feedback challenges, address logistical problems, and adapt delivery systems in response to pilot data.

Crucially, when reflecting on the improved outcomes compared to usual care exercise referral and between pilot[12] and trial[14] phases, the authors concluded that the iterative, participatory development process may be as important for effective and sustainable community-based physical activity prescription as the content of the intervention itself. Indeed, the former should inform the latter. This is consistent with wider design-focused work demonstrating how prototyping (iterative refining to delivery context while a programme is 'live') can offer a time-efficient alternative to full co-production.[17] These developing strands of work highlight a need for policy-driving evidence syntheses to look beyond standardised trial designs and positivist research paradigms. In doing so, policy-makers might seek good practices rather than best practice, and replace the quest for "off the shelf" content with sustainable models that allow context-driven adaptation.

2. Delivery

A second key area of development has been the implementation of schemes; that is, what should be delivered and how, to maximise effectiveness. While guidelines[2, 3] recommend access to activities alongside use of behaviour change techniques (e.g., goals, action and coping plans), work has demonstrated how delivery can be challenged by issues of technique fidelity,[18, 19] time pressures on the workforce,[20] and poor attendance.[21] Innovations in this area are trialling new delivery methods, including theory-based behaviour change consultations,[14] referral to "green" physical activity in outdoor environments,[22] and home-based delivery.[23] Such diversification of delivery may be particularly important amidst the changing climate of the Covid-19 pandemic, where home-based or outdoor PA could offer accessible alternatives to the traditional gym environment for elderly or clinically vulnerable populations.[24]

Findings are not always as expected. For example, the PACERS pilot trial[25, 26] explored the feasibility of embedding a web portal and accelerometery-based monitoring device within the Welsh National Exercise Referral Scheme versus scheme-only provision, aiming to diversify delivery, widen access, and enhance motivational support to improve adherence and outcomes. The trial demonstrated challenges of device engagement (due to technical access and literacy) and disproportionately high engagement from those in the least deprived quintile. Of note, this differs from patterns of engagement observed in a multi-scheme dataset that show greatest uptake in the higher (but not the highest) deprivation deciles.[27] Together this reinforces the need to better understand how different delivery approaches may impact, or be tailored to suit, different types of participants.

3. Evaluation

One longstanding challenge in understanding the impact of exercise referral in the UK has been the heterogeneity of data collected and reported. In recent years we have seen considerable innovation in the evaluation of schemes. For example, the now open-access National ReferAll Database (NRD)[28, 29, 30] curated by ukactive (UK-wide professional member organisation), Refer-All (a company providing software solutions for exercise referral), and the National Centre for Sport and Exercise Medicine, enables between-scheme comparisons at scale. So far, research using the database has highlighted key areas for development, including the need to adapt practices if we are to recruit and retain participants who are least active,[30] and that schemes do well at engaging (but not retaining) participants from ethnic minority communities.[27] In addition, key learning from the processes of constructing and analysing the NRD reinforces the need to support schemes in the production of high quality and consistent outcome evaluation data, and of engaging delivery partners in evaluation.

Given the relative paucity of evaluation of long-term behaviour change and maintenance of outcomes, it is clear that longitudinal follow-up must become more commonplace.[31] Progress is being made, for example in work exploring longitudinal uptake and referral patterning in the Welsh National Exercise Referral Scheme by linking referral scheme and health data.[32] Considering the heterogeneity seen in scheme level outcomes in multi-scheme datasets,[28, 30] long-term follow ups might better inform as to what schemes work best and for whom.

In a contrasting approach, theory-driven realist evaluations are increasingly being used to explore interactions between proposed mechanisms, contexts and outcomes. Such work[15, 33] has identified that people within schemes (e.g., participants, deliverers, commissioners) provide rich sources of information about factors that enhance outcomes. These include diverse and well-integrated staffing team, accessible venues (leisure and non-leisure), and embedded social opportunities.[27] Learning from these in-depth evaluations with multiple stakeholders has also reaffirmed the importance of understanding the complexity and politics of delivery contexts. For example, in a case study of an East Midlands county scheme[15] researchers identified conflicting interpretations, power imbalances, and tensile relationships between service users, practitioners and commissioners, that ultimately affected the scheme's decommissioning. Similarly, a recent ethnography highlighted the importance of person-centred climate and established supportive communities of practice when seeking to influence motivation and capability within exercise referral practitioners.[33] More research on operational contexts is needed to complement traditional effectiveness studies.

Another final key shift in evaluation focused work has responded to calls[27] for more consideration of the impact of schemes on health inequalities. While schemes target those with poorer health or risk of poor health, emerging work highlights a mixed picture as to the success of supporting these groups. Data has demonstrated widening inequalities in recruitment to a national scheme, over time,[32] and also, that although a regional exercise referral programme largely did not increase inequalities in patients

referred for weight reasons, it did not reduce them either.[34] The publication of a new Physical Activity Referral Scheme taxonomy[35] is likely to support consistent reporting and classification of schemes, enabling more informed interpretation of differences in outcomes. Relatedly, while the breadth of outcomes impacted by schemes is encouraging, both the case for their use, and evaluation of their effectiveness, are altered depending on how their stated purpose is framed. Examples of primary outcomes vary, including: demonstrating a clinically-meaningful change (e.g., in physical or mental health indices), achieving a guideline-based physical activity level (potentially important in some clinical populations, e.g., cancer pre-habilitation),[36] or demonstrating readiness for, or engagement in, sustainable independent activity. Transparency in purpose at commissioning stages, and selecting outcomes both appropriate to the population and realistic given the scheme, are vital for meaningful design, delivery, and evaluation.

Conclusions

Crucially, emerging evidence is reinforcing that meaningful health and social gains can be provided by exercise referral schemes, whilst highlighting some consistent messages and recommendations. First, that 'one size' does not fit all; researchers should design and develop new methods of delivery with underserved groups to support those who cannot engage with traditional schemes. Second, while scheme content may justifiably differ based on tailoring to individuals and local contexts, there is a need for some standardisation of reporting and evaluation, at least in similarly-designed

189 approaches, to facilitate robust understanding of effective practices. We argue that this
190 must take place alongside evaluation approaches that appropriately capture relevant
191 contextual details, factors that influence and impact on inequalities, and the nuances of
192 complex delivery systems. Third, the projects discussed demonstrate that it is vital to
193 continue to work with stakeholders to enhance the quality, awareness, and impact of
194 emerging evidence. Whilst individual tailoring, standardised evaluation and stakeholder
195 engagement have been established within the public health landscape for some time,
196 they have not consistently been applied within the exercise referral field. With the
197 expansion of social prescribing, and political focus on physical activity in COVID-19-
198 related discourse, this presents a key 'policy window'[37] to enable a change in agenda
199 and messaging relating to physical activity prescription. To ensure we take advantage of
200 this opportunity, we must continue to strengthen the evidence base to earn a seat at the
201 policy table[38] and extend our engagement with the service users, practitioners and
202 policy-makers who use it.
203 In this commentary we have drawn together key findings and lessons learnt from
204 emerging research within the UK to demonstrate how understanding of community-
205 based physical activity prescription schemes is advancing. Specifically, we highlight
206 innovations in scheme design, delivery, and evaluation, and invite broader engagement
207 in and with this research to inform future policy and practice. In particular, work that
208 shares and contrasts both intra- and inter-national data is particularly required, to
209 amalgamate learning from different policy, funding, political and structural contexts.

Doing so will drive progress towards ensuring that the potential benefits of exercise referral schemes are fully realised, in an equitable way.

References

[1] Sowden SL, Breeze E, Barber J, et al. Do general practices provide equitable access to physical activity interventions? *British Journal of General Practice*. 2008;58(555):e1-e8.

[2] Department of Health. Exercise referral systems: a national quality assurance framework. 2001; https://webarchive.nationalarchives.gov.uk/+tf_/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009671

[3] National Institute for Health and Clinical Excellence. Public Health guidance [PH54]: Physical Activity: exercise referral schemes. 2014; https://www.nice.org.uk/guidance/ph54

[4] National Institute for Health and Clinical Excellence. 2018 Surveillance of physical activity: exercise referral schemes (NICE guideline PH54). 2018; https://www.nice.org.uk/guidance/ph54/resources/2018-surveillance-of-physical-activity-exercise-referral-schemes-nice-guideline-ph54-4909662685/chapter/Surveillance-decision?tab=evidence

[5] Oliver EJ, Hanson C, Lindsey I, et al. Exercise on referral: Evidence and complexity at the nexus of public health and sport policy. *International Journal of Sport Policy and Politics.* 2016;8(4): 731-736.

[6] Rowley N, Mann S, Steele J, et al. The effects of exercise referral schemes in the United Kingdom in those with cardiovascular, mental health, and musculoskeletal disorders: a preliminary systematic review. *BMC Public Health.* 2018;18(1):949

[7] Campbell F, Holmes M, Everson-Hock E, et al. A systematic review and economic evaluation of exercise referral schemes in primary care: a short report. *Health Technology Assessment.* 2015;19(60):1-110

[8] Pavey TG, Taylor AH, Fox KR, et al. Effect of exercise referral schemes in primary care on physical activity and improving health outcomes: systematic review and meta-analysis. *British Medical Journal.* 2011;343: d6462

[9] Williams NH, Hendry M, France B, et al. Effectiveness of exercise-referral schemes to promote physical activity in adults: systematic review. *British Journal of General Practice,* 2007;57(545):979-986

[10] Eynon M, Foad J, Downey J, et al. Assessing the psychosocial factors associated with adherence to exercise referral schemes: a systematic review. *Scandinavian Journal of Medicine & Science in Sports*. 2019; *29*(5): 638-650.

[11] Hanson CL, Oliver EJ, Dodd-Reynolds C, et al. How do participant experiences and characteristics influence engagement in exercise referral? A qualitative longitudinal study of a scheme in Northumberland, United Kingdom. *BMJ Open.* 2019; 9(2): e024370.

[12] Buckley BJ, Thijssen DH, Murphy RC, et al. Preliminary effects and acceptability of a co-produced physical activity referral intervention. *Health Education Journal*, 2019; 78(8), 869–884.

[13] Buckley BJ, Thijssen DH, Murphy RC, et al. (2018). Making a move in exercise referral: co-development of a physical activity referral scheme. *Journal of Public Health*. 2018. 40(4): e586–e593.

[14] Buckley BJ, Thijssen DH, Murphy RC, et al. Pragmatic evaluation of a coproduced physical activity referral scheme: a UK quasi-experimental study. *BMJ Open*. 2020; 10: e034580.

[15] Henderson H, Evans A, Allen-Collinson J, et al. The 'wild and woolly' world of exercise referral schemes: contested interpretations of an exercise as medicine programme. *Qualitative Research in Sport, Exercise & Health*, 2018; 10(4): 505-523.

[16] Ogilvie D, Craig P, Griffin S, et al. A translational framework for public health research. *BMC Public Health*, 2009: 9: 116.

[17] Dodd-Reynolds CJ, Nevens L, Oliver EJ, et al. Prototyping for public health in a local context: a streamlined evaluation of a community-based weight management programme (Momenta), Northumberland, UK. *BMJ Open.* 2019; 9(10): e029718.

[18] Murphy S, Raisanen L, Moore G, et al. The evaluation of the National Exercise Referral Scheme in Wales. 2010; Social Research. Number: 07/201.

[19] Beck F, Gillison F, Koseva M, et al. The systematic identification of content and delivery style of an exercise intervention. *Psychol Health.* 2016;31:605–621.

[20] Duda J, Williams G, Ntoumanis N, et al. Effects of a standard provision versus an autonomy supportive exercise referral programme on physical activity, quality of life and well-being indicators: a cluster randomised controlled trial. *Int J Behav Nutr Phys Act.* 2014;11(10):10.

[21] Shore C, Hubbard G, Gorley T, et al. Insufficient reporting of factors associated with exercise referral scheme uptake, attendance and adherence: a systematic review of reviews. *Journal of Physical Activity and Health.* 2020; 16(8): 667-676.

[22] McHale S, Pearsons A, Neubeck L, et al. Green Health Partnerships in Scotland Pathways for Social Prescribing and Physical Activity Referral. *International Journal of Environmental Research and Public Health.* 2020; 17: 6832.

[23] Hesketh K. *High intensity interval training: moving away from the laboratory and into the real-world.* 2020; Doctoral thesis, Liverpool John Moores University.

[24] Goethals L, Barth N, Guyot J, et al. Impact of Home Quarantine on Physical Activity Among Older Adults Living at Home During the COVID-19 Pandemic: Qualitative Interview Study. *JMIR Aging*. 2020;3(1): e19007.

[25] Hawkins J, Edwards M, Charles J, et al. Protocol for a feasibility randomised controlled trial of the use of Physical Activity monitors in an Exercise Referral Setting: The PACERS study. *Pilot and Feasibility Studies* 2017; 3(1): 51

[26] Hawkins J, Edwards M, Charles J, et al. Acceptability and feasibility of implementing accelorometry-based activity monitors and a linked web portal in an exercise referral scheme: a mixed-methods feasibility randomized controlled trial. *Journal of Medical Internet Research*. 2019; 21 (3). e12374.

[27] Oliver EJ, Dodd-Reynolds, C, Kasim A, Vallis D. Inequalities and Inclusion in Exercise Referral Schemes: A Mixed-Method Multi-Scheme Analysis. *Int. J. Environ. Res. Public Health* 2021, *18*, 3033.

[28] Rowley N, Steele J, Mann S et al. Delivery approaches within exercise referral schemes: a survey of current practice in England. *Journal of Physical Activity and Health.* 2021; 18(4): 357-373.

[29] Steele J, Wade M, Polley M, et al. The National ReferAll Database: An Open Dataset of Exercise Referral Schemes Across the UK. *International Journal Environ Res Public Health,* 2021; 18(9): 4831.

[30] Wade M, Mann S, Copeland RJ, et al. The effect of exercise referral schemes upon health and wellbeing: Initial observational insights using individual patient data meta-analysis from The National Referral database. *J Epidemiol Community Health*. 2020; 74(1): 32-41.

[31] Prior F, Coffey M, Robins A, et al. Long-Term Health Outcomes Associated with an Exercise Referral Scheme: An Observational Longitudinal Follow-Up Study. *J Phys Act Health.* 2019;16(4):288-293.

[32] Morgan K, Rahman M, Moore G, et al. Patterning in Patient Referral to and Uptake of a National Exercise Referral Scheme (NERS) in Wales from 2008 to 2017: A Data Linkage Study. *Int. J. Environ. Res. Public Health.* 2020; 17:3942.

[33] Downey J, Shearn K, Brown N, et al. Behaviour change practices in exercise referral schemes: developing realist programme theory of implementation. *BMC Health Services Research,* 2021; 21:335.

[34] Dodd-Reynolds CJ, Vallis D, Kasim A et al. The Northumberland Exercise Referral Scheme as a universal community weight management programme: a mixed methods exploration of outcomes, expectations and experiences across a social gradient. *Int J Environ Res Public Health,* 2020; 17(15): 5297.

[35] Hanson C, Dodd-Reynolds CJ, Oliver EJ, et al. A modified Delphi study to gain consensus for a taxonomy to report and classify Physical Activity Referral Schemes (PARS). *International Journal of Behavioral Nutrition and Physical Activity,* 2020; 17: 158.

[36] Moore J, Merchant Z, Rowlinson K, et al. Implementing a system-wide cancer prehabilitation programme: The journey of Greater Manchester's 'Prehab4cancer', *European Journal of Surgical Oncology,* 2020.
[36] Kingdon JW. *Agendas, alternatives, and public policies*, 2nd ed.; Longman: New York, 2003.

[37] IJzerman H, Lewis NA, Przybylski AK. et al. Use caution when applying behavioural science to policy. *Nat Hum Behav.* 2020; 4: 1092–1094.

Conflicts of Interest

The authors have no conflicts of interest to declare.

Acknowledgement

JH was funded in part by the Centre for the Development and Evaluation of Complex Interventions for Public Health Improvement (DECIPHer), a UKCRC Public Health Research Centre of Excellence. Joint funding (MR/KO232331/1) from the British Heart Foundation, Cancer Research UK, Economic and Social Research Council, Medical Research Council, the Welsh Government and the Wellcome Trust, under the auspices of the UK Clinical Research Collaboration, is gratefully acknowledged.

386 *Table 1: Summary of lessons learnt and future directions for community-based physical activity prescription*
387

Lessons learnt	Recommendations for future action
Outcomes can be enhanced by co-designed schemes and through processes that enable iterative refinement of delivery.	Scheme development (and ongoing refinement) should involve stakeholders that represent all facets of the delivery process. This should include commissioners, referring health professionals, service managers, practitioners and service users. For more holistic, systems-level approaches, there may also be value in including local sports development, community liaison, social prescribers/link workers, physical activity officers, and clinical representatives. It must be recognised that complex interventions take time to develop, thus smaller-scale pilots might be useful prior to wider implementation. Commissioners and service providers should be open to altering delivery approaches, including post-contract award.
There are important differences in how individuals access and respond to schemes, with some concerns evidenced about groups experiencing health inequalities. Some good practices regarding inclusion are emerging.	We echo NICE's research recommendations[3, 4] that work should aim to identify differences in scheme effectiveness based on socioeconomic statues, age, gender and ethnicity. We call for enhanced data collection and reporting regarding other characteristics linked to health inequalities, and at the intersections of these identities. Reporting is not enough. In addition, commissioners and researchers should design and develop new methods of delivery to support those who evidence has do not engage with or benefit from traditional

	schemes. These underserved and/or underrepresented groups include: people from black and minority ethnic groups, people with multiple co-morbidities, and people with a mental health condition. Monitoring, evaluation, and commissioning frameworks should capture, recognise, and reward the impact of schemes on these and other underserved groups.
The impact of operational context on scheme delivery, performance, and sustainability is potent.	Consideration needs to be given to how behaviour change can best be supported within complex operational systems. Behaviour change principles can be integrated on multiple levels within schemes (e.g., within the scheme design, training for staff, integration of behaviour change techniques and via education for service users within service delivery). Evaluation approaches should appropriately capture and report relevant contextual details as standard. This should be complemented by work understanding the nuances of complex delivery systems involved in physical activity prescription. Work that shares and contrasts both intra- and inter-national data is particularly required, to amalgamate learning from different policy, funding, political, and structural contexts.

Standardised evaluation is an established monitoring and evaluation approach within the public health landscape, but has not consistently been applied within the exercise referral field.	Variability between schemes represents opportunities for natural experiments; however, subsequent collation of evidence for comparative trials requires better quality minimum datasets. We echo NICE's[3] recommendations that data is collected as standard concerning: programme and evaluation details, participant demographics, baseline and follow up data, and process evaluation. Recognising that data collection and evaluation is often underfunded and/or time-pressured, researchers, commissioners, and service providers should work together to design, adopt, and share viable data collection approaches. Emerging examples are promising but require wider implementation. Regional, national, and international systems for sharing evidence and good practice across and between schemes are needed. The 2018 removal[4] of NICE's recommendation to develop a centralised system for collating local data was unhelpful in this regard. Some systems exist (e.g., the UK's National Refer-All Database), but wider scheme engagement is unlikely without changes to access and/or commissioning requirements.
The evidence base concerning exercise referral is still fragmented; wider perceptions of exercise referral need addressing.	Community-based physical activity prescription needs to continue to develop from its reputation and practices as gym-based "exercise referral" to reflect the diversity of needs, preferences, and opportunities for supporting activity uptake available.

	Framing evidence, and communicating the benefits of the evidence, clearly to policy makers and commissioners, is vital for expanding its use and impact. Researchers should ensure they communicate the importance and relevance of findings to those in wider system roles. Stakeholders concerned with exercise or physical activity prescription, or similar models (e.g., social prescribing), should be receptive to the complexities of service delivery, and recognise the need for diverse research designs to capture learning.

388