



Title: Implementation of the Healthy and Active Rehabilitation Programme in Ayrshire and Arran (Multi modal and multidisciplinary

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Description

The Healthy and Active Rehabilitation Programme (HARP) was designed to build on the evidence of single condition rehabilitation to target people affected by multiple long-term conditions who have the biggest impact on unscheduled care admissions. By applying the principles of a multi modal exercise and education model to support lifestyle modification it was possible to investigate outcomes and build an evidence base for this new model. The project was set up by a multi-agency collaboration between health, social care, leisure as well as third sector partners, who worked collaboratively to produce a sustainable generic approach to rehabilitation. To reduce health inequality HARP situates its clinics and classes in areas of rurality and/or deprivation. HARP was designed as a four-tiered model with people able to move between levels depending on need.

Introduction

Around two million people in Scotland are living with at least one long-term condition and the number of people living with more than one condition (multi-morbidity) increases with age. At present around 27 per cent of people in Scotland aged 75-84 have two or more conditions

It was recognised that a new model of rehabilitation was required that takes account of the increasing prevalence of chronic multiple morbidities facing our ageing population, however there was no evidence initially for this new model of support. The model was designed initially to

- Develop and test a new model for delivering evidenced based rehabilitation, and health and well-being programmes.
- Develop general/specialist skills for working with people with multi-morbidities at tier 3 across localities that can be shared and used to inform future practice with this complex client group.
- Develop the role that volunteers can play in supporting individuals with multi-morbidity, both in building assets within local communities and in working with individuals
- Develop a robust evaluation strategy



Method

The team background is cardiac rehabilitation, the team wished to include people with angina and atrial fibrillation in the programme. In order to achieve this there was an application made to the Integrated Care Fund with the offer of New Tier 3 Multimorbidity Rehabilitation to increase service options and access to more groups of people experiencing multiple long-term conditions. The project was designed collaboratively, working with health partners as well as community partners. An approach based on PDSA principles was adopted. The tiers were designed with condition specific specialists. As each new condition was brought on board to be assessed the knowledge and skills of the team members were enhanced by inclusive an inclusive training programme. We invited AHP's, and our leisure partners to training events where we invited specialists locally and nationally to present and form partnerships with us. To keep up with challenges that arose during the project we started an issues' log that anyone could submit, these were compiled, answered with a solution and shared again back to all staff. Evaluation looked at staff needs, team training, service and people outcomes, case-studies. As evaluation

occurred HARP evolved continuously, for example, looking at people who failed to attend showed that most were experiencing persistent pain. We then did further training for the team in this area and brought it in as an education topic. The project enhanced the relationship between people in all the tiers and people were able to move between tiers in a flexible way.

Outcomes

- The project successfully demonstrated it was financially viable using EQ5DL by coming under the cost effectiveness threshold of £30,000 for quality adjusted life year.
- Visual Analogue Scales show an average 20-30% improvement across all quality of life measures.
- Emergency admission data was examined in three groups of age and sex matched individuals who had been referred to HARP. In those who completed the 10-week programme they demonstrated a 70% reduction in bed days one year post intervention.
- Two volunteer roles have been created and a third role is under development and about to be piloted. Our volunteers have high levels of satisfaction and deliver peer support to many of our service users in classes and group settings. Two of our volunteers won Ayrshire Achieves.
- We have been recognised nationally in the work we are doing and have a Scottish Government meeting following a poster merit from NHS 18
- Feedback from participants in Kilbirnie (a small, rural town with high levels of deprivation) told us that they would not have travelled for these classes, but the effect on individuals had been transformative, emphasising the importance of local targeted interventions in areas of inequality.

	Aim	Outcome Measures	Results
Tier 1 Community assets	- Develop volunteer role within new programme - Improve Links with community groups - Self referral	- Input to community groups - Positive exit destinations for clients i.e. volunteering	Volunteer programme= 21 Improved links between tier 1/2 Moving on together : 6 classes Weigh to go 37% losing 5%
Tier 2 SA Leisure/vibrant communities/KA leisure	- Develop general/specialist skills for working with people with multi-morbidities - Supported self management programme	- Staff knowledge - Referral process - Cost effectiveness - Behaviour change i.e. activity levels at 1 year - Links with tier 1	~2000 referrals since Mar 15 >800 referrals/year >6000 fitness sessions - Review of individual outcomes ongoing - Improved knowledge of staff
Tier 3 Health and well-being for complex multiple conditions	- Develop general/specialist skills for working with people with multi-morbidities - Supported self management programme - Tiers developed and agreed	- Referral process - Cost effectiveness - Bed days - Impact on Patient outcome	590 referrals since Nov 15 - Improved patient outcomes - Awaiting cost effectiveness data analysis - Awaiting healthcare utilisation data
Tier 4 Specialised rehab programmes	- Develop general/specialist skills for working with people with multi-morbidities - Adjust referral utilising HARP resource	- Referral to lower tier programmes - Qualitative review - Number of education sessions for staff	- Improved knowledge of specialist staff - Improved referral to tier 2 - Changes to current service provision - Tests of change

The Staff Journey

"The changes we've made to people's lives. Some of the individual journeys have just been amazing..... the impact.....people saying 'I wouldn't be here today, if it wasn't for this class'"

"From a nursing perspective, it's just made everything that we do better. Thinking initially that this would dilute our identity as a cardiac specialist nurse, it has absolutely not done that...it has enhanced it, and made me more confident to ask questions and broach other subjects (than cardiac) with patients...the barriers are away...I can speak to patients about anything. I don't think we can ever go backwards now."

"The whole thing is more like a community now"

Apprehension	For Patient	Safety
		Quality
	For Service	Quality
		Overall 'fit'
Confidence Growth	For Self	Master of all
		Dilution of specialist skill set
	In Service	Willingness to promote
		Enhanced referrer awareness
Patient Experience	Within Self	Realisation of pre-existing competence
		Training
		Role enhancement
	Care	More holistic
Integrated Working		Better choice / individualisation
		More seamless pathway
	Comparison	Within the peer group
		With Tier 4 CR population
Awareness		As HARP has evolved
	Support	Services and roles within HARP tiers
		Wider HSC landscape
		Across tiers
Volunteers		

[3 focus groups of tier 2-4 staff; nursing=8, physiotherapy=2, OT=1, leisure=7 (n=18 total)]

Key Learning points

That a multi-modal multimorbidity rehabilitation model is safe and effective. The staff journey is just as important, and requires to be alongside the change, transformation of a service is possible. Landaeta et al (2008) identify thought processes common to healthcare change, several of which were apparent within discussions around apprehension. Specifically, there was concern that delivering HARP would be at the expense of the existing care and service (the 'cannibalisation cost' of the change), plus the perception that they lacked capability to deliver the change. To overcome such barriers, Landaeta et al (2008) advocate that - as occurred during the transition to HARP, staff have the opportunity to help shape the change, which enables them to challenge their own embedded work routines and pre-existing ideas about practice.

The aim of this work was not to diminish single condition rehabilitation but to build a more inclusive model and show its effectiveness.

This model is about tertiary prevention- focusing on managing established diseases to reduce complications, improving Quality of Life, and preventing further deterioration.

As HARP progressed the caseload became more complex, in order not to create a service bottleneck the relationship and support of leisure has to be ongoing and evolving.

The future includes recovery of classes from Covid, working with people affected by Long Covid, seeking opportunities of delivering rehabilitation through a locally delivered walking groups.

Advice is determination, coproduction and relationships, backed up by funding to support a transition with staff knowledge and skill development being part of that journey.

References

Landaeta et al, Int. J. Healthcare Technology and Management, Vol. 9, No. 1, 2008