Public Health England

Protecting and improving the nation's health

# Rotherham Active for Health

| Which family of community centred approaches does your project relate to? | | | |
|---|---|---|---|
| Strengthening communities | Volunteer and peer roles | Collaborations and partnerships | Access to community resources |
| □ community development<br>□ asset based methods<br>□ social network approaches | □ bridging<br>□ peer interventions<br>□ peer support<br>**X peer education/mentoring**<br>□ volunteer health roles | □ community-based participatory research<br>□ area-based initiatives<br>□ community engagement in planning<br>**X co-production projects** | **X pathways to participation**<br>□ community hubs<br>□ community-based commissioning |

## 1) Title and author

**Rotherham Active for Health**

Submission Author: Functional Fitness (Delivery Partner)
Programme Author: RMBC Public Health (Commissioners)
Funding Sources: Sport England / RMBC Public Health / Rotherham CCG
Research Partner: Sheffield Hallam University (Centre for Sport & Exercise Science)
Delivery Partners: Functional Fitness / Places Leisure / Speakup Self Advocacy

## 2) Brief summary

A multi-agency approach to the delivery of condition specific exercise for people with cancer, chronic obstructive pulmonary disease (COPD) musculoskeletal (MSK) lower back pain, falls prevention, stroke, cardiac and heart failure. The programme linked healthcare to specialist community-based exercise rehabilitation.

## 3) What was the timescale for the project?

November 2015 – October 2018

## 4) What was the setting and population covered?

The programme was a borough wide project targeting people with at least one of the 7 long term conditions and who were registered with a Rotherham GP. The community-based approach used various settings to deliver the specialist exercise provision

including community centres, church halls, leisure centres and country parks. The programme is built on a 3 Step model (1. **Rehabilitation** – 2. **Moving On** – 3. **Keeping Active**) requiring a health professional referral and sign off to access the provision delivered by a Level 4 exercise specialist (REPs). Delivery partners liaised directly with acute rehab services to generate referrals and forge a seamless pathway into community-based exercise rehabilitation.

## 5) What were we seeking to achieve?

The 3-year evaluation set out to understand how effective Active for Health was in providing condition specific support via physical activity pathways for seven long-term conditions. The evaluation aimed to:

1) Understand how Active for Health influenced physical activity behaviour across seven long term conditions
2) Assess the impact of the programme on quality of life
3) Understand what works for each pathway and why?
4) Explore the delivery experiences of health care professionals, providers and the project management team
5) Explore the participation experiences and understand activation levels from patients
6) Assess the cost effectiveness of the programme.

## 6) Why did we decide to take action?

'Active for Health' was informed using pilot data from a local falls rehabilitation pathway. The work identified that after 12 weeks, the majority of patients improved their function, confidence and one third of patients were at a lower risk of falling. The continuity of delivery, the role of the Exercise Specialist, engagement of healthcare professionals (HCP's) and social and physical outcomes were essential for maintenance. Using pilot findings, stake holder knowledge and insights, Rotherham Public Health designed seven exercise pathways, specifically for priority long term health condition groups. The project looked at Level 4 condition specific exercise provision as a pre-requisite, rather than the mainstream Exercise Referral delivery.

## 7) What did we do?

A quasi-experimental research design with mixed methods was used to obtain qualitative and quantitative data which explored the impact and implementation of Active for Health. Methods included self-reported outcome measures (physical activity, quality of life and NHS service use) and semi-structured interviews which explored the experiences of all key stakeholders. Three evaluation approaches were used; formative, outcome and process evaluation.

RMBC Public Health commissioned two deliver partners, including Functional Fitness / Speakup Self Advocacy (cancer, stroke, COPD, MSK lower back pain, falls prevention) and Places Leisure (cardiac, heart failure). Each organisation managed a team of Level 4 Exercise Specialists who were responsible for delivering the condition specific exercise

and liaising with health care professionals across each step of the programme to generate and engage referrals.

Public Health coordinated a buddying scheme which was managed out in the community by the delivery partners and monitored internally. These buddies were a mixture of Step 3 participants who had already gone through the programme and who were great advocates, as well as local volunteers with a natural interest in supporting this area of work. The buddies sometimes accompanied the exercise specialists on their acute Step 1 visits to NHS rehabilitation services, for example; a buddy and cancer pathway participant would speak to people in rehabilitation and give them an insight into their engagement and experience on the Active for Health programme. Our 30-minute social time with refreshments after exercise was also a great place to forge new friendships and get some welcomed peer support from the buddies. This was recognised as an important element for both physical and mental wellbeing and long-term adherence to physical activity.

A community-based approach was adopted due to the findings and response from people involved in pilot work (see more below). People expressed their desire to attend venues and provision close to home that were accessible. Not everyone felt comfortable attending a leisure centre, therefore, local churches, halls and community centres played a key role in delivery.

Public Health worked strategically with healthcare professionals and provided training and development on the benefits of physical activity and exercise for people with long-term conditions and provided information on how to make a referral. Sheffield Hallam University carried out the evaluation.

**8) Why did we choose this approach?**

The approach was developed from intensive pilot work undertaken at both local and regional level originally with a falls programme, which resulted in published research papers. The approach was further developed from the recommendations of the pilot work alongside the need locally from healthcare services. The model was also developed utilising appropriate guidance, and quality assurance (NICE, Reps, CMO etc.), which was an important element in engaging healthcare professionals.

We worked within a funded budget to test the approach and gather the evidence. The programme could be extended if the budget allowed.

The approach is dependent upon healthcare service buy-in and integration into healthcare service pathways in creating a successful sustainable model. Co-production was high on the agenda from the start and at the forefront of the development, delivery and evaluation of the programme.

The reason for the buddying scheme was to identify real life advocates of the programme who could share their own positive experiences and encourage new referrals. Because the buddies had a something in common with those who attended the class, new referrals coming through immediately felt connected and at ease with the people, the environment and the programme.

## 9) What was the outcome?

**Economic Analysis:**

- There is a 93% chance that the intervention is cost saving
- There is a 99% chance it improves health
- When considered together there is a 99% chance that it is cost-effective at a threshold of £20,000 per QALY gained

**Cost Saving Analysis Per Person Per Pathway: (No. engaged over 3 years)**

- Cardiac Phase IV = **£1,709** **(269 people)**
- Heart Failure = **£1,392** **(57 people)**
- Stroke = **£3,479** **(105 people)**
- COPD = **£2,565** **(159 people)**
- Cancer = **£2,382** **(173 people)**
- MSK = **£624** **(405 people)**
- Falls Prevention = **£757** **(292 people)**

  (The COPD result needs further analysis, but it is envisaged that due to the debilitating disease, people's health decreases over time which comes with an added cost. We also recognise that the condition can exacerbate with seasonal variations which might have had an impact on when the consultation took place).

**General Analysis:**

- The study observed a reduction in health service use across **all** chronic disease pathways and in all aspects of healthcare, including GP use, specialist visits, admissions, A&E attendance and inpatient bed days.
- Active for Health increased the proportion of patients who undertook one 30-minute bout of moderate to vigorous physical activity (MVPA), from 30% to 90.5%.
- Perceptions of Quality of Life (QoL) improved throughout the first three months of Active for Health measured by a Visual Analogue Scale (VAS). Health status improved on average from 65 to 75.
- A decline in QoL was observed after six months, suggesting that specialist Level 4 Instructors could be critical in helping people to maintain QoL. However, health status improvement scores still remained higher at 12 months than at baseline.
- 15% of patients reported losing at least one day of work due to ill health within the previous 12 months. This decreased to 6.3% among patients who engaged with Active for Health for 12 months.

## 10) What did we learn?

***What went well***

The average age of referrals across the three years was 65 years. When you consider an individual with a long-term health condition at this age and older, many will be in their last 10 years of life, where they are generally less mobile, less independent, in poorer health and experiencing reduced quality of life. These individuals are often socially isolated and one of the greatest financial burdens to the NHS. We are extremely proud to have been able to reach out through Active for Health to these people who are often the hardest to engage and the ones who require the most support in the community.

Building a professional team of exercise specialists with the knowledge, understanding and transferable skills to engage and support people with long term conditions into regular physical activity was a challenge but a major success and one of the reasons why people adhered to the programme and continue to support its legacy.

We are delighted of our conversion rates from Step 2 (Moving On) into Step 3 (Keeping Active – After the 12-week intervention) which indicates long-term adherence to physical activity. These were as follows:

- Falls Prevention **(60%)**
- COPD **(78%)**
- Stroke **(78%)**
- Cardiac **(90%)**
- Cancer **(56%)**
- MSK Lower Back Pain **(43%)**

(Cancer and MSK were the most activated patients, which is reflected in the conversion rates, because as they recovered, felt better after their illness/disease they would tend to revert back to their daily routines like work, family commitments etc.).

Very early on in the project we realised the importance of allocated social time. Allowing time for people to connect, socialise and support each other after the session was a major hit. People became attached to their group and their peers who would offer guidance, support and encouragement during their weekly visit and back at home during everyday life. The fact that we still have 7 sustainable pathways 12 months after the programme is a true testament to this newfound community and the 3 Step sustainable model.

It goes without saying we are very pleased with the evaluation and the result of the economic analysis as mentioned above.

***What didn't go so well***

The paperwork and admin time required to undertake such a large community project was massively underestimated including phoning/chasing referrals, monitoring, consulting with healthcare professionals and patients. Future programmes should consider an admin team who are equipped to deal with the referral process.

The referrals were heavily dependent upon people being discharged from NHS rehabilitation services. This dictated and restricted the flow of referrals. Moving forward more work needs to be done around GPs and the primary care networks so that more people can benefit and access provision.

Embedding the project at strategic level was a challenge, until the results were published; be mindful of timescales for commissioning and reports and align appropriately.

Don't underestimate the time and resource required to truly engage services and achieve co-production. It is also essential that this partnership work and communication is factored in post funding to ensure a sustainable legacy is achieved.

If it was not for a whole system approach, this project would not be sustainable and have a proven legacy. Engaging the correct services and integrating Active for Health into healthcare pathways is and was imperative.

Quality/purposeful outcomes – we would not have got the impact/health gains without delivering specialist Level 4 exercise provision (REP's) appropriate to the needs of the patients. We aligned Active for Health delivery to appropriate guidance and all sessions were delivered by a qualified Level 4 Exercise Specialist in each condition. All instructors carried more than one REP's Level 4 qualification which gave them transferable skills to work with other comorbidities. This was also vastly important for both patients and primary and secondary care services who require a significant level of assurance and confidence before referring anyone into the community.

Keep the monitoring process simple. Have a system that is easy to input and extract data from at any point during the life course of the project.

***What is most transferable to other projects, other people and other places***

A model that has been piloted, tested and evaluated and can evidence improvements in health and cost savings for patients across seven long-term conditions. This model can easily be scaled up, modified to suit service provision and picked up and delivered in other areas. However, having a competent, professional, experienced and well managed team of exercise specialists is essential…Remember people buy into people, so your workforce needs to be right!

We are in the process of piloting the model across other long-term health condition pathways i.e., Mental Health, Multiple Sclerosis, Disability, as we believe there to be no reason why we cannot replicate this success.

***Evaluation***

An Independent **Full Evaluation and Peer Review** were undertaken by Sheffield Hallam University.

As part of the evaluation process patients, health care professionals and leisure providers were all interviewed. In summary key topics, recommendations were highlighted by the stakeholders:

**Patients** were positive about their engagement and the importance of suitable exercise to prevent exacerbation of their long-term health condition. They also mentioned social support during and after the exercise and the reassurance they got from having qualified, professional staff delivering the sessions.

**Healthcare Professionals** mentioned the importance of a simple, streamlined referral process and were encouraged by a condition specific pathway where the instructor was appropriately qualified. Trust and clarity between HCPs and leisure providers was essential across all aspects of the programme.

**Leisure Providers** commented on how key partnerships across the healthcare system were crucial in strengthening the referral process and ensuring people had easy access into community-based rehabilitation. The social buddies were instrumental in supporting people in the classes but also at arranging social activities external to the class which increased patient motivation and adherence. Celebrating birthdays and engaging in Christmas parties were all activities which naturally evolved over the life course of the programme. The Level 4 pre-requisite standard for delivery was a great benchmark in gaining confidence both from the patients and the HCPs.

Also see the **Active for Health BJSM published paper** (published interim results). Both documents can be accessed at the link below:
**https://www.functionalfitnesstrx.co.uk/activeforlifesolutions**

**11) What is the single most important one line of advice which we can give to others starting a similar project? [Word limit: 20]**

Consider the time/resource to engage and embed physical activity-based projects within the healthcare system, which is vital to sustainability.
A project is only as good as the people delivering it!

**12) What is happening next with this work?**

In the short term – Raise the profile of the report published in September 2019 at local, regional and national levels, to showcase the evidence and positive outcomes such a project can have on patients with long term conditions. We will continue to work at a local level with healthcare professionals and health services to ensure every patient in Rotherham is offered the opportunity to access the Active for Health Legacy programme.

In the medium/long term - We are currently engaging with new partners across various conditions and pursuing opportunities to extend the programme into other conditions and potentially across other geographical areas. We believe Active for Health has the potential to be co-produced across any given long-term health condition and feel that building on this evidence must be our number 1 priority! Strategically, we aim to build a strong working relationship with the local primary care networks.

**13) Where can people find out more?**

**Rotherham Active for Health Full Evaluation / BJSM Interim Results / Promotional Video:** https://www.functionalfitnesstrx.co.uk/activeforlifesolutions

**Falls Pilot Work (Research Paper):**
https://www.tandfonline.com/doi/abs/10.1080/09593985.2017.1328721

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