Healthy Active Rehabilitation Programme

HARP

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Healthcare in Scotland: The current situation

- Health Boards and Integrated Health and social care partnerships
- Realistic medicine
- National clinical strategy
- Integrated Care Fund
- Multi-Morbidity Action plan
A growing problem

- The majority of over-65s have 2 or more conditions, and the majority of over-75s have 3 or more conditions.
- More people have 2 or more conditions than only have 1.
- There are more people with multi-morbidity aged <65 than aged ≥65 (MM is more common in older people, but there are many more middle aged.)
Multi-Morbidity in Scotland

![Graph showing the percentage of patients with zero to eight conditions across different age groups.](image-url)
### Long Term Conditions: The scale of the challenge (2)

<table>
<thead>
<tr>
<th>Condition</th>
<th>% of patients with condition</th>
<th>% who also have this condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coronary heart disease</td>
<td>18</td>
<td>52</td>
</tr>
<tr>
<td>Hypertension</td>
<td>59</td>
<td>57</td>
</tr>
<tr>
<td>Heart failure</td>
<td>29</td>
<td>61</td>
</tr>
<tr>
<td>Stroke/TIA</td>
<td>23</td>
<td>54</td>
</tr>
<tr>
<td>Diabetes</td>
<td>19</td>
<td>33</td>
</tr>
<tr>
<td>COPD</td>
<td>14</td>
<td>34</td>
</tr>
<tr>
<td>Cancer</td>
<td>14</td>
<td>34</td>
</tr>
<tr>
<td>Painful condition</td>
<td>16</td>
<td>36</td>
</tr>
<tr>
<td>Depression</td>
<td>10</td>
<td>23</td>
</tr>
<tr>
<td>Schizophrenia or bipolar</td>
<td>6</td>
<td>16</td>
</tr>
<tr>
<td>Dementia</td>
<td>21</td>
<td>41</td>
</tr>
<tr>
<td>Any other condition</td>
<td>11</td>
<td>27</td>
</tr>
</tbody>
</table>

Data from the Scottish School of Primary Care’s Multimorbidity Research Programme.
Emergency and potentially preventable admissions

Annual admission rate per 1000 patients

- Potentially preventable admission
- Other emergency admissions

No of conditions

<table>
<thead>
<tr>
<th>No of conditions</th>
<th>Potentially preventable admission</th>
<th>Other emergency admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>20</td>
<td>3</td>
</tr>
<tr>
<td>1</td>
<td>31</td>
<td>5</td>
</tr>
<tr>
<td>2</td>
<td>51</td>
<td>9</td>
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<tr>
<td>3</td>
<td>74</td>
<td>14</td>
</tr>
<tr>
<td>4</td>
<td>115</td>
<td>21</td>
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<tr>
<td>5</td>
<td>151</td>
<td>34</td>
</tr>
<tr>
<td>6</td>
<td>200</td>
<td>47</td>
</tr>
<tr>
<td>7</td>
<td>242</td>
<td>64</td>
</tr>
<tr>
<td>8</td>
<td>318</td>
<td>85</td>
</tr>
<tr>
<td>9</td>
<td>342</td>
<td>100</td>
</tr>
<tr>
<td>10+</td>
<td>479</td>
<td>151</td>
</tr>
</tbody>
</table>
Objectives of MM action plan

- Make every health and care contact an enabling experience and an opportunity to improve health and wellbeing.
- Support staff to learn from each other so that specialist staff have better general skills, and staff in community teams develop extended roles.
- Managed Clinical Networks work together to develop care and support pathways and guidelines that make sense for people who have multiple conditions. This will help individuals and staff to make the right decisions, and will ensure people with multiple conditions have the right care, support and rehabilitation, including support to remain in work.
- Identify people with multiple conditions so that they can access the right level and type of care and support as their needs change. This should include coordinated health and care services, along with support from peers, third sector and use of technology.
Designing a Multi-morbidity service
Evidence Base

- Some small studies of mixed groups
- Strong evidence for Cardiac and pulmonary
- Some evidence for Cancer, Stroke and Falls
- No evidence could be found of a programme suitable for all.
Project brief

- Three Health and Social care partnerships
- Funding £168,000 for Health (plus LA funding)
- Health and well being programme based on CR/PR
- One of CHD, Cancer, Stroke, Falls, Respiratory
- Plus at least one other condition
- 360 places a year
- 6 classes and 6 clinics across Ayrshire
- Different tests of change across the partnerships
Partners

- Local leisure
- Voluntary sector
- MCN’s
- HSCP
- Individuals with MM
- Multi-Disciplinary Rehabilitation teams
- Keep well
What is HARP

- Multi morbidity will provide a multidisciplinary assessment from a nurse and a physiotherapist who specialise in supporting lifestyle change and promoting self-management. They also have the skills to identify appropriate red flags that would mean further medical advice may be necessary. The patient will then be offered a menu of services which could include:
  - Class based exercises
  - Home based exercises
  - Dietary advice / Weigh to Go
  - Self management advice
  - Moving on Together
  - Smoking cessation
  - Psychological support
Outcomes

The expected outcomes for the project are:

- Participants feel able to make positive personal decisions about their health and well-being and receive the support they need to achieve their aims.
- Participants live as independently as possible and play an active role in their community.
- Participants are engaged in the design and delivery of the generic rehabilitation model and it is tailored to local need utilising the skills and expertise of volunteers and building community assets.
- Participants benefit from improved lifestyles, health and quality of life.
- Staff engaged in caring for individuals with multi-morbidity, learn from each other and pathways and guidelines will be developed that make sense for people who have multiple conditions.
Tiers of Rehabilitation

Tier 4
- Specialist evidence based rehab programmes
  - Cardiac rehab, pulmonary rehab (Stroke, cancer group 1-1)

Tier 3
- Evidenced based health rehabilitation health and well-being programmes for people with co-morbidities

Tier 2
- Local linked leisure programmes for people with long term conditions and co-morbidities

Tier 1
- Community and voluntary exercise and activity groups, walking groups, Buddies
Workstreams

- Training:
- Volunteer development:
- Service development:
- Evaluation
Training:

- Formal lecture programme on all conditions
- Shadowing of different specialities
- Sharing of practice
- Additional BACPR training for leisure
- History taking and clinical assessment
Volunteer development

- Volunteers involved in programme
- Development of job profile for volunteer helper
- Third sector engaged
- Activity buddies being trained
Service development:

- Based on Cardiac Rehabilitation standards
- Development of Tiers
- Referral process and paperwork
- Staffing in place
- 6 additional classes
- Classes started end of Nov
- 400 referrals by 1/10/16
# Tiers for referrers

## Multi-morbidity tiers

<table>
<thead>
<tr>
<th>Pulmonary</th>
<th>Cardiac</th>
<th>Cancer</th>
<th>Stroke</th>
<th>Falls</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tier 4</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pre and post-lung transplant</td>
<td>Cardiac Surgery</td>
<td>Anyone being treated with palliative intent</td>
<td>Patients that require highly specialised treatment for tone and facilitation of normal movement.</td>
<td></td>
</tr>
<tr>
<td>Interstitial lung disease</td>
<td>Myocardial Infarct</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Brittle asthma</td>
<td>Heart Failure</td>
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<td></td>
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<tr>
<td>O2 dependent</td>
<td>Percutaneous coronary intervention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRC =5 COPD</td>
<td>Implantable Cardiac</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRC=3/4/5 with frequent admissions</td>
<td>Defibrillator</td>
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</tbody>
</table>

## Multi-morbidity

<table>
<thead>
<tr>
<th>Pulmonary</th>
<th>Cardiac</th>
<th>Cancer</th>
<th>Stroke</th>
<th>Falls</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tier 3</strong></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>MRC ¾ who can self manage.</td>
<td>Stable cardiac conditions:</td>
<td>Patients on active treatment</td>
<td>TIA’s who require support to change lifestyle.</td>
<td>To act as a screening service to identify and signpost to further input.</td>
</tr>
<tr>
<td>Bronchiectatics</td>
<td>Angina</td>
<td>Lung Cancer</td>
<td>Referrals from stroke clinics.</td>
<td></td>
</tr>
<tr>
<td>Stable Asthma</td>
<td>Pacemaker</td>
<td>Myeloma</td>
<td>Patients who require support to manage symptoms e.g fatigue, exercise</td>
<td></td>
</tr>
<tr>
<td>Lung cancer</td>
<td>Controlled Atrial Fibrillation</td>
<td>Bone disease/known metastasis</td>
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<tr>
<td></td>
<td></td>
<td>Fluctuating blood counts</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Anorexia/cachexia</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Cancer related osteoporosis</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>A requirement for symptom management</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>High DVT risk patients</td>
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</tbody>
</table>

## Leisure services

**Tier 2**

Referrals from Tiers 3 and 4 for ongoing support and to maintain physical activity levels.

## Community sector

Community and third sector organisations.

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*NHS Ayrshire & Arran*
Evaluation

- Three stage approach
  - Strategic outcomes
    - Numbers assessed
    - Interventions carried out
    - Impact on organisation
  - Individual outcomes
  - Qualitative outcomes
Referral Source

Consultant
Other AHP
Specialist nurse
GP
Practice nurse

total
Referral Primary Diagnosis

- Cardiac
- Respiratory
- Cancer
- Stroke
- Falls
Strategic outcomes

- Numbers referred = 334
- Numbers assessed = 261
- Interventions carried out
  - Transferred tier 7%
  - HARP 52%
  - Part programme 13%
  - UTA 6%
  - FTA 22%
- Impact on organisation
Individual outcomes (provisional)

- Physical activity: Increased from 30% to 64% at or near guidelines
- Waist: went from 22% at guidelines to 44% at guidelines or made improvements
- BP: went from 61% at target to 85% at or improved to target
- Visual Analogue scales: all improved from 16-75%, all areas
- Health Thermometer: improved by 18%
Mr D, aged 60, has angina and diabetes.

At assessment, Mr D was clinically obese and had abnormal blood sugar and cholesterol levels. His mood was low.

Commenced the HARP programme, accessed weigh to go, exercise programme and moving on together.

Referral for HARP.

Mr D’s wife also has now been referred to HARP. She asked to go when she saw the improvements in her husband.

Mr D’s general health has improved. Blood sugar is stable. Blood pressure and cholesterol are within normal limits. He is able to exercise more and self-manage his condition.

Achieved target weight loss of 5% = 1 stone 1lb.

6 Months:

Taking part in community activities. Achieved target weight loss of 10% = 2 stone 2lb.

Volunteered as activity buddy.

Mr D’s wife also has now been referred to HARP. She asked to go when she saw the improvements in her husband.
Patient Anecdotal Feedback

I wondered if it was right for me, but having tried it, it was right for me.

I have spent a year mixing with people with cancer, but mixing with others is so useful.

I go home knackered but I'm so glad I came.

The condition is not important; we are more interested in peer support.
Staff Anecdotal Feedback

Patients are saying that the programme is working for them and we need to continue it.

My patient was dancing down the corridor after achieving their 5% weight loss.

I really didn’t want to do this, but it is not so different and I have learned so much.

Doing this means I am more comfortable when I talk to patients in cardiac rehab about their other conditions.
Applying Evidence to Practice

Key Messages:

• Multi-morbidity is one of the largest challenges we face

• Cardiac Rehabilitation programmes face increasing numbers of patients with multiple conditions

• There is little evidence for generic rehabilitation

• Exploratory work in NHS Ayrshire and Arran suggests there may be benefit to developing this concept further

#bacpr2016