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Poster Abstract

The evolution of physical activity: from health to leisure

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Abstract

Introduction: In order to facilitate delivery of a musculo-skeletal (MSK) service in adherence with the evidence base outlined in the National Physical Activity Implementation plan for care pathways, which include physical activity as part of the recognised treatment for many long term conditions and physical limitations due to disability, in a climate of reduced funding and waiting time targets, our department undertook a service wide redesign to deliver a supported continuum of integrated care for our patients, from healthcare to self-management in the community.

Practice change implemented: A process of skill mix was undertaken to facilitate the creation of 2 unique roles; Exercise Specialist and Community Health and Activity Officer. The development of these roles included leisure staff in the healthcare setting and healthcare staff in the local authority/leisure environment. Following a substantial pilot, post holders created two symbiotic services; PACE (Physical Activity and Community Education) service within East & Midlothian Physiotherapy service and ACE (Active Choices in East Lothian) in East Lothian Council.

These changes ensured patients were fully supported from MSK health care to community, through the development of a clear and simple clinical pathway.

Aim and theory of change:
1. Reduce MSK waiting times by challenging conventional models of care
2. Support change of physical activity behaviour in line with Transtheoretical Model of Behaviour Change [1]
3. Normalise activity in the community through promotion of independent lifestyle change

Targeted population and stakeholders: The targeted population is all MSK patients.

Stakeholders included NHS Lothian, East Lothian Council, Enjoy leisure and 3rd sector organisations.

Timeline: Our model was piloted in 2008. PACE was then established in 2009, and ACE established in 2011.

Highlights (innovation, impact, outcomes): This redesign led to: enhanced patient rehabilitation, decreased physiotherapy waiting times, with reduced pressure on review slots; enhancement of partnership working between health and leisure; and increased participation in, and maintenance of, physical activity in the community.

Sustainability: Based on average staff costing, this service model allows for 4 times as much service provision to the patient, in comparison to a standard physiotherapy only service, at half the cost.

Strong partnerships are essential to sustain this model. Appropriate training of Exercise Specialists is an ongoing issue across leisure, but can be overcome. Working with existing established community groups allows for longevity with smaller financial impact.

Transferability: This model of delivery translates to a range of services including MSK, Learning Disability, Mental Health and weight management services, though success is directly dependent on good partnership working, peer leadership, and shared understanding of delivery priorities and therefore implementation may vary between service areas.

Discussion and Conclusion: (key findings) Resistance when challenging conventional delivery of care is always a consideration. Clear communication of transparent goals has been essential in mitigating the impact of this on service delivery. Patient feedback has been very positive about the new model of care.

This is an excellent example of financial adversity driving transformational change in service delivery facilitating a decrease in waiting time and an increase in capacity.

Lessons learned: Establishing common goals with key partners at the outset is essential. Articulating these clearly and concisely to all stakeholders is vital.

Keywords

integrated care; physical activity; behaviour change; partnership

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References

1. Prochaska JO and Velicer WF. The transtheoretical model of health behaviour change. American Journal of Health Promotion 1997;12(1):38-48.

PowerPoint presentation

http://integratedcarefoundation.org/resource/icic15-presentations