Document converted by PDFMoto freeware version

Presentation to the Public Health Partnership Board, 18 October 2006

Local Public Service Agreement
Health and Well Being Target 2 (Improving Health & Well Being Through Physical Activity)

Background

The project is working with patients with Coronary Heart Disease and/or Diabetes. The aim is to improve habitual physical activity levels as described in the performance measure below and encourage healthier lifestyles generally.

The Active Lifestyle Project (ALPO) Co ordinator was appointed in December 2005 and the project launched April 2006. The projects' initial focus was in the North of the city, where support could be given by the already established Community Healthwise Scheme (HAZ). However the project now covers the whole of the city with significant support from other city wide referral schemes. This is due to considerable work of the co ordinator and other colleagues within Activity Sheffield, to work with those partners to enhance the overall access to physical activity opportunities across the city

Outcome

The increased longevity and improved health and well being of people suffering from chronic disease through a sustained increase in their level of activity

Indicators by which performance will be measured

The number of patients with chronic disease [1] who do not undertake the current recommended minimum levels of physical activity [2] (i.e. the majority of people with chronic disease) who, between point of referral and 52 weeks [3], achieve a minimum increase in physical activity levels [4]

Method of Measurement

All patients engaged complete the short form IPAQ questionnaire (see attached) and the process is repeated at day 365 to measure performance (see indicator above)

Other data that is being measured by the scheme and to monitor attrition rates includes

- Number of patients engaged to the Active Lifestyle Referral Scheme
- Number of patients recruited
- Numbers of patients recruited and completing 52 week programme

Document converted by PDFMoto freeware version

Progress To Date

- 100 patients have been recruited April – September 2006(Target number 150, 25 per month)

  Attrition rate allows for 36% dropout, therefore only 54 recruits were predicted to remain on project at this point in time, however 100 individuals are currently adhering to the scheme

- Practices engaged include,
  - Foxhill Medical Centre
  - Page Hall Medical Centre
  - Darnall Community Health
  - York Road Medical Centre
  - Also referrals from other referral schemes

- Referrals are also being made by the Northern General Hospital and the Hallamshire Hospital through the Diabetes Centres and Cardiac Rehabilitation unit and the cardiac rehabilitation centre at Graves Tennis and Leisure Centre

Future Proposals

- Hillsborough Leisure Centre proposing a 6 week educational component in partnership with the PCT i.e. Smoking cessation, pharmacology, health walks and dietician
- Evening activities to target patients who are back to work
- Home exercise kits to loan to patients
- Provision of more specific activity e.g. chairobics, Tai Chi, walking and gentle exercise classes etc for LPSA patients
- York Road Medical Centre has not identified many patients and it has now been agreed to look at moving a referral session to Pitsmoor Medical Centre

.

Foreseeable Risks and Concerns

- Capacity issues for co ordinator. Extra Support for Co ordinator by other Health Professionals as more patients join scheme e.g.
  Home visits - Community nurses, Community Link workers, Advocacy Workers
- Completion of IPAQ questionnaire
- GPs understanding of Importance of completion of necessary documentation
- More GP Referral qualified staff
- More BACR qualified staff

Document converted by PDFMoto freeware version

Notes: Performance Indicator Measures

[1] Chronic disease is defined as those people identified through patients records as suffering with diabetes or coronary heart disease.

[2] The recommended level of physical activity for the general population is defined as 30 minutes of moderate exercise on 5 or more days a week. For patients recording their exercise levels using pedometers, 4000 steps a day is equivalent to 30 minutes moderate exercise (Welk et al, 2000). Moderate intensity is defined as exercise that makes an individual breathe harder of feel warmer than normal.

[3] Patients' physical activity levels will be recorded at baseline and at 52 weeks as part of an individual's clinical review with their GP or primary care provider. Activity levels will be recorded through methods to be agreed by Sheffield City Council, Sheffield Health Agencies and the Department of Health.

[4] For patients with chronic disease a minimum increase in physical activity is defined as doing two or more 30 minutes sessions of moderate activity or equivalent a week over and above what they were doing at the point of referral. Thus a patient, who moves from undertaking one thirty minute session per week to three, or from three to five, would be classed as having achieved the minimum increase. However a patient who moves from five to seven would not, because he/she was already undertaking the minimum level of activity at the outset, and thus is not eligible to be considered in the programme.