

ESCAPE-PAIN

THE STORY OF SCALE-UP

Scaling up a rehabilitation programme for people with chronic knee or/and hip pain



VERSUS
ARTHRITIS

escapepain

brightpurpose

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have been possible. Finally, we would like to thank colleagues at the Health Innovation Network (HIN) for their continued hard work and determination to make ESCAPE-pain accessible to many more thousands of people with arthritis. It is heart-warming to hear endless stories and case studies from participants whose lives have been transformed as a direct result of attending the course.

2.0 PURPOSE OF REPORT

Versus Arthritis has produced this report so that others can benefit from our local and operational learnings when implementing the ESCAPE-pain programme. The report is primarily aimed at the Academic Health Science Networks (AHSNs) to support them with local implementation of

ESCAPE-pain. The content is based on findings from a broader external developmental evaluation carried out by Brightpurpose. We hope this report may also be of benefit to others who wish to scale up other evidence-based interventions.

3.0 VERSUS ARTHRITIS AND ESCAPE-PAIN

About Versus Arthritis

We are a new charity here to demand and deliver better with and for people with arthritis. We are a movement of volunteers, healthcare professionals, researchers, family and friends doing everything we can to push back against arthritis. We invest in and deliver cutting edge research, provide quality services and advice, and campaign for arthritis to be a health priority, so the pain, fatigue and isolation of arthritis are no longer tolerated. Versus Arthritis came to life in September 2018 as a result of the merger of two of UK's largest arthritis charities – Arthritis Research UK and Arthritis Care.

VERSUS ARTHRITIS WANTS TO ENSURE 'NO ONE IS LIVING IN MUSCULOSKELETAL PAIN WITHOUT SUPPORT.'

Versus Arthritis is a charity that exists to support the 18.8 million people in the UK who live with a musculoskeletal (MSK) condition, including an estimated 6.98 million who have osteoarthritis of the knee or hip.^{1,6} People with these conditions lose their ability to move freely and often experience ongoing pain and fatigue. This can make ordinary, everyday activities a struggle or an impossibility. Arthritis affects every aspect of people's lives, including their ability to remain independent or to stay in work. As well as the personal impact, arthritis also impacts wider society; in 2007, the total annual cost to the UK economy of working-age ill health, for which arthritis is the top cause, was estimated to be £103–129 billion.²

About ESCAPE-Pain

ESCAPE-pain or '*Enabling Self-management and Coping with Arthritis Pain through Exercise*' is a six-week rehabilitation programme for people aged 45+ with persistent hip and/or knee osteoarthritis. ESCAPE-pain involves group education and exercise delivered over 12 sessions. The ESCAPE-pain programme was originally developed by Professor Mike Hurley* with funding from Arthritis Research UK (now Versus Arthritis).

The aim of the ESCAPE-pain programme is to support and educate people to manage their osteoarthritis better, and to use exercise as a safe and effective self-management strategy. As well as proven benefits for people with arthritis, ESCAPE-pain delivers value for money for the healthcare system, offering a return on investment of £5.20 for every £1 spent⁴. The programme has received significant endorsements and support from key organisations within the health sector.

In 2016 Versus Arthritis, then known as Arthritis Research UK, worked with NHS England, Public Health England and the Department of Health to publish the report 'Providing physical activity interventions for people with musculoskeletal conditions'.³ As part of this, an independent panel reviewed the published evidence and found ESCAPE-pain to be the most promising community rehabilitation programme for people with osteoarthritis of the knee and hip.

¹ Global Burden of Disease Collaborative Network. Global Burden of Disease Study 2017 (GBD 2017) Results. Institute for Health Metrics and Evaluation (IHME), Seattle, 2018.

² C. Black, "Working for a healthier tomorrow: Dame Carol Black's review of the health of Britain's working age population," 2008.

³ Arthritis Research UK (2016) Providing Physical activity interventions for people with musculoskeletal conditions.

⁴ Public Health England (2017) Return on Investment of Interventions for the Prevention and Treatment of Musculoskeletal Conditions

⁶ Musculoskeletal calculator Versus Arthritis and Imperial College London. www.arthritisresearchuk.org/arthritis-information/data-and-statistics/musculoskeletal-calculator.aspx

* Intellectual Property for the programme resides with the Health Innovation Network (hosted by Guys and St Thomas' NHS Trust), Kingston University and St George's, University of London

Forming a partnership

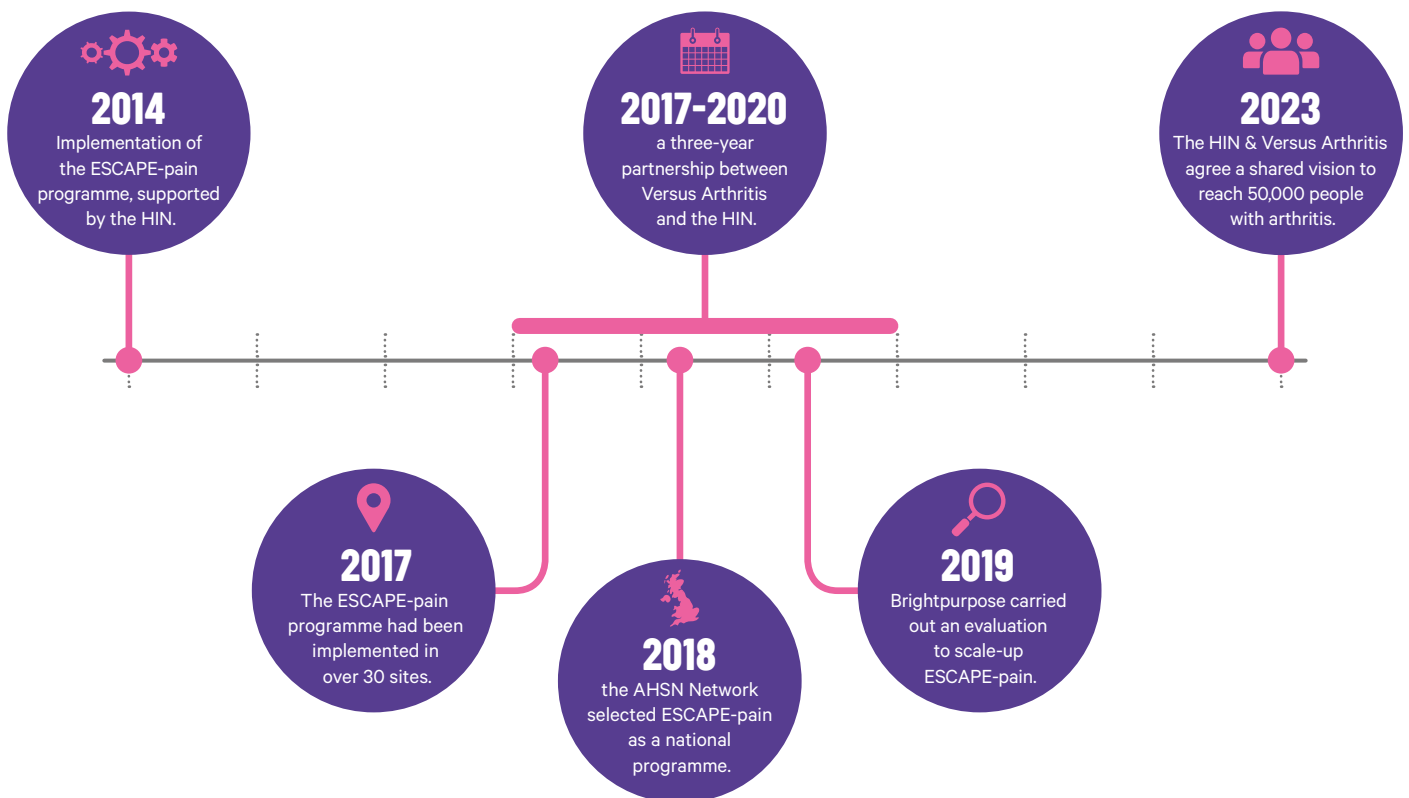
Versus Arthritis wanted to explore a new role in supporting the adoption of effective healthcare interventions. This led to a three-year partnership from March 2017 until March 2020 between Versus Arthritis and the Health Innovation Network (HIN). The HIN is the South London Academic Health Science Network. Implementation of ESCAPE-pain has been supported by the HIN since 2014, and by March 2017 the programme had been implemented in over 30 sites largely focused in the South East of England. The approach included clinical (physiotherapy) sites, as well as hybrid models involving partnerships between physiotherapy and the leisure sector.

Partnership discussions between HIN and Versus Arthritis focused initially on methods of wider scale up, and then moved to how to support spread across the UK and develop a sustainable business model for the future. The partnership moved forward in agreement that HIN would continue to provide the operational knowledge and support for spread (a team providing programme

leadership, project management, clinical advisors, website/app support, and communications) with Versus Arthritis acting as a critical friend. The partners agreed a shared vision to reach 50,000 people with arthritis per year by 2023.

To support this, Versus Arthritis developed partnerships with three additional areas, to provide capacity and expertise to manage roll-out locally. Two of these were Academic Health Sciences Networks (AHSNs) in the north of England, and the third was an Active Partnership in Dorset (previously known as a County Sports Partnership). The purpose of these test areas was to provide learning on how scale-up can be managed and achieved in different contexts. In 2018, following the relicensing of the AHSNs for a further five years, the AHSN Network selected ESCAPE-pain as a national programme that all AHSNs would implement in their areas. Versus Arthritis commissioned Brightpurpose to carry out a developmental evaluation of the charity's support to scale-up ESCAPE-pain between April 2018 and April 2019. This report contains extracts from the final report submitted in May 2019.

PARTNERSHIP TIMELINE



4. KEY FINDINGS FROM THE EVALUATION

In the year from January 2018, the number of sites delivering ESCAPE-pain increased from 50 to 160, and considerably more sites are expected by the end of 2019. More than 10,000 people have now participated in ESCAPE-pain.

The rapid progress and growth of ESCAPE-pain has not necessarily been easy. Scale-up test areas and other AHSNs have experienced significant challenges in the implementation process, reflecting the reality that having a tried-and-tested, well-liked, evidence-backed intervention is no guarantee of implementation success.

Looking at research into the success of scaling up other innovations in the UK⁵, this evaluation concludes that ESCAPE-pain is doing better than scale-ups of other similarly complicated innovations, despite the challenges experienced.

A significant success factor was the adoption of ESCAPE-pain as a national AHSN programme. This created impetus for adoption in all parts of England, with investment and performance targets attached. It also created an extended local workforce to support implementation. The HIN would not otherwise have had the capacity for promotion and spread on that scale. In part, the AHSN adoption is likely to be attributable to the presence of a major national charity as a partner, providing leadership, influence and credibility, as well as funding.

Whilst the scale-up has progressed well, some AHSNs have been under pressure to get delivery up and running quickly, without necessarily having time to plan for how delivery will be sustained. This evaluation raises concerns that this sort of externally driven and incentivised rapid adoption may be less sustainable than organic growth because the foundations may not be as strong.

4.1 Local collaboration approach

A particularly effective approach was when AHSNs were successful in bringing commissioners, clinicians and project managers from across the local health sector together. This enabled everyone to work together to define and design a model that would be workable and sustainable. This local ownership of ESCAPE-pain implementation supported successful identification and resolution of barriers and challenges. It also ensured that the delivery model was designed in a way that fully accounted for local context and available assets, from education and the referral pipeline through to delivery, onward referral and post-participation opportunities. Furthermore, it enabled the whole locality to be considered, in terms of coverage and accessibility, also giving greater scope to consider and test a variety of delivery models. Whilst still early days for some of the resulting models, AHSNs believed this approach created the greatest opportunity for sustainable success.

4.2 Operational lessons

Leadership was an important factor in successful local roll-out, appointing named roles with dedicated time to support the work; a combination of clinical leadership (from a clinical champion) and practical project management was required to have an impact. Commitment from local organisations and their leaders was also required; passionate frontline staff are important, but senior managers buy-in is needed to influence decision-makers and commissioners.

4.3 The impact of context

Contextual factors can positively or negatively affect implementation and are different in every locality and site. They need to be well-understood and worked with, or else they risk stopping implementation in its tracks. The table below sets out the common contextual factors that have affected implementation, with examples of how they have done so.

⁵ Greenhalgh T, Wherton J, Papoutsis C, Lynch J, Hughes G, A'Court C, Hinder S, Fahy N, Procter R, Shaw S. Beyond Adoption: A New Framework for Theorizing and Evaluating Nonadoption, Abandonment, and Challenges to the Scale-Up, Spread, and Sustainability of Health and Care Technologies. *J Med Internet Res* 2017;19(11):e367.

Table 1 Local factors affecting implementation (4.3)

Contextual factor	Examples
Commissioning arrangements and cycles	Physiotherapy providers with block contracts have more flexibility to change their provision to include ESCAPE-pain than those with very specific contracts who may need to wait until contract renewal.
Complementary provision	It is relatively easy to integrate ESCAPE-pain into an already established exercise on referral scheme.
Fit with current services	If the local physiotherapy team already offers similar group-based support, they may not see the benefit of adopting ESCAPE-pain. If all physiotherapy is provided one-to-one, group-based ESCAPE-pain offers a more cost-effective model for appropriate patients.
Staff capacity	If there are insufficient staff to deliver ESCAPE-pain, it cannot be done. Long physiotherapy waiting lists can be an enabler to exploring leisure-based provision.
Culture	Some organisations are more open to change and will therefore adopt and drive innovation. Conversely, where there is resistance to change, particularly from senior clinicians, it can be very difficult to move forward, even if frontline delivery staff are enthusiastic.
Access to facilities	In some rural areas and smaller communities, physiotherapy teams do not have access to space for group work. Likewise, leisure provision is often based in larger population centres. Leisure and clinical facilities are sometimes already operating at full capacity, especially at peak times.
MSK pathways	Where MSK pathways are agreed and well-defined across the system, it is easier to integrate ESCAPE-pain into routine provision.
System-wide change	If other large-scale change is underway within the physiotherapy or MSK system, it may be impossible to introduce ESCAPE-pain during the change process. In this case, the most appropriate approach is to explore how it can be integrated into the new system.

4.4 Delivery models

Whilst the majority of AHSNs wanted to see implementation of ESCAPE-pain in different settings, they did not make a conscious effort to influence adoption of one particular model over another in any area. Most AHSNs started with an organisation that expressed interest in delivering ESCAPE-pain (for example, a leisure provider, community organisation or NHS Trust) and built implementation around that, though some started by bringing together relevant local partners, and supported them to define the most suitable model.

4.5 Leisure providers and community organisations

Some AHSNs found that there was greater interest from leisure providers and some community-based

organisations, than from NHS organisations. The AHSNs were attracted to the leisure provider/ community organisation delivery model because they saw the sector as better placed for onward referral and future options after a participant has completed ESCAPE-pain. Success here needed early collaboration with clinicians and Clinical Commissioning Groups (CCGs) to develop effective referral pathways, as referral from healthcare professionals was needed to drive participation, although some also accepted self-referral. Factors that helped smooth the collaboration process were:

- Where organisations already had experience of exercise on referral schemes, to provide examples of processes and systems that already worked.

- Long waiting times for physiotherapy, as physiotherapy teams saw them as a route to improve patient experience and release capacity, and therefore participated enthusiastically.

All leisure and community-based models provided a new service unlike some health-services based models which instead reconfigured existing services. New services require new funding, and different funding models were tried:

- ***Pay what you can*** – one community organisation asked participants to pay what they felt able to; this did not cover the full cost of delivery, but the health trainers delivering the programme were funded through public health funding and had capacity to deliver interventions that were well-aligned with their public health remit, such as ESCAPE-pain.
- ***Participant charge*** (full cost recovery, in-course) – the delivery organisation charged participants a fee that covered the full cost of delivery and was in line with other exercise on referral charges; some organisations combined this with the offer of reduced membership fees after the programme.
- ***Participant charge*** (full cost recovery, lifetime value) – the delivery organisation charged participants a fee that covered part of the cost of delivery (again in line with other exercise on referral charges); they recovered the remaining costs based on modelling food and drink spend and likely membership conversion at the end of the programme.
- ***Participant charge*** (partial cost recovery) – some CCGs part-funded delivery, with participants paying a fee that enabled recovery of the remainder.
- ***Redeemable fee*** – the delivery organisation charged an upfront fee equivalent to full cost recovery (in-course), and this was redeemable against the cost of membership upon course completion.

- ***Cross-subsidisation*** – a CCG permitted a delivery organisation to fund free delivery in a deprived area, by charging for delivery in an affluent area of the same locality.

- ***Pump-priming*** – one AHSN funded £50 for each participant that completed the first cohort of a course, to pump-prime future delivery.

4.6 NHS Organisations

Implementation in NHS Organisations was often smoother and less time consuming than in community or leisure organisations. There were still hurdles to overcome including identifying capacity to deliver the programme, and access to suitable space. Referral pathways were usually also easier to establish, as participants were commonly drawn from existing caseloads or waiting lists or referred through an existing triage point. However, there was still a need to educate referrers, and that was an ongoing process due to staff turnover and rotations.

‘IMPLEMENTATION IN NHS ORGANISATIONS WAS OFTEN SMOOTHER AND LESS TIME CONSUMING THAN IN COMMUNITY ORGANISATIONS’

When initial interest came directly from frontline physiotherapists, the buy-in and support of team managers or service leads was also required. This was not always a given, and in some cases stopped progress in its tracks. Conversely, when initial interest came from a team manager or service lead, AHSNs reported that frontline physiotherapists were usually very receptive to exploring implementation.

4.7 Understanding demand

Versus Arthritis and Imperial College London have developed a *Musculoskeletal Calculator*, a prevalence modelling tool for musculoskeletal conditions. This tool provides estimates of the burden of musculoskeletal conditions to local areas. Estimates are available for osteoarthritis (OA) of the hip and knee. There are an estimated 4.08M people aged over 45 years with osteoarthritis of the knee, and 2.90M people aged over 45 years with osteoarthritis of the hip in the UK (excluding Northern Ireland where data is not available).

“I HAVE FOUND THE MSK CALCULATOR USEFUL WHEN TALKING TO CCGS AND CLINICIANS. MANY HAD NOT SEEN THIS BEFORE.”

Dr Rachel Turnbull

The North West reported that, despite the Musculoskeletal Calculator, they struggled to understand demand for ESCAPE-pain as they had limited knowledge of the local burden of musculoskeletal ill health and existing provision. Whilst prevalence data provided by Versus Arthritis provided a useful overview, it did not provide the level of detail to help them understand where and by whom services were already being provided, and therefore what the potential demand for ESCAPE-pain might be.

This AHSN therefore took the approach of growing organically and opportunistically rather than taking a more planned approach to growth. With hindsight, they reported it would have been better to take the time to research existing demand and NHS provision more fully, as well as potential provision through leisure and private providers. Those AHSNs, including the North East and Yorkshire and Humberside, that worked with local providers to explore demand as part of the planning found this to be useful.

Understanding demand was also important at a smaller scale. Courses need to run near to capacity to be viable. Planning requires knowing the eligible population who could benefit from ESCAPE-pain. In addition, exploring participant demographics and preferences to inform decisions about location, frequency and times of day of courses, and acceptability of charged-for models is also important. Understanding the granularity of local demand was key for planning delivery, to ensure courses ran near capacity.

4.8 Lessons from across the AHSN Network

Approaches across other AHSNs was varied. Where there was buy-in, involvement has been light touch, providing training but then allowing CCGs and providers to get on with implementation. Elsewhere there needed to be more of a sell to get buy-in. There were sometimes contractual constraints for commissioning. This ruled out some providers; until the funding cycle hit the right point there was no means of progressing service change.

The AHSNs were conscious of their targets and focussed on meeting those, so were concentrating on working with the willing and enthusiastic first. However, once they had the willing on board, there was a shift as those later adopters needed more support. One lead described how his role had changed as the programme developed, from being a salesman to becoming a partner helping with mobilisation.

Some reported the target-driven approach was at odds with sustainability, which is crucial to CCGs. This could be considered a flaw with this approach when contrasted with the non-target approach experienced by the scale-up test area AHSNs, which allowed for a longer period of discovery and an opportunity to consider sustainability from the outset. As one lead said, “one size does not fit all, and just because something works in one place you can’t necessarily just drop it into another area without some adaptations”.

Other AHSNs also reported the roles of Clinical Champion and dedicated Project Manager as essential elements, not only in terms of the expertise they bring but as a dedicated resource. Where such a role had not been in place, capacity to devote to roll-out was a constraint as most AHSN leads were also responsible for delivering other programmes concurrently.

4.9 Indicators of success

AHSNs had differing definitions of success, with some still in the early stages of delivering. The indicators of success we heard about were:

- Reaching all patients that could benefit, not just those that want to participate;
- Inclusion of successful paid-for models, justified by the argument that paying for sessions could be less expensive than travelling to a free session;
- Freeing-up time for more vulnerable and complex patients, by the more able participating in group therapy;
- Reduced waiting times for treatment;
- Sustainable delivery beyond the national programme;
- Stakeholders having bought-in to sustainability, and working together on business planning and commissioning;
- Looking for, trying and adopting innovative approaches to delivery, from a wide range of organisation types;
- Being able to meet the target set as part of the national programme.

4.10 Barriers to local scale up and sustainability

Roll-out was still in its early stages in many of the sites during the evaluation, but these barriers to sustaining delivery have been identified:

- **Cost of training** – finances are constrained to the extent that sites would not be able to fund ESCAPE-pain training for new staff, for example to increase delivery capacity or to replace trained staff who leave.

“WHAT WE DON’T HAVE IS INFORMATION REGARDING THE INTERACTIONS PATIENTS HAVE WITH GP SERVICES AND HOW MANY RETURN BACK INTO THE SYSTEM.”

Jen Gilroy-Cheetham

- **Cost of delivery** – leisure-based models need to generate income in order to be sustainable, which involves charging for ESCAPE-pain, cost-recovery based on future membership revenues or being commissioned to deliver; at this stage it is not yet clear whether cost-recovery or charged-for models will be sustainable, and commissioning seems unlikely in the current financial climate.
- **Fidelity to the model** – providers may choose to deliver a programme similar to ESCAPE-pain under another name to avoid training costs, or offer fewer sessions of a similar approach to improve affordability, with unknown impact on efficacy.

5.0 WORKING TOGETHER

The partnership has added value to both partner organisations and to the scaling of ESCAPE-pain, as follows:

Added value for people with arthritis

An estimated 10,000 people with osteoarthritis have participated in ESCAPE-pain across England at the time of writing, thanks in part to Versus Arthritis's investment and involvement. Feedback from participants is overwhelmingly positive and dozens of case studies have been collected and shared. People report reduced pain, improved sleep, better mobility and an improved ability to cope with their condition. A range of videos and case studies can be found at <https://escape-pain.org/personal-stories>

Added value for the HIN

- Versus Arthritis's involvement brought additional funding, which ensured there was sufficient capacity for the HIN team to be spread beyond its known patches and early adopters.
- The involvement of a national charity in the partnership was a factor in selecting ESCAPE-pain as an AHSN national programme. Versus Arthritis has provided critical friendship and challenge to the HIN, which has stimulated them to think differently; whilst this has not always been comfortable, on reflection it has been valued.

'10,000 PEOPLE WITH OSTEOARTHRITIS HAVE PARTICIPATED IN ESCAPE-PAIN ACROSS ENGLAND AT THE TIME OF WRITING'

The AHSN national programme has strengthened the HIN's profile with the other AHSNs, and built an excellent reputation for their programme management and community-building approaches.

Added value for Versus Arthritis

- Versus Arthritis has proved its ability to use its networks, expertise, authority and resources to support national implementation of interventions that make a difference to people with arthritis.
- Versus Arthritis has learnt about spread and scale interventions, and about working effectively in partnership, building knowledge and confidence about how to select programmes and partnerships to work with in the future.
- Versus Arthritis has made connections with more people with arthritis, many of whom have received information we publish and who know we exist to support them.

6.0 SUMMARY

ESCAPE-Pain has proved to be of great benefit to the 10,000 people who have taken part so far. Versus Arthritis believes that everyone who could benefit from ESCAPE-pain should be able to access it. By working together with the HIN we have increased access to the programme, yet there are still hundreds of thousands more people who would benefit and who we need to reach. We hope by sharing these early learnings with the AHSN network, we will complement the continuing support from the HIN and reach more people who would otherwise not have the benefit of ESCAPE-pain. Versus Arthritis has developed strong links with local NHS teams and ASHNS and hopes to be able

to maintain these relationships for scaling up other interventions in the future.

For all the details on the ESCAPE-pain programme visit escape-pain.org

For more information about Versus Arthritis visit versusarthritis.org

**‘VERSUS ARTHRITIS
INCREASED ACCESS FOR
PEOPLE WITH ARTHRITIS
TO ESCAPE-PAIN’**



7.0 CASE STUDY AREAS

The evaluation explored how implementation took place in each of the test areas, their approach, relationship with stakeholders and factors influencing progress. In addition, as ESCAPE-pain became a national programme for all AHSNs, we explored how implementation is progressing in a sample of other AHSN areas.

The three scale-up test areas were:

- North East Academic Health Science Network
- Innovation Agency: Academic Health Science Network for the North West Coast
- Active Dorset

For readability of the report these are referred to as North East, North West and Dorset respectively. The three scale-up test areas tested different models

of delivery. The two AHSNs supported roll-out in a combination of health, leisure and community settings, depending on local interest, capacity and context. Active Dorset attempted roll-out into leisure settings only, due to physiotherapy capacity issues in the county, but leisure instructor capacity also proved a barrier in some parts of the county. As would be expected, the approach to introducing ESCAPE-pain was different in every site, as no two organisations are alike. The two AHSN scale-up test areas invested a lot of time in conditioning the local system, generating interest and demand, and supporting sites to ensure local commitment and referral pathways were in place. All three scale-up test areas and the other AHSNs funded training places for sites to become ESCAPE-pain facilitators, and saw this as crucial to securing commitment.



7.1 Overview of the scale-up test-areas

AHSN North East and North Cumbria (North East)

The roll-out of ESCAPE-pain sits within the AHSN's Health Improvement workstream, with internal governance provided by the executive team. In addition to Versus Arthritis's funding support, the AHSN also received matched funding from NHS Right Care for the roll-out of ESCAPE-pain. The project team comprises a project manager and a clinical lead (physiotherapist), who are leading the roll out and implementation of ESCAPE-pain across the areas in their region. The region has 15 Trusts and 11 CCGs.

The North East's aspiration was to have ESCAPE-pain being delivered in at least one site in each of the localities in their area, with a mix of delivery across community and clinical settings. At the start of the project, one ESCAPE-pain site was already established and had been delivered for the previous three years by the Sunderland community MSK physiotherapist team as part of their CCG contract. There were also three community-based organisations funded through the Sport England programme.

Including the existing four sites, seven organisations delivered the programme across eight sites, and each completed delivery of at least one cohort of patients:

- South Tyneside NHS Foundation Trust
- Age Concern South Tyneside (Sport England Funded)
- City Hospitals Sunderland NHS Foundation Trust
- North Tees and Hartlepool NHS Foundation Trust (2 sites)
- Greenwich Leisure Limited (Sport England funded)
- Healthworks and Newcastle upon Tyne Hospitals NHS Foundation Trust
- Age UK North Tyneside (Sport England funded)

The active sites represent an even mix of clinically-based and community-based delivery (four sites each), with some clinical sites also having ambitions to expand provision into a community setting. Of the four remaining localities in the area, three are committed to providing ESCAPE-pain and training has taken place. South Tees remains the only

locality not fully engaged but, at the time of writing, initial discussions had taken place with the local CCG and the lead physiotherapist from South Tees Hospital NHS Foundation Trust.

The North East will maintain contact with active sites in future, although they've received a limited number of requests for support from sites once they are up and running. Where it has been sought, support was requested when referral pathways were not working as effectively as expected. The North East will also continue to support sites that are yet to go live with delivery and have also received interest from other potential providers that they will pursue. They are also exploring education sessions for referrers into ESCAPE-pain, to maximise the effectiveness of referral pathways.

'IT HAS BEEN A POSITIVE FOR THE PHYSICAL ACTIVITY TEAM IN THAT THE TRAINING CONFIRMED THEIR SKILLS AND KNOWLEDGE'

Sarah Cowling, CEO, HealthWORKS

Innovation Agency:

AHSN For The North West Coast

The North West started the roll-out of ESCAPE-pain as part of its work under the Patient Safety Collaborative (PSC). The PSCs are nationally defined programmes of work delivered through AHSNs, focussed on identifying and spreading safer care initiatives. A clinical champion was appointed in June 2018 to support the programme manager and help co-ordinate the promotion as well as support implementation of ESCAPE-pain across the AHSN area.

Their area comprises 22 NHS Trusts and 19 CCGs serving a population of around 4.1 million. At the start of the project there were three identified ESCAPE-pain sites within the area, but none were actually delivering the programme. Therefore, in effect they started from zero provision.

There are now 11 organisations delivering across 25 sites and, at the time of writing, a further six sites were due to start delivery soon. The organisations delivering ESCAPE-pain were:

- Blackpool Teaching Hospitals NHS Foundation Trust (3 sites)
- Bridgewater Community Healthcare NHS Foundation Trust (2 sites)
- Cheshire and Wirral Partnership NHS Foundation Trust (2 sites)
- East Lancashire Hospitals NHS Trust (7 sites)
- Platt Bridge Health Centre
- Healthiness Ltd (Sport England funded)
- Lancashire Care NHS Foundation Trust (4 sites)
- North West Boroughs Healthcare NHS Foundation Trust (2 sites)
- North West Boroughs Healthcare NHS Foundation Trust & Healthy Living Collaborative
- Age UK Wirral
- Wirral Community NHS Trust

The majority of the providers were physiotherapy services delivering the programme mainly in NHS settings, both hospital-based and community clinics. One collaborative approach was led by a lifestyle instructor in a leisure setting, with physiotherapy support. A further collaborative of this type was in development. In addition, at least one site was referring onto leisure services on completion of the programme to encourage continuation of exercise. There was a Sport England funded leisure service provider, however, we understand that this site was struggling to recruit.

The North West team saw delivery of the programme in the community as being the end goal, but recognised the challenges of setting up outside healthcare facilitates. They felt the combined physiotherapy and leisure model offered the best opportunity to both provide good clinical input (through physiotherapy) and lead to behavioural change (through engagement with leisure services). The North West was planning to use the solid foundation of sites so far, to grow the number of sites. Whilst they expected that some CCGs not currently delivering ESCAPE-pain would begin to do so after seeing it in delivered at other sites, they also recognised that a more proactive approach

would be needed to fill some of the gaps (both geographic and demographic). The team therefore planned a dual purpose going forward: supporting existing sites to ensure sustainability, and expanding into areas not yet reached, to continue scale-up and roll-out.

Active Dorset

The NHS Dorset CCG MSK working group secured non-recurring CCG funding to train leisure instructors to deliver ESCAPE-pain. This was part of a local response to physiotherapy workforce capacity issues, long physiotherapy waiting lists, and overprovision of hip and knee replacements. Active Dorset is the Active Partnership (previously known as County Sports Partnership). Given its strong network within the leisure sector, it acted as project manager for identifying, recruiting and coordinating training for leisure providers interested in running ESCAPE-pain.

“HAVING A VALIDATED PROGRAMME HAS MEANT THAT WE CAN EMBED ESCAPE-PAIN INTO OUR PATHWAYS GOING FORWARD”

CCG Officer

BH Live in Bournemouth and Active 4 Health in Christchurch and East Dorset both expressed interest and put forward instructors for the training. Organisations in other parts of Dorset had either no or very few Level 3 leisure instructors, and those they had were already employed at full capacity on other programmes.

Whilst Active Dorset was well-connected in the leisure sector, it didn't have the necessary connections to create a referral pipeline. It therefore relied on local providers to generate their own referral pathways. Six courses were run in Dorset, four by BH Live and two by Active 4 Health. BH Live recruited participants mainly from their own membership (recent completers of exercise on referral, users of the assistive exercise suite) or via exercise on referral. Active 4 Health recruited via exercise on referral, and they included ESCAPE-pain as an option

on the GP referral form to encourage GPs to consider it. Neither organisation generated sufficient numbers to make courses viable, even running at off-peak times and charging for the course.

Active Dorset originally hoped that ESCAPE-pain would be included as one of the interventions in the new MSK triage service being introduced. However, the CCG decided this was not appropriate, and that patients should not be triaged directly to an exercise programme without being assessed by an MSK clinician first. The CCG then decided to undertake a physiotherapy review, in response to the capacity and demand challenges in physiotherapy. This meant that all service developments, including the expansion of ESCAPE-pain, were on hold pending the results of the review. Active Dorset and the MSK working group advocated for the inclusion of ESCAPE-pain in the new physiotherapy service that arose from the review and were successful in doing so. The results of the review were ratified in December 2018, and the new service will be fully implemented over the coming months.

In the meantime, Active Dorset explored options to ensure that enough trained staff and provider sites would be available to offer the county-wide service once it came available. The limited availability of Level 3 leisure instructors was a barrier to expanding the initial model, and the project manager investigated alternatives. A solution being developed involves BSc Sports Therapy final year students delivering ESCAPE-pain as their work placement. The faculty staff at Bournemouth University were very enthusiastic as many students want experience in community settings rather than elite sport or private practice. This model has been agreed as the way forward, and Active Dorset is working with Bournemouth University to prepare the next cohort of final year students to be ready to deliver from September/October 2019.

Whilst this model solves the local capacity issue, it is a significant departure from the qualification and experience levels required by the HIN for ESCAPE-pain delivery. The HIN examined the model in detail and decided it diverged too far from the established model to be acceptable as an ESCAPE-pain model. Active Dorset and the MSK group have agreed to

continue to develop the model with a plan to evaluate and re-visit with the HIN as soon as possible, another alternative also being explored is to move forward with the Sports Therapy student model, albeit not branded as ESCAPE-pain, integration into the MSK pathway is planned from Autumn 2019.

7.2 Learning from delivery in the scale-up test areas

AHSN North East and north Cumbria (The North East)

Initially the project team used their networks and contacts to raise awareness of ESCAPE-pain, identify potential contacts, facilitate introductions and generate interest in each of the different localities. They found the literature, evidence base and the cost calculator useful during this period.

“WE CONTINUALLY LOOK FOR WAYS TO IMPROVE SERVICES FOR OUR POPULATION AND WERE KEEN TO ENGAGE WITH THE ESCAPE-PAIN ”

Katie McLeod, NHS Commissioner

In each locality, the aim was to engage all relevant stakeholders from across the healthcare, community and leisure sectors. This involved a combined top-down and bottom-up approach, to engage frontline staff, team managers and service leads and secure buy-in at all levels. This was not always successful, and the project team had to be pragmatic and work with the willing. In localities where not all stakeholders were fully engaged it did not necessarily stop progress or ESCAPE-pain being implemented. However, the project team always aimed to create the conditions for both initial implementation and longer-term sustainability. They believed that there was a greater likelihood of ESCAPE-pain becoming sustainably embedded in the MSK pathway when there was support and involvement of all stakeholder groups.

Using this approach meant the biggest investment in time effort and resource was at the front-end of the process, to ensure everything was in place for implementation. Support and contact reduced

thereafter, but the project team were still available should support needs arise, for example overcoming issues with referral volumes. In localities where they were not able to engage all stakeholder groups initially, they continued to try throughout implementation, in an attempt to get everyone on board. Being considerate of local contexts was key. In some instances, the project team had to pause due to contextual issues such as Trust restructuring or commissioning cycles. In these cases, stakeholders' priorities and focus were elsewhere, and it was too challenging to get people round the table to discuss ESCAPE-pain.

The North East's approach involved working with every locality, driven by their original aspiration to have at least one delivery site in each locality. They were very close to achieving this aspiration at the time of writing, with only one locality not either delivering or committed to delivering in the near future. Across the localities there was a mix of delivery settings and staff, reflective of where the interest came from in each locality.

Innovation agency: AHSN for the North West coast

The North West adopted a facilitating and enabling approach to implementation in the early stages, sharing information with potential providers, allowing them to access the evidence base and make a decision about whether ESCAPE-pain warranted further investigation. This was largely driven by their limited experience of working with MSK services, which meant they did not have a pre-existing network of contacts they could bring together to share information in a system-wide approach.

Once a contact had been made, the team provided practical support and training to enable sites to implement ESCAPE-pain. Providers were asked to produce an implementation plan and projected start date before training was provided. Over time this 'application' process evolved to ask for an increasing level of detail, to ensure potential providers understood the programme and were exploring the practicalities of delivery more fully before training was provided. In the early days a few providers took training without fully understanding ESCAPE-pain, and it was only when they had the training that they realised it wasn't appropriate or

feasible for them to implement. Such changes have been brought about by the team adopting a model of implementation which allowed them to learn and apply lessons learned as they progressed through the scale-up period.

“WE HAD THE OPPORTUNITY TO EMBED ESCAPE-PAIN WITHIN EXISTING SERVICES. FEEDBACK TO DATE HAS BEEN REALLY POSITIVE”

Katie McLeod, NHS Commissioner

Being able to provide training free was an essential enabler for implementation, as providers reported their organisations would probably not have been able to pay for the training, and so ESCAPE-pain would have fallen at the first hurdle. Training was also regarded as playing a role in motivating the staff that would deliver ESCAPE-pain. The offer of professional training is fairly rare these days, so having a training opportunity, especially off-site, made staff feel valued and motivated them to help make the transition to ESCAPE-pain.

The presence of a local Clinical Champion was vital, in providing information and practical support from a position of clinical expertise and experience, and being a relatable link to the AHSN. Once training had been provided, most sites were able to get on with implementation, but support was available if requested. Where sites were known to be struggling, support has been offered; but if not taken, it wasn't pressed upon a provider. Ownership was left very much with the providers.

In the early stages, the AHSN also provided some seed funding to organisations that were already delivering a group-based therapy programme over fewer sessions. This financial support enabled providers to extend to the 12 sessions required by ESCAPE-pain without incurring additional cost.

In addition to supporting individual sites, the team acted as broker, bringing organisations together and facilitating discussions, to help with the development of collaboratives as their aim was

to get community-based delivery in place. Acting as broker is fundamental to the AHSN's role and therefore something they were well equipped to do.

They have also operated at system level, trying to influence commissioners, as they saw it as essential for fully embedding ESCAPE-pain into MSK pathways across the area. Being able to align ESCAPE-pain to CCG priorities has been important. They requested a local cost calculator from the HIN, which was developed. This was a key part of their strategy to get buy in, by being able to demonstrate the cost-effectiveness of implementing ESCAPE-pain at system level locally.

In sites that had been operating for several months at the time of writing, the programme was well embedded. These tended to be the sites that have converted from a similar but shorter programme, and that already had effective triaging and referral pathways. In newer sites, and particularly non-clinical models, it was too soon to say they were fully embedded. However, the collaboration in St Helens, again an extension of a well-established exercise referral and lifestyle behavioural change service, appeared to be settling well into the pathway.

The AHSN's ambition is for everyone within the area to have access to ESCAPE-pain. There are geographical gaps, where CCGs and or providers are not readily adopting ESCAPE-pain, and demographic gaps where existing may not be reaching all sectors of the community. Moving forward the North West was planning to target localities where these gaps exist.

Active Dorset

There has been very limited operationalisation, given the challenges experienced. Nevertheless, there have been useful lessons from the Dorset experience. Firstly, leadership and ownership were challenges in the county, with Active Dorset delegated responsibility for the roll-out and limited leadership from the clinical sphere, despite there being clinical leaders involved in the MSK working group. The leisure-focused choice of project manager made sense on the surface, given the need to embed ESCAPE-pain in the leisure setting. However, without a clinical referral pipeline, the courses weren't filled.

“ESCAPE-PAIN IS A POPULAR INITIATIVE TO BOTH PATIENTS AND STAFF WHO FOUND IT A USEFUL TREATMENT OPTION”

Kelly Holehouse, BCW

There was also a lack of clarity about the scope of the project management role, with Active Dorset staff believing their responsibility was only to identify and recruit providers and coordinate their training, whereas other stakeholders perceived the role to be project manager of the whole endeavour.

With no practical operational routes into clinical settings, there was no active exploration of how to build referral pathways from clinicians. Each provider was left to liaise with their own GPs, which did not generate sufficient demand.


MSK capacity challenges were the trigger for Dorset exploring ESCAPE-pain in the first place, but capacity in another profession (leisure instructors) acted as a barrier to implementation. Earlier assessment of whether there was capacity within the leisure sector to support ESCAPE-pain would have been helpful.


Despite these challenges, Active Dorset persevered in seeking ways to deliver ESCAPE-pain. The context of MSK capacity challenges halted developments temporarily, whilst the physiotherapy review took place. At the time, this caused frustration as it finally stalled the roll-out plans for ESCAPE-pain in the county. However, a further nine months down the track we can see that the physiotherapy review has enabled an exercise programme for people with hip and knee pain to be integrated into future MSK pathways (albeit not branded as ESCAPE-pain). The context that seemed a deal-breaker six months ago has proved to be an enabler in the longer term. Sometimes, timing is everything.

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