

LEV PEDRO & ASSOCIATES



# West Yorkshire & Harrogate musculoskeletal pathway evaluation

September 2021

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## (1) Introduction

Seed funding enabled the establishment of an innovative pilot service to improve health and wellbeing of people suffering from musculoskeletal (MSK) conditions, with a focus on reducing health inequalities. Funding was provided by the Health Equalities Partnership programme and the programme of work was managed by the West Yorkshire and Harrogate Health and Care Partnership (the Partnership).

A service was established that created two pilot pathways to alternative and complementary therapies and activities for people suffering with MSK. To address health inequalities, the service was aimed at people potentially experiencing barriers to accessing services, such as people:

- living in deprived communities
- from an ethnic minority group
- with learning disabilities
- with severe mental illness
- on long waiting lists, for example due to Covid.

Patients selected activities or therapies according to their own interest and these were delivered by a partnership of voluntary, community and social enterprise (VCSE) organisations in Keighley and Bradford, West Yorkshire.

The Partnership produced a first-stage evaluation report in June 2021. This provided a snapshot of the status of the pathways at the end of the funding period (March 2021). It was structured around the intended impacts and success indicators outlined in the Partnership's application for funding. It included early indicators of outcomes for patients that showed positive benefits in terms of increased well-being and self-management.

The Partnership has now commissioned an independent analysis of all the data captured so far, which will enable the health system to evaluate whether such a service could be of benefit, with a view to developing a transferable model.

We conducted a desktop review of a wealth of data collected from patients and associated professionals (see Section 3 'Methodology of evaluation' below). Patients had accessed one of the two pilot pathways (see Section 2 'Activities delivered' below). Our focus was to evaluate the usefulness of the service according to the Partnership's stated outcomes. There were intended service processes and outcomes both for patients and for system economics. We analysed all the data that was provided to us, and these data covered the period March to July 2021, and include data collected throughout as well as a post-period assessment.

It must be noted that, whilst the data so far show clear benefits to patients and to the healthcare system, the sample size was small, and the timeframe for this evaluation was rather too short to claim success in terms of some of the outcomes that were hoped for, but nevertheless, this study gives some invaluable insight into how a community-based patient-focused intervention, targeted at specific population groups, can have benefits.

## (2) Activities delivered

The pathways were conceived, designed and delivered by partnerships of locally based VCSE organisations working in collaboration with NHS primary care networks in various localities within the Bradford local authority area.

## Pathway 1 – ‘Ease My Pain’

The pathway was designed by Health Action Local Engagement (HALE) and Affinity Care NHS primary care network, and the service was based in north and south Bradford.

Their service information states:

*There is growing evidence to show that people taking part in activities with others, including art, mindfulness, crafting, massage and exercise, can manage their pain symptoms better, suffer less with their pain and have an improved quality of life. Affinity Care in partnership with HALE (Health Action Local Engagement) are pleased to offer this programme of activities available for patients who are living with chronic pain.*

Activities were:

- Massage - 4 online group instruction sessions delivered
- Craft, art and model making - 24 group sessions delivered
- Exercise sessions - 30 group sessions delivered.

## Pathway 2 – ‘MSK Connect’

The pathway was designed by Keighley Healthy Living (KHL) and Project 6 (P6), working in partnership with Modality NHS primary care network, and the service was based in Keighley.

As stated in service publicity:

*MSK Connect is a free local service which supports people living with musculoskeletal (MSK) conditions affecting the joints, bones and muscles, and includes autoimmune diseases.*

*MSK Connect will link you to a variety of local services and activities to support your physical and mental wellbeing, alongside the care you receive from your doctor or hospital.*

*Our friendly team will introduce you to opportunities which support independent living, making social connections and other meaningful activities aimed at managing your pain and giving back quality of life.*

*We are not about a ‘one size fits all’ approach. We talk to you, understand your individual needs, and hear what you think will help you and others living with MSK conditions and long-term pain.*

Activities were:

- **In-person activities**
  - MSK Conditions Peer Support Group (with guest speakers)
  - Weight loss and lifestyle change courses
  - One to one meetings and phone calls
  - Cookery courses
  - Walks (outdoors, including opportunities to share food & socialise)
  - Conversation café (outdoor café with activities & social opportunities)
  - Games café (outdoor games & social opportunities)
  - One-to-one breathing therapy for pain management and reducing anxiety
  - Chair based yoga
- **Diet and nutrition support**
  - A healthy balanced diet
  - Food and Mood

- Diet and bone health
- Diet and supporting immune function
- Diet and inflammation
- Diet and combatting fatigue and low energy
- **In-person exercise groups**
  - Chair based 'Staying Steady' exercise classes
  - Ballet-Be-Fit exercise classes
  - DDMix Dance based exercise
- **Online exercise activities**
  - Staying Steady
  - Core and floor exercise
  - Bums and Tums

### (3) Methodology of evaluation

We have attempted to explore the following areas (as agreed before we undertook the work):

1. **Has this intervention met the desired patient outcomes? If so, how?**
  - Have the different streams worked differently?
  - What does success look like?
  - Do stakeholders and patients have different views on meeting these outcomes?
  - What is the distance travelled in meeting these outcomes?
  - What have been the challenges to meeting these outcomes? How might different groups have experienced these differently?
2. **Has this intervention met the desired systems outcomes? If so, how?**
  - How strong is the data on this?
  - How has it addressed health inequalities?
  - Has there been any differences in this across the board, between the different programmes and groups?
3. **What are the key lessons that can be learnt from this? What would be replicable?**

We explored the data using both quantitative and qualitative methods.

#### Pathway 1 – Ease My Pain

We received and analysed the following data:

- Pain Diaries. These were distributed to **64 participants**. They included a scoring questionnaire for each week and an "I feel" page for each week, with positive and negative words linked to their emotional and physical wellbeing to select from, and additional space to write down reasons for choosing those words and any further reflections that they had. **32 diaries** (50%) were received back from patients.
- Statements made or shared with the facilitators during sessions and in-between sessions via email and WhatsApp group.
- Reports from **15 phone call conversations** with participants undertaken by the Engagement / Social Prescribing Team
- GP Evaluation

- Demographic information.

## Pathway 2 – MSK Connect

We received and analysed the following data:

- Musculoskeletal Health Questionnaire (MSK-HQ) (before and after intervention) – **14 questionnaires received**
- Case studies (patients)
- GP evaluation
- Demographic information.

## (4) Results

The two pathways were designed and delivered independently, and had different evaluation methods, therefore under each of the aspects that were measured, we are presenting the results for pathway 1 and pathway 2 separately. We will provide learning across the whole programme at the end of this report (section 5).

There were merits in both data collection methods, and a good learning point would be to use the best methods from both pathways when collecting data in future. For example, in pathway 1 the primary care engagement / social prescribing team contacted patients directly to gather qualitative intelligence, which provided a richness of intelligence, whereas pathway 2 administered pre- and post-test questionnaires.

We investigated the data according to the following stated service processes and outcomes for the programme:

Service processes	
Service design	1. Pathway codesigned by clinicians, patients, VCSEs, etc.
Service delivery	2. Pathway delivered through VCSE at community level offering long-term MSK patients a route to better self-management of their condition 3. Patients in the pathway are from the target populations 4. Improved connection of the patients in the pathway with sources of support in their local communities
Patient response	5. The adoption of self-management strategies (by patients in the pathway) that empower people to live with their long-term condition
Outcomes	
Patient outcomes	6. Slowed progression of long-term health conditions 7. Improved mental and physical health

System outcomes	<ol style="list-style-type: none"> <li>8. Savings in clinicians' time</li> <li>9. A set of principles for targeting interventions towards those with the greatest need that can be shared</li> <li>10. Greater shared understanding of how the VCSE sector can support patients with long-term MSK conditions</li> <li>11. A model for a health and wellbeing pathway that complements and reduces the need for medical intervention tested and refined in two geographical areas.</li> </ol>
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## 1: A pathway co-designed by clinicians, patients, VCSEs etc.

This was a stated 'service design' process.

### Pathway 1

There is strong evidence that the 'Ease My Pain' service was individualised to the needs of individual patients. However, it does not appear to have been 'codesigned' at service level together with patients and other stakeholders.

Previous feedback and work with patients informed the development of this service based on what has been successful and well received previously.

The service was individualised in that:

- patients were invited to take part in a survey helping to identify what activities would appeal to them, when and how they would like to access those activities.
- facilitators and the engagement team contacted potential participants to discuss the programme and find out about any specific needs that they may have.

Feedback from patients showed good results and led to service improvements:

- Feedback relating to the facilitators about their approach, skills and their willingness to help and support the participants was excellent.
- Feedback from first cohort of patients led to further tweaks to the questionnaire.
- Feedback from facilitators continues to inform tweaks and reviews of the delivery model.

### Pathway 2

There was a strong element of service codesign on the 'MSK Connect' service. Most notably, there was:

- co-design between VCS, Modality and GPs in pilot planning and delivery
- co-design of participant information leaflet
- co-design of the community health offer
- co-design of ways to promote pain management, where, how and whom to
- co-design of what a peer support group would run like and entail (and feed into pilot)

- co-design of 'guidance' for initial contacts with patients and how to move them forward
- intent to include experts by experience or community champions to co-design the pilot further.

This is a strong co-design ethos in all areas of the project, although we were not able to ascertain from the data if feedback led to changes to delivery or data collection.

## 2: Additional health and care pathways delivered through VCSEs at community level offering long-term MSK patients a route to better self-management of their condition

Items 2 to 5 were anticipated service delivery processes.

### Additional health and care pathways

These pathways were in addition to clinical services delivered by the NHS. Patients were not denied any clinical appointments by joining the programme.

### Delivered at community level

Both pathways were indeed delivered at community level in that they were delivered by local VCSE organisations.

### Offered patients a route to better self-management

The sessions did offer a route to better self-management in that:

- they aimed to broaden understanding about pain symptoms, triggers, how certain activities can distract and therefore reduce or ease symptoms of pain.
- introduced practical activities that patients could do themselves
- enabled patients to continue activities after the intervention.

Given the short timeframe of this pilot and evaluation, and the small size of the sample group, we cannot ascertain to what extent the patients continued with the activities after their engagement in the programme. This would be an interesting inquiry in a follow-up evaluation.

## 3: Patients in the pathway are from the target populations

The target populations were:

- living in deprived communities
- from an ethnic minority group
- with learning disabilities
- with severe mental illness
- on long waiting lists, for example due to Covid.

## Pathway 1

The criteria for patients included those with a long-term MSK condition who were on a waiting list and living in deprived communities, learning disabilities or severe mental illness.

Seven identified as having a disability, but we do not know if these included 'learning disability'. We could not see 'mental wellbeing' having been recorded.

The service reached six participants with no access to a computer, laptop, internet and/or smartphone, for those who needed them tools we provided including I.T equipment and support to get online and access the support.

Take-up was fairly well gender-balanced: 30 men and 34 women. This could be considered a good achievement in attracting men, given that complementary health type activities tend to attract more women.

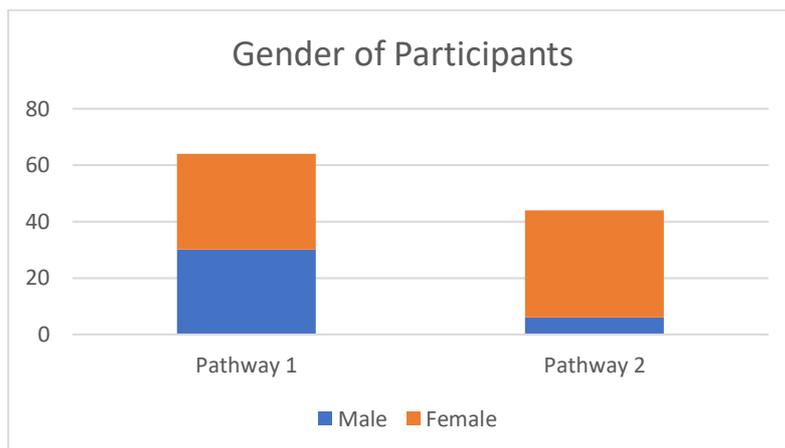
42% of those targeted did not take up the offer. Although some did take up the offer in the next cohort.

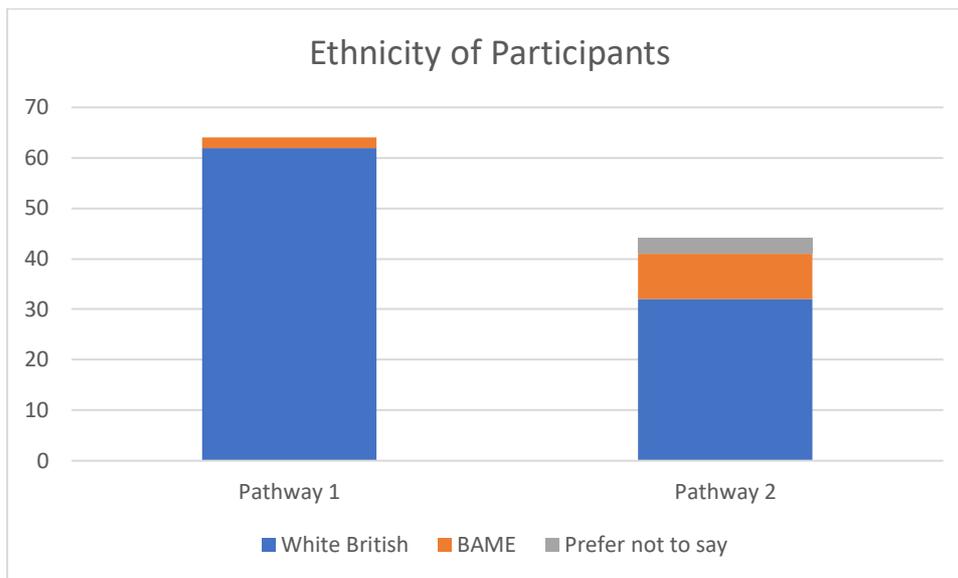
## Pathway 2

Of the 44 participants on pathway 2:

- 9 identified as from ethnic minority groups with three not speaking English
- 27 had diagnosed/expressed mental health conditions
- 6 were men and 38 were women
- 20 people were classed as digitally excluded
- 4 people were housebound.

Below are two graphs which demonstrate the gender and ethnicity identities of participants from both pathways. They demonstrate how the different pathways had quite different participants.





## Challenges to engagement

### Ethnic minority groups

*“I ... spoke to several patients who for different reasons have not engaged with the offer of support. The reasons vary from patients with chronic pain who may still be “cure seeking” or those with other commitments such as work or caring for a family member. Unfortunately, cultural barriers and communication or lack of spoken English also played a part.” (GP)*

Results of this study show that it was harder to engage people from ethnic minority groups, but also the providers noted that placing into groups and so on was difficult. Examples of why the MSK Connect team think it was more difficult to place people from ethnic minority groups are:

- Accessibility, language barriers
- Accessibility, literacy barriers (completing forms etc.)
- Cultural sensitivities
- Appropriateness of community-health offer for people with MSK conditions and chronic pain
- Fewer, or less awareness of, community health offer options meeting needs of ethnic minority groups
- Decision making process includes more voices than just that of the individual
- Transport
- More time and resource for engagement and signposting than this pilot allowed for.

Some women from ethnic minority groups (Bangladeshi and Pakistani) told practitioners they preferred to come to the Keighley Healthy Living Centre (a community centre that serves mainly white British people in Keighley). Their reasoning was that they wanted to avoid the ‘segregation’ issues in their community, which they believed were present in other community centres in Keighley (centres perceived to cater to particular ethnic minority groups).

*“I don’t want to get into that whole minefield of “Are you Bangladeshi?” Then that’s not for you because you’re Pakistani, you need to go to [community centre]”.*

In contrast, some other ethnic minority participants expressed they would prefer to have their needs met in a centre catering to people from their specific ethnic minority group.

*“Is [the centre] for women like me, from Pakistan? where they’ll speak in Urdu?”*

Some patients from ethnic minority groups raised points about the cultural appropriateness of the health offer, language barriers and a wish to be integrated into a group in ways that meet their needs and that were culturally sensitive.

*“I can see why it’s harder to place my Mum because she’ll want to be with people who are the same as her [culturally]”. (Daughter of Mum aged 47)*

*“Yes, if you send some information, me or my brother can read it to Mum and then she’ll decide”. (Daughter of Mum aged 47)*

*“I suppose you get less Asians than white people and so it’s harder to find them somewhere to do this and get this sort of support [MSK Connect] than it would be if they were white ..... but we’re just glad of someone’s trying to help, we’re really grateful”. (Son of Mum aged 64)*

*“Mum will only be able to do stuff or go to stuff that are for Pakistani women and with other Pakistani women, and with no men there”. (Son of a Mum aged 64)*

### Experience of programmes being transient

There were also concerns that programmes ‘come and go’. Participants were sceptical of new initiatives because other support services they had signed up to had stopped due to changes in funding or strategic direction etc. People want more consistency and longer-term, locally-accessible initiatives.

*“She was very open to having a conversation with us about the community health offer, but had some reservations because she had engaged with support offers before which had suddenly ceased.”*

*“You wonder if to get involved because things like this stop and start, I was doing ‘Living with Pain’, Bradford and then, well, that just stopped!”*

*“The physio is just for a bit, then it stops, I still try and do the exercises they gave me”.*

### Recognition that it might take time

Practitioners noted that some patients may be disinterested, lack confidence, or feel there is no point in engaging with the community health offer. They noted that with this cohort (who could be described as harder to engage), a high percentage just need more time and support to get them to a point of readiness and that this requires, time, capacity, funding and resource.

Staff used innovative methods and invested time and resource to increase engagement, for example a ‘traffic light’ system was used to categorise where people are, moving from red to yellow to green. There was an example of a participant with very little English who received four weeks of phone contact (with children translating) and one-to-one wellbeing calls, which then turned into 12 weeks of active engagement (phone calls and in-person activities).

Another example was a woman who had negative clinical experiences, and it took time to build her confidence and get her to engage. This entailed six weeks of phone contact and one-to-one wellbeing calls, which then led to 12 weeks of active engagement.

*“The MSK Connect team needed to have the skills sets to manage the conversation and bring it away from her clinical experiences, back round to the community-health support offer. Getting*

*[client] to explore what she thought might help or that she'd like to try took time, to move [client] forward on her own terms to a point of willingness and her wanting to engage.” (Case study)*

It was also noted that it can take a few trials of different activities to find something that suits and supports the client, their condition, self-care, and pain management.

### Preference for face-to-face activity

The context of the Covid pandemic, which resulted in a significant amount of the offer being online (particularly in pathway 1) may have also affected uptake where delivered online:

*“Exercise classes, I miss those, but I want to do them in person, I don’t want to do them online or over the phone”.*

### Gender

There was no requirement on the providers to target the pathways according to gender, but there were some interesting points to note on this.

Whilst pathway 1 had a relatively good gender balance, pathway 2 had notably low numbers of men (6 of 44, or 14%). Practitioners noted that health and community services often have a limited offer for men, and men commonly avoid health spaces. There was an interesting case study of man who ‘accidentally’ joined Ballet-Be-Fit because the course which he would have initially preferred was full but enjoyed it in the end! This may be indicative of the need for more consideration both when planning activities to ensure that there are things which may not appear to exclude men but also to talk about this when suggesting activities to men.

*I heard about the free exercise classes, but the Staying Steady was full and that’s when Alison said try ‘Ballet-Be-Fit’, I don’t think I heard her right [laughing]. Anyway, next thing this builder in his 60s was doing ballet moves.... I thought, I’m the only fella here! What am I doing here? But then there’s some men at Staying Steady and the lasses are really welcoming at the other classes”.*

## 4: Improved connection of the patients in the pathway with sources of support in their local communities

We could not find direct sources of data that enabled us to assess this for pathway 1 (Ease My Pain) beyond anecdotal examples of starting yoga or attending the gym. However, given the activities highlighted, we would expect some of the same outcomes in pathway 1 as were shown in pathway two.

For pathway 2 (MSK Connect), we did see evidence that participants increased their connection to sources of support in their community, although this was hampered somewhat by the delivery being online due to the pandemic, whereas in normal times it would have been mostly delivered face-to-face. For example:

- a GP cited several examples of patients engaging with the service who previously would have been unlikely to take up existing NHS services, demonstrating that they are taking up increased sources of support within their community.
- pathway 2 contained a peer support group, with participants creating a list of guest speaker topics which could be co-designed into the pathway and could be delivered in community settings

- one person who was very isolated as reliant on son and daughter to support to go out has signed up to do yoga classes in-person from September 2021.

The need to bring people face-to-face was recognised. Participants did not feel that being directed to a web support resource was enough. One participant was not keen to continue with online activity long-term but wanted to meet likeminded people in her community.

13 of the 44 people in pathway 2 (30%) expressed loneliness or isolation before the intervention took place, demonstrating the importance of increasing their community support. Even for those who were active community members it was difficult to connect with those who had similar experiences, as finding people who shared their experiences of MSK conditions proved difficult. In addition, it was useful to have a facilitated experience within the group to stop a spiral of negativity.

*“It’s good to get together with people who are like you. I feel like I’ve got a bit of a role to play too, you now when someone gets in a spiral of just talking about their illnesses and their pain, I’ve found the group lead is good at changing that conversation into more of a positive, but I feel like I’m coming in and helping with that”.*

Participants spoke about how prior to engaging in the programme they had a lack of knowledge about support outside of clinical settings. Through taking part in the programme there has been a shift in their thinking, recognising the support that has been given and the benefits of taking part in things outside of a clinical setting.

*“I think there’s such a big place for this kind of support from the moment my doctor said try this, because I’d have not known about it or thought about it [the community-health offer] but look what it’s done!”*

## 5: The adoption of effective self-management strategies that empower people to live with their long-term condition

This was defined as a ‘patient response’ criterion.

There is strong evidence in both pathways that participants gained self-management capabilities that they could use beyond the programme.

### Pathway 1

Two thirds of the participants contacted by their GP (10 of 15) reported that they are continuing with strategies learnt:

*“Thanks for the classes; I have found them very helpful. In fact, I am now doing the exercise set most days of the week”*

*“ I have started going back to the gym now”*

There was also qualitative evidence of increase in knowledge to help manage health conditions, in other words, knowing what they need to do to better manage their conditions:

*“You have been very helpful in answering questions and providing me with relative advice and links to have a look at in order to help with my health conditions.”*

## Pathway 2

*“I would have just been sat home alone thinking about my aches and pains, I’ve come here today and now there are so many things open to me to try that might distract me from myself, I can’t wait to try Tai-chi”.*

Of those who were engaged in pathway two and completed both before and after questionnaires (14 people) the biggest area of movement was in their confidence in being able to manage their condition, with almost three quarters (10 of 14) seeing improvements, with the average improvement being one stage improvement, for example moving from ‘moderately well’ to ‘very well’ or from ‘not at all’ to ‘slightly’.

In addition to this, eight people saw improvement in their understanding of their conditions with this ranging from 1 point of improvement to 3 points; in fact, one individual moved from feeling they ‘slightly understood’ their condition to ‘completely understanding’ it.

*“Now I might take some medicines for my conditions, but I also do some more stretches and see how I feel, see whether I need it [pain relief]”*

*“I know that medically for me, there’s nothing that can be done but this has helped me to do something for myself”.*

## 6: Slowed progression of long-term health conditions

Criteria 6 and 7 were anticipated outcomes for patient health and wellbeing.

‘Slowing progression’ is difficult to assess, particularly in a very short-term study, with a small sample size such as this. But, given that with MSK conditions one would expect that with no intervention the condition would generally remain stable or worsen over time, the fact that we found evidence of improved symptoms is encouraging.

The data for pathway 2 (MSK Connect) gave us a better understanding of its potential to slow progression because the patients completed pre- and post- intervention questionnaires, and we can see from these (table below) that for many of the participants there was an improvement in their condition during this period. However, given the short-term nature of the pilot and small sample size we do not know if this is long-term or generalisable.

It is also worth noting that we have not been able to control for other interventions (such as changes in medication) which may have had an effect on patients’ symptoms or the progress of their condition.

	Pain/stiffness during the day	Pain/stiffness during the night	Walking	Washing /Dressing	Physical activity levels	Work/daily routine
Number who saw improvement	5	6	4	3	9	4
Number no change	8	8	8	11	2	9
Number who got worse	1	0	2	0	3	1

Average points change on MSK health questionnaire	+0.36	+0.5	+0.14	+0.21	+0.36	+0.21
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These figures are numbers of patients out of a total of 14 for whom we saw pre- and post-intervention questionnaires.

The ‘average points improvement’ is a value out of a total of 5 points on the scale.

We can see from these figures that whilst a small number of the pathway 2 participants experienced a worsening of some symptoms during the programme, the overall direction of travel was positive improvement, which indicates slowing of progression. Given that the activities delivered in pathway 1 were similar, we may be able to extrapolate that pathway 1 showed similar outcomes, but this is an assumption.

## 7: Improved mental and physical health of patients in the pathway

Both pathways showed substantial improvements in mental and physical health.

### Pathway 1

In pathway 1 there were 32 diaries back from participants. Many of these demonstrated a shift from around week three, with comments about lack of sleep, being drained and irritable prior to that being replaced by feeling proud, greater flexibility and comfort. In addition, some diaries demonstrated some impact from early on (weeks 1 or 2), but this was uncommon.

One patient reported benefits from the very first activity:

*“I want you to know how incredible I felt the day after my first meeting. I still find it unbelievable. The pain and stiffness had receded so much, and I even managed to get some decent sleep. As you know, I keep active and had not expected too much from the lesson so you can understand my surprise. You deserve a gold star.”*

### Use of evaluation tools

Perhaps unexpectedly, the evaluation tools themselves may have had a benefit for participants in pathway 1, with a reflective diary acting as a tool to understand mental and physical wellbeing more. For one participant, the diary itself had therapeutic benefit:

*“She found the diary interesting as it got her to write things down and think things through. It got her realising and knowing things that she does and does not do and how this will affect her feelings of fatigue. She said it inspired her to start journaling.”*

Additionally, this may have been the case for other participants, which makes it more difficult to pinpoint where changes came from for this user group.

### Pathway 2

In pathway 2, around two thirds (9 of 14) who completed both pre- and post- intervention questionnaire saw an improvement in their emotional wellbeing. This was particularly

important, as practitioners noted that depression and anxiety, whether diagnosed and medicated or self-expressed and self-medicated, are included in the narratives of the majority of people we have been in contact with, or who are engaged in, MSK Connect and its activities.

Also, 10 out of 14 reported increased confidence in being able to manage their symptoms and seven of 14 saw an improvement in their sleep.

	Sleep	Fatigue or low energy	Emotional well-being	Understanding of condition and any current treatment	Confidence in being able to manage symptoms
Number who saw improvement	7	6	9	8	10
Number no change	6	7	5	6	4
Number who got worse	1	1	0	0	0
Average points improvement on MSK health questionnaire	+0.57	+0.29	+0.79	+0.86	+1.0

These figures are numbers of patients out of a total of 14 for whom we saw pre- and post-intervention questionnaires.

The ‘average points improvement’ is a value out of a total of 5 points on the scale.

## Common themes from the data

The qualitative data showed some distinct ways that the programme improved wellbeing:

### Feeling more positive and boosted confidence

Feeling more positive was a very common experience, sometimes related to the pride of ‘going outside of comfort zone’ in trying something new. Being able to do more in day-to-day life also gave a boost in confidence, as participants recognised that they could do things that they previously thought they could not.

*I personally feel that joining in with the exercise sessions has helped to reduce some of the constant pain I suffer on a daily basis due to fibromyalgia and arthritis. It has helped me to feel more confident in doing daily tasks. Joining in with other people has been an emotional boost as well, as I feel more confident in doing exercises independently at home.*

### Sense of community

Feeling connected to others, particularly those with shared experience, was a key aspect that came through from both pathways. In the diaries from pathway 1 this came up very strongly but quite late in the process, rather than in the initial stages, as we may have expected.

*“Joining classes has helped my emotional wellbeing and I feel happy and not alone. The group has been very supportive, and I would like to continue to the next sessions.”*

*“Found craft sessions a distraction. Although I think, it was the interaction with the people.”*

*“I found the last two weeks therapeutic, being able to talk to others with chronic pain.”*

### Space for oneself or distraction from symptoms

The opportunity to explore new activities and take focus away from the pain experienced was valued highly.

*“It’s been very nice to have an hour to myself each week to do something new and be allowed to mess about! “*

*“...The art sessions provided distraction from the pain I am living with. The positive feeling would last for the rest of the day!”*

### Change in mood

Practitioners reported that some participants had feelings of guilt for being unwell and having chronic pain conditions. They speak about the impact this has on friends’ and families’ lives and about friends dropping away as someone with these conditions is not much fun to be around, and the resulting loneliness and isolation that can lead to.

*“I have seen a big change in myself, I’ve a newfound confidence and a newfound vigour, people I know have noticed it, I’ve a spring in my step and they say it shows on my face. Before I got involved with this MSK Connect, I’d given up a bit, I wasn’t getting out of bed until 2pm, I wasn’t getting involved in anything. Since joining the groups and meeting new people who have the same things going on as me, that get it, I’m up at 6.30am now, I’ve got some purpose to my day”.*

*“You have someone else, outside the home and the doctors to talk to, a different space and that’s been a good thing”.*

*“Since I started on this, my moods have just lifted”.*

### Continuation of health challenges

It is worth mentioning that despite all the improvement, the people in this study still had the underlying condition. For some participants there were continuing pressures from not receiving the perceived appropriate levels of clinical support, including some feeling they were not believed by their GP or feeling despondent at their situation.

*“I’m still waiting for a diagnosis, which is not helping my mental health. Is this as good as it’s going to get?”*

For a small number of participants, we saw frustrations or pressures caused by programme itself:

*“Feel really frustrated behind on artwork and putting pressure on myself, I feel very angry with my body.”*

*“Found it hard to participate due to splints in both her hands.”*

## 8: Savings in clinicians’ time

Criteria 8 to 11 were anticipated outcomes for the health and care system.

There were significant savings in clinicians’ time across the two pathways.

## Pathway 1

Whilst three of the 15 interviewed by the primary care team had an increase in appointments during this period, there was an overall reduction of 35 appointments across the 15 participants.

The type of session didn't make a difference in small sample nor did age or gender.

Only two of the 15 perceived that they were more likely to contact a GP about flare-ups, and neither of these patients were continuing with what they had learnt. So, the majority (13 of 15) expected to contact their GP less.

*“Using the records to look at GP contacts, it would appear that for most people, they consulted GPs about their pain less after the sessions, even when they subjectively thought it would not affect how frequently they would contact the GP about their pain. However, due to small sample size and the concurrent pandemic it is hard to determine if this is clinically significant or not.” (GP)*

## Pathway 2

We do not have the same GP data above for pathway 2. However, one GP gave an example of a patient who is a “very high user of primary care and the MSK service.”

*Prior to the MSK Connect project she would often contact for a review appointment in the MSK service. She was very positive about the benefits she has already gained from the exercise classes (Ballet Be Fit, safe movement, dance etc. at KHL). Stretching advice made it easier for her to get moving in the mornings. She also reported that the group sessions with other people in similar situations have been therapeutic. She feels her pain is generally better and has reduced her use of painkillers. She feels she is more likely to deploy mindfulness, relaxation and distractions when pain flares rather than using painkillers or calling her GP surgery. She was very grateful for all the help she had received from the staff and exercise instructors at KHL.*

Of those who were engaged in pathway 2 and completed both before and after questionnaires (14 people) the biggest area of movement was in their confidence in being able to manage their condition, with 11 of the 14 seeing improvements in this, the average improvement being one stage e.g., from ‘moderately’ to ‘very well’ or from ‘not at all’ to ‘slightly’.

## 9: A set of principles for targeting interventions towards those with the greatest need that can be shared

We could not find any data that speaks to this intended outcome. It can certainly be extrapolated from the data that the targeting of the interventions to people with greater need did indeed increase take-up of and retention in the services, although for this pilot, it cannot be claimed that the service reached those in most need. This could be due to the constraint caused by the shortness of the timeframe. This only enforces more the need to spend significant time on engagement, if a service is to really reach the typically unengaged, and/or those with the greatest need.

The practitioners on pathway 2 (MSK Connect) highlighted the principle that for community-based services such as this programme there is a place for light touch engagement, but that this offer needs to be combined with more time- and resource-intensive methods in order to be able to engage those who may benefit, who are harder to engage. This use of light touch

engagement was successfully used within pathway 1 (Ease My Pain), demonstrating the use of community-based services in both settings.

## 10: Greater shared understanding of how the VCSE sector can support patients with long term MSK conditions

### Shared understanding between VCSE and primary care

It was an ambition of this pilot project to build shared understanding of how the VCSE can contribute to mainstream clinical pathways. As a result of this project, the Partnership produced a document ***'Pathways from PCNs to VCSE provision: Service model'*** (August 2021). This is intended to provide a template for future pathways involving the VCSE in West Yorkshire and Harrogate and potentially nationally. It highlights several enablers of success in building care pathways collaboratively:

#### Improving the likelihood of success

- Co-produced pathway proposal
- A simple referral pathway with bespoke selection criteria
- GP engagement/service proposals driven by clinical interests
- Clinicians who already see VCSE potential
- Working with existing good relationships
- Local VCSE infrastructure organization that is experienced in working with Health

#### Things that make life easier

- A structured process for identifying potential pathways (when you still need to make the case)
- An integrated, local Social Prescribing service

#### Compensating for missing ingredients (mitigation)

- No committed clinician
- No existing working relationship
- No engaged/active VCSE infrastructure organization

#### Contributory systemic elements to support VCSE provision

- Longer term funding
- Place-level forums for VCSE commissioning
- Accessible VCSE service directories
- Cross-sectoral training

This very much chimes with the messages contained in [Creating Partnerships for Success](#) (NCVO, 2020), which outlines the key components of successful cross-sector (ICS-VCSE) partnerships, and to which the West Yorkshire and Harrogate system was a contributor.

It would seem that shared understanding has been developed, certainly at PCN level. By designing and delivering the pathways collaboratively with PCNs, the VCSE providers would have built capability in working in an integrated way. It would be good to be able to share their learning with providers of future integrated care pathways, and the new service model certainly provides useful intelligence in support of that. However, it must always be considered that for

the VCSE to be able to engage strategically, not just as a commissioned service provider, this needs resourcing, both in terms of the time commitment of the VCSE and in upskilling the VCSE sector to engage at that level.

### Shared understanding between providers and patients

We also found evidence that supports the need for shared understanding between patients and providers. ‘Trust and confidence’ was a key issue. Above all, patients need clarity and consistency in order to build trust.

*“You don’t want to just go somewhere that’s not regulated or somewhere where you don’t know if people understand [her condition] but because of MSK Connect and the team I trusted I was going somewhere safe and who knew what they were doing”.*

The concept of a community health offer was new to many patients, who sometimes expressed a lack of interest to engage because of past failures in continuity of various schemes, and so they thought this support offer would cease, or they were cautious because they had had accessed an inappropriate community or clinical support option in the past.

There also seemed to be a mutual recognition that there is a limit to clinical intervention, and that there are practical constraints caused by lack of capacity in the clinical sector, that the VCSE is well placed to support:

*“The GP suggested this to me, you know doctors can only do so much and I don’t want to live forever taking pain tablets. He [GP] suggested trying this, a more holistic way to deal with the pain and manage each day and I thought, let’s see is there another way to get help, but it took the people contacting me [MSK Connect] to get me from thinking about it, to doing it”*

*“I think there’s a big role for this kind of support, for me and other people. There’s a lot of people who don’t get enough time and attention from their doctors, it’s not their [GPs] fault, they just don’t have the time! This way you feel like someone gives you some time, and that they understand”.*

It is also likely that patient confidence in the pathways was built by the fact that GPs or other primary care staff recommended the pilots to patients, and it was clear to patients that the VCSE providers were working closely with primary care. This would have given the services an added layer of ‘respectability’, for example, patients having a feeling that there was an element of clinical oversight.

## 11: A model for a health and wellbeing pathway that complements and reduces the need for medical intervention tested and refined in two geographical areas

Two pathway models were indeed designed, tested and refined in two geographical areas within the Bradford local authority area, as evidenced above.

It must be noted that due to the Covid pandemic, the pathways were delivered much more virtually than would happen in normal times. If these services continue, it would be interesting to see whether moving activities to a face-to-face setting increases benefit further.

*“I’m hoping that we can build on this work with higher numbers in the future and be able to get a more realistic representation of how patients act without a global pandemic.” (GP)*

We also saw evidence in the data that technical barriers affected participation to a certain extent. These was a lack of ability among some patients to use computers or digital platforms and in some cases a lack of capability in practitioners.

The main aspect that could be improved is the collection of data. There were advantages to both data collection approaches – namely the more qualitative approach taken by pathway 1 in terms of primary care professionals interviewing patients, and the more quantitative approach taken by pathway 2 with the administration of pre- and post- intervention questionnaires. A better approach would be to employ both approaches consistently across the whole programme.

It must also be noted that use of a journal is itself a therapeutic activity, and this may in a way ‘contaminate’ the outcome data. Some patients found the diary irrelevant or confusing, which points to the need for multiple data collection methods.

<i>“Didn’t fill the diary in as felt 80% was not applicable to me”</i>
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<i>“I feel a little confused by the diary and the purpose of it”</i>
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<i>“I found the diary to the point and it made me think more holistically about how things influence my pain. I found it really useful”</i>
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## (5) Learning

### Key learning

#### 1. The pilot pathways improved outcomes for patients and saved clinicians’ time

The pilot pathways to complementary and alternative approaches **did improve outcomes** for patients, as shown in sections 4.6 and 4.7 above. Even in this short study, we saw an average improvement **across all indicators of physical and mental wellbeing and slowing progression**. It is too early to evaluate whether the patients have maintained the self-help techniques in the longer term. There were also early indications of patients successfully **using the learnt self-help techniques on their own**, beyond the interventions.

It must also be noted that this improvement took place despite the services being delivered virtually much more than would have happened in normal circumstances.

#### 2. Clinician time was reduced

We saw that a key success factor in pathway 2 was patients’ **understanding of their condition** and **confidence** in helping themselves. This may have led to reduced take-up of NHS care. We **did see early indications of reduction in use of GP time** in pathway 1. This would be worth exploring further.

#### 3. The pathways increased take-up of wider community activities

Whilst the timeframe was short, there were indications that **participants increased their connection to sources of support in their community**. There was evidence that this continued after the programme, with some participants keen to take on new activities.

#### 4. Integration makes sense

**Integration of care makes sense.** By bringing primary care together with the VCSE, we achieve **clinical oversight** and the **VCSE's capability** in reach, closeness to communities and ability to build trust and confidence in the longer-term through consistency. People often do not feel 'seen' or 'heard' in clinical settings, and the VCSE can deliver on this.

The involvement of primary care, in particular the GP or a social prescribing link worker, gives an **added sense of confidence** to patients.

#### 5. People experience barriers, but these can be overcome

**Barriers** to accessing services such as this include language barriers, literacy barriers, cultural sensitivities, the appropriateness of the offer to the patient group, transport, and so on. For these to be addressed there needs to be **time, resources and skilled practitioners or facilitators**.

It was also interesting to note that some of the ethnic minority patients preferred to access mainstream services, rather than a service aimed at their ethnic group, which challenges the assumption that people from ethnic minority groups always require culturally bespoke provision.

While excellent work was done to engage and understand issues that prevent people participating, there are further opportunities to fully put this learning into practice. There will also be advantages in **sharing learning across the whole programme** if future service models entail multiple pathways delivered by different providers.

#### 6. Bespoke pathway design is advantageous

The fact that pathways were tailored specifically to the needs of people suffering from musculoskeletal conditions was an **advantage**, as this gave the services both **clinical relevance** and gave patients a **peer network** that that might otherwise not have had. It would be interesting to see whether this peer network can be maintained over time, and whether this is dependent on facilitation.

If **men** are a target audience, then thought needs to be given to how activities and indeed the entire programme are designed and promoted specifically to attract men. Pathway 1 had far greater numbers of male participants, but we could not see from the data why this was the case, so there is an interesting area for further study here.

#### 7. Building relationships with patients is important

Pathway 2 put a considerable amount of effort into **building relationships** with potential participants, which included in some cases several weeks of phone calls. This may have led to the **better reach** into the target populations in pathway 2. This dynamic should be studied further.

### Summary of key enablers

1. **Good collaborative processes**, shared vision and approach across sectors, leading to cross-sector collaboration being the default.

2. **Maximising the strengths** of both sectors – in this case the clinical oversight of primary care together with the reach and capacity of the VCSE sector to build trust and relationships and tailor services to individual needs.
3. **Adequate funding**, through commissioning processes, to enable the VCSE to deliver an effective service, and to enable good codesign.
4. Time and resource to **build trust and confidence** in patients and **build relationships**, and acknowledgement that it might take a long time for some people to engage.
5. **Continuity** of services provides opportunities for relationships to be built and for participants to build trust, both in the service providers and in the changes that they are making in their lives.
6. A **wide range of activities**, and the ability for patients to try several things before finding the right activity, with attention paid to specific groups, such as men.
7. A **longer timeframe** to assess longer-term impact, and the success in terms of patients applying self-help techniques beyond the programme.
8. **Consistent data collection methods** and clarity on what should be collected and why. Also, an ability to disseminate data across the health and care system to assist in the collaborative development of other clinical pathways.