Meeting Date	**26 April 2022**	**Agenda Item**	**4.4**
Report Title	**Supporting Patients who are waiting for treatment in Swansea Bay**		
Report Author	Michelle Davies, Head of Strategic Planning		
Report Sponsor	Craige Wilson Deputy COO		
Presented by	Craige Wilson Deputy COO		
Freedom of Information	Open		
Purpose of the Report	The purpose of this report it to provide an update on the schemes initiated to support patients whilst on the waiting list in 2021/22, and the plans being progressed in 2022/23.		
Key Issues	• Whilst efforts are being made to increase outsourcing/ insourcing capacity and through new modular builds surgical activity has been severely affected with a record number of patients waiting for surgery. • Outpatient waiting lists continue to present a challenge to the Health Board in recovering its position on Planned Care services. Outpatient services have been greatly impacted by the COVID-19 pandemic and recovery has been challenging. • Negative feedback from people about their lived experiences of waiting for elective surgery for joint replacement, orthopaedic and spinal surgery – report by the Swansea Bay Community Health Council. • The lack of a formally agreed prehabilitation service in Swansea Bay UHB.		

Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☐	☒	☐

Recommendations	Members are asked to: • **NOTE** the work undertaken to date to develop services to support patients waiting in 2021/22. • **NOTE** future plans to develop and scale these schemes up in 2022/23

Supporting Patients who are waiting for treatment in Swansea Bay

1. INTRODUCTION

The purpose of this paper is to provide an update on the schemes progressed during 2021/22 and those that will continue and be scaled up during 2022/23 as part of the Health Board's Recovery & Sustainability Plan for Planned Care.

The following schemes were in receipt of recovery funds in 2021/22 and varying progress was made with the short-term funding provided.

- Primary Care optimisation clinics (Lifestyle GP Prehabilitation)
- Prehabilitation for those waiting for Orthopaedic Surgery
- Pelvic Pain Clinics

Prehabilitation has been identified within the Planned Care Recovery & Sustainability Plan as a priority to receive recurrent funding and supports the delivery of the Planned Care Goals, Methods and Outcomes.

2. BACKGROUND

2.1 The Case for Change

In 2021, of the 17,000 people referred to Swansea Bay UHB for investigations, 2,353 people were diagnosed with cancer. At present, these people are referred into secondary care for investigations and potential diagnosis with little other intervention or support. MOT (health optimisation, prehabilitation) uses the pre-treatment time frame to prepare people for any forthcoming treatment. This intervention has shown to improve functional status, physical and psychological health outcomes and decrease overall health care costs. Macmillan Cancer Care and the UK Centre for Perioperative Care (CPOC) summarised the evidence and strengthened the growing case for prehabilitation for patients prior to the commencement of treatment in a recent publication from 2019 in which they introduced the principle that prehabilitation may commence prior to a confirmed diagnosis. This position is further endorsed in Wales by the principles of the National Optimal Pathways as part of the Single Cancer Pathway and the Quality Statement for Cancer and underpinned by Public Health Wales who have highlighted the negative impact the pandemic has had on the fitness of the population.

A report written by the Swansea Bay Community Health Council - ***Is my life worth living?*** Including lived experiences of patients waiting in pain for elective orthopaedic surgery. The report and its findings were published in September 2021, and was a follow-up report to their earlier report 'Feeling Forgotten' which was a report undertaken on behalf of the seven community health councils in Wales. The report was specifically about waiting for elective orthopaedic surgery, and based on feedback received from 948 people, highlighting the impact the wait

for surgery is having. The full report is attached as annex a, and some of the key findings are as follows:

- 92% - 827 people agreed the length of time they have been waiting for surgery has seen their condition worsen
- 74% - nearly 3 quarters (654 people) agreed the length of time they have been waiting for surgery has affected their mental health and wellbeing

The report highlighted that the word, "Pain" was used 686 times in the feedback, with many people reporting the pain was beyond words, "constant" and affecting their lives in many ways. It was reported that people feel isolated due to their pain and struggle to sleep, and to maintain their mobility.

The Health Board currently spends approximately £3.0m on 450 hip replacement procedures per year. This service has previously had to rely heavily on the use of private provider facilities.

According to recent SBUHB data there are around 2000 patients currently sat on the Orthopaedic waiting list for knee or hip arthroplasty surgery. A high proportion (65%) of these patients have been waiting already over 2 years. 71% of the patients surveyed by the CHC had not been offered any form of treatment to help with pain management during their wait for surgery. Although we know there are currently around 1900 patients awaiting knee or hip arthroplasty for over 1 year in SBUHB. Work is currently ongoing to understand and monitor health data from this group of patients. Early data has suggested that around 14 % of these patients have a current BMI >40. Almost 90% report their condition being worse since being listed. Nearly 69% have seen their GP for support whilst sitting on the waiting list (data based on recent audit of 147 patients SBUHB patients awaiting knee arthroplasty surgery).

2.2 Schemes initiated in 2021/22

In 2021/22, non- recurrent funding was secured for prehabilitation however, due to the timing of the funding – the Health Board's ability to set-up these systems and services was severely restricted. The following schemes were initiated in Q4 using recovery monies.

Optimisation of Orthopaedic waiting list	£120,000	A Pilot in 2021 funded by early release of recovery funds offered 100 Orthopaedic waiting list patients Lifestyle intervention. The support was based on offering patients the current SBUHB "Exercise and lifestyle programme". It saw a patient uptake of around 55% onto online based exercise and weight loss classes (due to Covid policy there was only digital delivery options available). Business case is being submitted on 13/03/22, recommending increasing the service to offer 240 new appointments for Hips + 1900 Prehab places within expanded ELP+ service. Aimed at waiting list Knee & Hip arthroplasty patients.	£26,950

Primary Care optimisation clinics	£120,000	Project group has been established to co-ordinate the implementation of the prehabilitation project for patients with suspected GI cancer. Unfortunately delays to recruitment and project sign off has prevented monies being spent in 21/22 financial year. Funding requested for 22/23 to implement scheme.	£0
Endometriosis – Pelvic Pain	£24,000	Patients benefited from both pre- and post-treatment, through having easier access to telephone support and signposting for additional support mechanisms.	£9,916

In addition to the above, the Welsh Government has made available funding to enable the Health Board to commission a service from the British Red Cross. The value of the contract is £413,939, and will provide a service to patients throughout 2022/23.

2.3 Recovery & Sustainability Plans for 2022/23

2.3.1 Prehabilitation for suspected Cancer

In Primary Care there is a strong appetite to deliver prehabilitation services using a Lifestyle GP approach, and it was planned to invest in this scheme towards the end of 2021/22- utilising the non-recurrent investment. Whilst the service was not implemented, some development work was carried out as follows:

- Procurement processes completed, finance processes established, staffing confirmed, and identification of Llwchwr cluster to commence work.
- Governance structures are in place, and Information Governance and Cyber security elements to support the programme are established.
- Patient Reported Outcome measures collation are being developed with Values Based Healthcare Team.
- Working relationships with the Rapid Diagnostic Service (RDC) at Neath Port Talbot Hospital were developed, and both the RDC and pharmacy are keen to develop a prehab model to ensure that those patients referred to the RDC receive the prehabilitation service.

A Prehabilitation Business Case has been prepared by the Clinical Lead and Service Improvement colleagues for those patients suspected of Cancer, and Management Board will consider the implementation of an integrated Prehabilitation pathway.

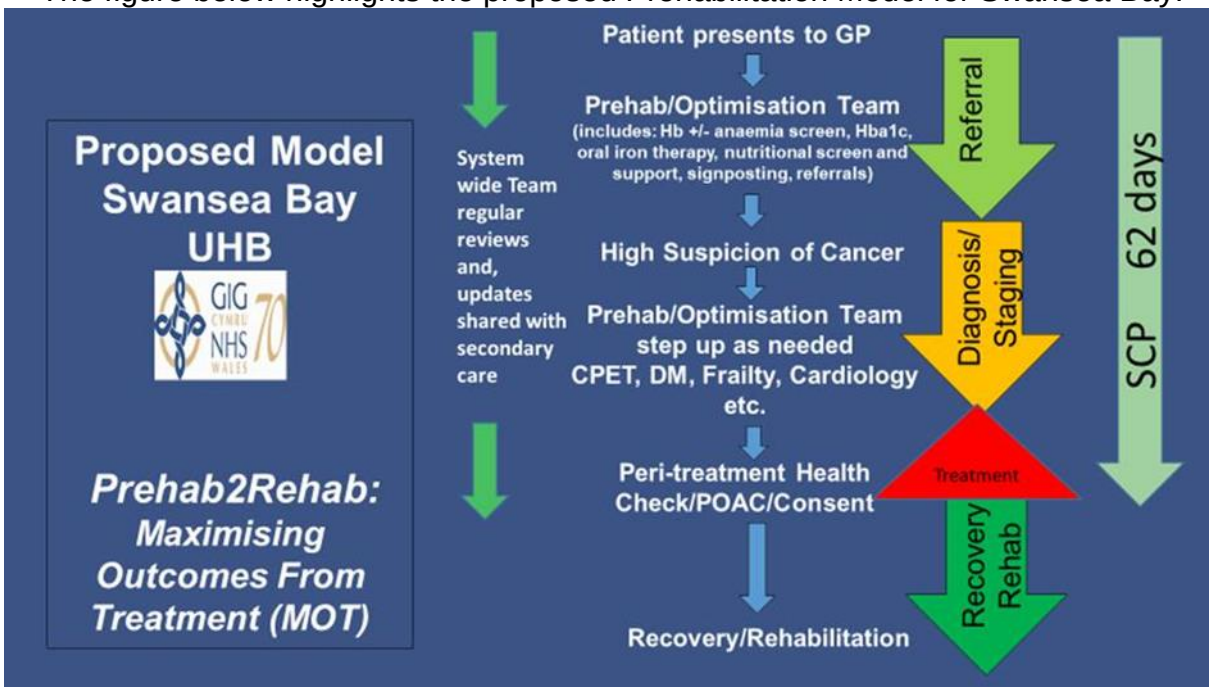
In Swansea Bay there are three stages at which we should be providing a prehabiltation service to patients with suspected Cancer as follows:

1. **Primary Care Optimisation Bundle Model**.

2. **Rapid Diagnostic Centre (RDC)**

3. **Point of High Suspicion/At Diagnosis**

The figure below highlights the proposed Prehabilitation Model for Swansea Bay.



Evidence shows that the Health Board must change how we support patients who are referred with symptoms (of cancer) and who are subsequently diagnosed with cancer. Whilst the non-recurrent investment did not allow us to test the concept, the Health Board were able to learn from other Health Boards and apply the same logic to the Swansea Bay population to assess the impact. In addition, a study was recently undertaken to inform the prehabilitation business case, to provide some local context and to highlight the complexity of the people presenting to the Health Board with vague symptoms (potentially cancer). Below is a summary of the results and from 272 patients attending Rapid Diagnosis Centre (RDC). Approximately, 10% of people assessed by the RDC will be diagnosed with cancer, with another 20% confirmed to need hospital treatment for another pathology.

- **High levels of pre-existing chronic disease**
  53% of people already had 3+ chronic disease.
  23% Known Diabetes or Pre-Diabetes.

- **High levels of Long-Standing Medication**
  51% were prescribed 5+ Medications of repeat prescription before attending the RDC.

- **Risky Health Behaviours**
  15% smoking levels
  47% overweight or obese

- **18% have Malnutrition**

There are other examples of where prehabilitation will have a positive impact within secondary care, and one of those examples included within the business cases is the impact on post treatment recovery time. Swansea Bay UHB has higher than average post-operative hospital stays, critical care occupancy, readmissions etc. This reflects the high risk and acuity of people as they enter into treatment such as surgery. For colorectal cancer pathway patients alone, is proposed that there is the potential to release 374 beds days which would support increased flow of patients allowing more people to be treated in a timely manner. If this approach was extrapolated across multiple tumour sites this could release 1,749 bed days.

There are a number of options which can be considered for Prehabilitation. However, the integrated model with Primary Care, Secondary Care and RDC is preferred as this provides patients presenting with colorectal/UGI symptoms at different points of the Cancer Pathway the opportunity to access Prehabilitation screening process, access to exercise referral scheme and receive specialist Allied Health Professional input if required. To realise all the benefits of Prehabilitation a system wide approach has been advised by the Clinical Lead. The lifestyle GPs will be able to undertake all aspects of the model and will have local knowledge of support services.

2.3.2 Orthopaedic Prehabilitation

A pilot in 2021 funded by early release of recovery funds offered 100 Orthopaedic waiting list patients Lifestyle intervention. The support was based on offering patients the current SBUHB “Exercise and lifestyle programme”. It saw a patient uptake of around 55% onto online based exercise and weight loss classes (due to Covid policy there was only digital delivery options available). Limitations of this pilot included a treatment that only offered a digital delivery. Exercise was aimed at patients who were very mobile. This 100 patient pilot had no resources suitable for patients with high levels of pain, poor function, mobility issues and BMI > 40. The limitations of this pilot was likely reflected in the poor patient uptake. Audit of patients that declined this support showed “not able to access with IT” and “too much pain” as the main reasons for patients not to engage.

The Swansea Bay Physiotherapy Team have developed a business case to provide an Orthopaedic Prehab model that offers a broad range of support options. Allowing for most levels of functional and health status deficit that patients may present with. Due to the limited knowledge and lack of current data available. We cannot accurately predict patient uptake into these support services. In line with the brief of “offering support to all knee and hip replacement patients” the business case proposes a programme of support options allowing a maximum patient uptake of:

- 75% requesting supervised exercise classes (1200) **
- Unlimited Self-management or online exercise to independently follow (digital or paper)

· 100% requesting pain relieving steroid injections (1200 knees only)

· 15% specialist dietician led weight loss for patients with BMI >39 (230)

· 35% community based weight loss programmes for BMI 30-38 (600)

· Unlimited Self-managed NHS weight loss programmes to independently follow (digital or paper)

** Based on 1640 patients on Ortho waiting list from Nov 2021 (n 1774 – 7.5% removed via validation)

Expansion of ELP HIPs (240): Background

The current pathway for Hip Osteoarthritis (OA) patients is fragmented and not fit for purpose. It includes multiple referrals to individual services within primary care and community services. Previous to the introduction of the Exercise & Lifestyle Programme for knee OA in 2021 these limitations were also present in the Knee pathway:

- Multi centred delivery
- Separate waiting lists and times
- Non MDT approach
- No links between services to oversee patient care and collate outcomes
- No patient outcome collection

Which all lead to increased primary & secondary care referrals and result in delays in patients receiving the care they need, and therefore their condition may deteriorate, which could result in surgery that could have been avoided and potentially longer length of stay and recovery time.

In line with Osteoarthritis NICE guidelines (2014), the recommended appropriate management should include exercise and weight loss employing patient education and self-management promotion. There needs to be planned follow up's and review of patient's condition, whilst monitoring the effectiveness of current interventions through patient reported outcomes.
Research suggests that a combination of interventions (exercise and weight loss) as being most effective for patient outcomes rather than delivering in isolation (Messier et al, 2004).

This lifestyle programme (ELP) has been piloted and expanded already in SBUHB for patients with Knee OA. An initial pilot took place in 2017 with 90 patients, this was followed by the current pilot Stage 1 of Exercise & Lifestyle Programme (ELP) conducted on up to 1000 patients, attending an 8-week programme; analysis and findings of this current programme showed:

- Integrated approach to management
- Patient focused/ Active Intervention
- Co-ordinated multi professional/ organisation

The preferred model as outlined in the Prehabilitation business case includes the following:

Patients with advanced Osteoarthritis with persistent severe symptoms may decide to seek a surgical pathway (arthroplasty surgery). These patients are usually identified in primary care and listed directly onto an Orthopaedic surgeons list for consultation. At present patients cannot currently be duel referred to a Lifestyle programme and Orthopaedics. Majority will therefore be directly listed onto Orthopaedic waiting list with or without any prehab input. The current exercise and lifestyle programme is ideally situated within the Knee & Hip OA pathway to offer a prehab service to patients waiting for joint replacement surgery. Appropriate patients would be offered a minimum of 8-week education, exercise and diet programme suited to their needs to best prepare them for any potential surgery. This will optimise their non-surgical management with the aim of improving post-surgical outcomes.

A recent pilot of this Ortho Prehab was completed in SBUHB. 50 patients awaiting Knee replacement surgery completed the current Exercise Lifestyle programme. Although due to Covid 19 policy at the time these patients were only able to access digital delivery or self-management. The PROMS collected from this group has shown some benefits. Patients' average weight loss was 3 Kg, pain and disability outcomes were slightly increased over the initial 12 week intervention period (0.7 OKS increase). Repeated outcomes at 6 months showed some deterioration from the point of completing the lifestyle programme, suggesting that this group would normally show deterioration over time. The data also indicates the need to offer patients ongoing independent lifestyle guidance once completing the intervention. Whilst interpreting this 50 patient Ortho Prehab PILOT. It needs to be understood that patients accessed a Lifestyle programme not specialised for their required level of support. The PILOT offered patients a place on the current ELP which is not aimed at a population with chronic advanced arthritis changes.

2.3.3 British Red Cross - Waiting Well Support Service

Investment has been provided by the Welsh Government to all Health Boards in Wales to commission the Waiting Well Support Service for 12 months. The offer from the Service is as follows:

> Pastoral care will be offered within the service user's own home, initially on a face to face basis for up to six weeks, followed by a further period of telephone support for up to six weeks, dependent upon the assessed need of the person referred. The service contributes to the continued well-being of the service user awaiting treatment from their local hospital(s) and will maintain contact with the referrer and will liaise with them, as necessary. It will comprise health and well-being checks and will alert the referrer should there be any change or deterioration. It is expected that having someone, who is dedicated to the service user's well-being as they continue to wait for treatment, will lessen anxiety and

assist in their day to day ability to function. The service will continue to be available during the wait for admission and/or treatment and will link with other services which may be able to provide any ongoing support either prior to or following treatment.

In addition to the above the British Red Cross will continue to liaise with other BRC services as well as other organisations within the service user's locality. Through this approach, service users, referred through the BRC service, can be referred on for additional support should their needs change. BRC support staff and volunteers will be based in the service user's local area and will provide appropriate and timely support based on assessed needs and referral specification.

Aims of the Service

The service will offer support to individuals who have been waiting two years or more for elective procedures or treatment from the NHS and, through continued communication and reassurance, reduce the risk of reliance on emergency, acute and primary care health services and empower people to better self-manage their physical health and well-being as they continue to wait for treatment. It will work in conjunction with NHS and Local Authority services enabling people to engage with their local communities, which would otherwise prove difficult due to frailty or anxiety. Our primary objectives are to:

- Support the service user whilst they await treatment and/or admission to hospital
- Improve service user health and well-being
- Facilitate or provide practical help in their own home
- Connect service users with community-based services to support their well-being & reduce their anxiety

3. GOVERNANCE AND RISK ISSUES

The schemes outlined in this paper provides risk mitigation for patients who are at risk of potential harm as a result of long waiting times. Improvements in prehab provision will improve patient optimisation prior to surgery and reduce the need in some cases for potentially additional surgery as a result of the long waiting times, and access to other services such as mental health.

Supporting patients whilst their waiting will contribute to improving the quality of life of people waiting for surgery in Swansea Bay, and the schemes outlined in this paper present an approach that is equal for all patients.

There is a need to ensure that these schemes where appropriate are aligned, and that all patients receive access to these services. It is therefore proposed to develop a prehab steering group in Swansea Bay, this will allow for strong clinical leadership and develop robust integrated services across the pathway.

4. FINANCIAL IMPLICATIONS

Business cases have been developed for prehab and will be considered by the Health Board's Business Case Scrutiny Group, and Management Board in April. The costs are outlined in the table below:

Integrated model including Primary Care with lifestyle GP, Secondary Care, and RDC.	£702,279	Provide Prehabilitation for all colorectal and Upper GI patients at point of suspicion, and point of diagnosis. This will ensure equity of service for all patients presenting with Upper and Lower GI Cancer. Patients requiring specialist input will have timely will receive timely access to AHP staff if required to strengthen prior treatment.
Ortho Prehab model	£563,254	A recurring investment of £563,254 is required to expand the Exercise Lifestyle Programme for patients with Knee Osteoarthritis into Hip Osteoarthritis, and the addition of a Prehabilitation Service for those people awaiting surgery.

5. RECOMMENDATION

- **NOTE** the work undertaken to date to develop services to support patients waiting in 2021/22.
- **NOTE** future plans to develop and scale these schemes up in 2022/23

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☐
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☐
	Excellent Staff	☒
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☐
	Individual Care	☒
	Staff and Resources	☒

Quality, Safety and Patient Experience

The schemes outlined in this report will improve Quality, Safety and Patient Experience for the most vulnerable cohort of patients waiting for surgery and treatment.

Financial Implications

Business cases have been prepared for prehab, and will be considered by the Health Boards Business Case Advisory Group and the Management Board in April.

Investment has been allocated within the Planned Care Recovery & Sustainability Plans for planned care.

Legal Implications (including equality and diversity assessment)

The schemes will provide a level of equality for the most vulnerable cohorts of patients living in Swansea and Neath Port Talbot.

The support for patients will mitigate the risk for patients against potential harm as a result of waiting.

Staffing Implications

The business cases do present the need for additional staff, and planned care is under significant pressure in relation to workforce planning. However, by utilising GPs and staff working within therapies this position is much improved. There is a need however to recruit these staff members on a recurrent basis.

Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)	
Whilst the Health Board are progressing plans to improve waiting times, the need to provide these services to support patients who are waiting must be a long term investment, and not only for the recovery, and providing this support now will prevent further problems occurring or getting worse. The support provided will improve the quality of life not only for patients but for their families and carers who support them, this has the potential to have a positive impact on all public services.	
Report History	This is the first report on this area.
Appendices	Annex A - Community Health Council Report  BRC Waiting Well Support Service Propc