Worthwhile Waiting Evaluation Report

October 2022

Hilary Bungay Leica Claydon-Mueller

Michelle Hawkins

Commissioned by Meridian Primary Care Network

Funded by Eastern Academic Health Science Network

Acknowledgements

Thanks go to the Worthwhile Waiting team Will Bailey CEO Meridian Primary Care Network, Vicky Lawrence Head of Personalised Care Team Meridian PCN and Ben Jackson Advisor Eastern Academic Health Science Network who together provided valuable input into the design of the evaluation and were generous with their time throughout the evaluation period. Thank you to all the patients and staff who contributed to this evaluation.

Executive Summary

Worthwhile Waiting aims to transform the post-referral, pre-appointment (referral to treatment) period from one in which patients are passively waiting to one where they are actively preparing for specialist intervention.

The evaluation investigates the first 9 months of the programme using both quantitative and qualitative evaluation methods. All patients enrolled on the programme were invited to complete an online survey to gather demographic data and measures of quality of life, subjective wellbeing, self-efficacy, and a loneliness measure as a proxy for social isolation. Staff involved in Worthwhile Waiting and patients enrolled in the programme were interviewed about their experiences and perceptions.

Findings

- Recruitment to the programme was 10-15% of the anticipated take up, 33 patients completed the baseline survey and 13 patients had completed the survey at the first follow up point.
- From the interviews reasons for the low recruitment were linked to a lack of interest and the ages of the eligible population. However, it was also noted that there is anecdotal evidence that recruitment to other programmes in the region followed a similar pattern.
- The interviews with staff and patients found most had a good understanding of the purpose of Worthwhile Waiting and how it could have a potential impact on overall health and wellbeing. There were some patients whose main reason for joining was to stay on the radar and have a contact point, to avoid being forgotten by the system.
- There were barriers to taking part identified by both patients and staff and this included access and transport issues, but also and perhaps more important a lack of understanding in the wider population and amongst health care professionals of the potential value of health coaching and alternatives to the traditional medical model of care.

From the Quantitative data the following observations are highlighted

On entry into the study:

- The participants are female to male 2:1, and about 50% are aged 65+ and retired.
- The Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS) scores are close to the population norm.
- The EQ5D5L (instrument which evaluates generic quality of life) index scores are about 60% of normative data except people aged 80-89 who meet population norm levels, EQ5D5L Visual Analogue Scale health scores are close to 60%.
- Perceived Health Competence Scale (PHCS) scores are low compared to normative data overall and even more so for younger age groups (although there are only a few participants in this group)
- English Longitudinal Study of Ageing question on loneliness (ESLA) 21 (62%) of the of participants were hardly ever/never lonely, 10 (29%) were lonely some of the time and 3 (9%) were often lonely.

At follow up:

- Participants are female to male 1:1 ratio and largely aged 65+ and retired.

- SWEMWBS scores remain the same (no statistically significant difference comparing scores at entry to follow up).
- EQ5D5L index and visual analogue scale (VAS) scores remain about the same with no statistically significant differences.
- EQ5D5L index scores for people aged 70-79 years improved by 25% and could be worth further investigation in a larger sample.
- 6/13 participants improved their EQ5D5L pain levels and 4/13 improved their mobility levels again this could be worth investigating in a larger sample.
- PHCS scores remain about the same (no statistically significant difference), except the average scores for participants aged 65-74 (n=3) improved their scores to over that of the normative population data again this could be worth investigating in a larger sample.
- ESLA – scores for 10 participants remained the same, 3 participants loneliness increased.
- Worthwhile Waiting satisfaction evaluation - all 13 participants agreed or strongly agreed they were satisfied with the programme and valued it. 92% agreed or strongly agreed help was available from the Health and Wellbeing Coaches, 77% agreed or strongly agreed Worthwhile Waiting helped them reach their goals, 69% agreed or strongly agreed Worthwhile Waiting helped them to prepare for surgery.

Recommendations:

- The Health and Wellbeing Coaches need to be integrated into the individual Practices and ideally -have a greater visible presence on regular basis to raise the profile of Worthwhile Waiting.
- There needs to be dedicated administrative support to take on the role of recruitment to the programme, this would be someone to collate names and to make initial contact with patients to encourage them to consider taking part in Worthwhile Waiting.
- The range of activities offered needs to be considered to take account of a broad range of interests and preferences.
- Accessibility also needs to be considered when offering alternative activities to patients.
- Other primary care networks considering similar programmes need a ‘champion’ in post to engage people in the process and raise awareness of the programme more widely.

Introduction

Worthwhile Waiting is an innovative programme set up in a primary care network consisting of six GP practices in the East of England. It aims to transform the post-referral, pre-appointment (referral to treatment) period from one in which patients are passively waiting to one where they are actively preparing for specialist intervention. The initial phase of the programme specifically focusses on patients waiting for hip or knee orthopaedic procedures and is being piloted in six GP surgeries in the Meridian Primary Care Network. The aim of the programme is for patients to arrive at hospital in the best possible physical and mental state to make the most of their treatment and facilitate their recovery. Patients work with a Health Coach to identify a bespoke package of support from organisations across arts and culture, sports and physical activity, and financial advice and practical support.

Since its inception, the National Health Service (NHS) has been plagued by waiting lists with waiting times used as an indicator of service performance (Sheard, 2018). The COVID 19 pandemic had a direct consequence on waiting lists, and in March 2020, NHS England instructed that all elective surgery should cease by 15 April 2020 for a minimum of 3 months (NHS England 2020). By the end of October 2021, the number of people in England waiting for treatment was 6 million, of whom 312,665 had been waiting more than 52 weeks (NHS England 2021). The situation has continued to deteriorate and in August 2022 figures show a record of over 7 million people waiting for treatment (British Medical Association 2022).

The statistics on waiting do not in themselves capture the experience or impact of waiting for the individual patients. Yet waiting for elective surgery is associated with a deterioration in symptoms and has an impact on quality of life (Oudhoff et al 2007). In addition, patients who are waiting for surgery may experience anxiety (Gagliadi et al. 2021). Pain and mobility issues may also lead to restrictions on people's ability to work and engage in social activities however, whilst waiting can cause distress for some, others may use the time to prepare for surgery (Carr et al 2017). There is a growing interest in 'prehabilitation' which according to Wynter-Blyth and Moorthy (2017) is a strategy which begins the rehabilitation processes prior to surgery and is a proactive approach which enables patients to be active participants in their care. Therefore prior to surgery, patients may be referred to prehabilitation services to enhance functional capacity and there is some evidence that the functional independence of patients who engage with such services returns to baseline quicker than those who don't (Moran et al 2016, Shaughness et al, 2018). Prehabilitation services can improve patient's fitness for surgery, but most existing services have focused on physical activity and the optimisation of diet and have not taken account of the psychological impact of waiting (Levett and Grimmett 2019). People with better physical fitness, nutritional status, and mental health, experience quicker and smoother recoveries from major surgery (Tew et al 2020). However, such services need to be personalised and include regular support and contact from the healthcare team to maintain patient motivation (Wynter-Blyth and Moorthy 2017)

Worthwhile Waiting

Worthwhile Waiting was introduced in response to the long and growing waiting lists for surgical and other interventions. There were three main influences which led to the development of the programme, first and foremost was the acknowledgement of the experience of patients waiting for procedures and how this could be made better. Adopting

the principles used in Disney theme parks where long waits for rides have been transformed through providing distractions whilst queuing; Worthwhile Waiting offers cultural and sporting opportunities to patients in addition to the more traditional health promotion interventions such as smoking cessation and dietary advice. Second, its introduction was based on the theory that physical activity and optimising people's physical and mental health prior to surgery would reduce bed days in hospital post-operatively and enhance recovery. Finally, it addresses the notion of the 'teachable moment' (Cohen et al 2011) whereby the moment of diagnosis and referral to a specialist is believed to be the optimum time to encourage patients to make lifestyle changes to enhance their health and wellbeing. A further supporting factor in its implementation was government policy with an emphasis on the concept of personalised care and new funding provided to primary care networks under the Additional Roles Reimbursement Scheme (ARRS) which resulted in the appointment of Health and Wellbeing Coaches and Social Prescribing Link Workers in the network.

Health coaching is a supported-self management intervention which is part of the NHS Long Term Plan and is integral to the implementation of personalised care. This includes social prescribing and community-based support. Health coaching is defined as *'Helping people gain and use the knowledge, skills, and confidence to become active participants in their care so that they can reach their self-identified health and wellbeing goals'.* (NHS England 2019). Social Prescribing is designed to support people with a wide range of social, emotional, or practical needs such as those with long term conditions social isolation and those with long term mental health needs. Typically, a GP or other health care professional will refer a patient to a Social Prescribing Link Worker who may refer or signpost people to local non-clinical services. There is to some extent overlap between the two roles, but a health coach tends to address the physical determinants of health whereas the link workers focus more on the social determinates of health. Within the Meridian Primary Care Network there are four Health and Wellbeing Coaches as well as two Social Prescribing Link Workers. It is the Health and Wellbeing Coaches who are involved in Worthwhile Waiting

The first year of Worthwhile Waiting has been a pilot study and initially patients included in the pilot were those with a knee or hip condition who were referred to a Musculo-skeletal (MSK) specialist in secondary care by a General Practitioner (GP). Once this referral was made the secretaries within the six participating practices added the names to a spreadsheet which was given to the Health and Wellbeing Coaches, and a letter or email was sent to the patients on behalf of the GP. The letter invited people to take part in Worthwhile Waiting and included a link to the programme website (https://worthwhilewaiting.meridianpcn.nhs.uk/) where people could find out more information about the services and resources provided through the programme. There is also an online survey for patients to complete to provide baseline data at the start of the programme (for details of the survey see below). If patients had not registered with Worthwhile Waiting within two weeks of the initial letter being sent, then the Health and Wellbeing Coaches phoned the patients to remind them about the invitation and to invite them to a health coaching session. In the first session the Health and Wellbeing Coach initiated a conversation with the patient about the patient's needs and hopes for the waiting period followed with the development of a personalised care plan, including possible referrals to partner organisations (for details see the website). Regular coaching sessions are scheduled to take place – initially every two weeks extending to monthly depending on the needs of the individual patient.

It was anticipated that the potential outcomes for patients involved in the programme could include:

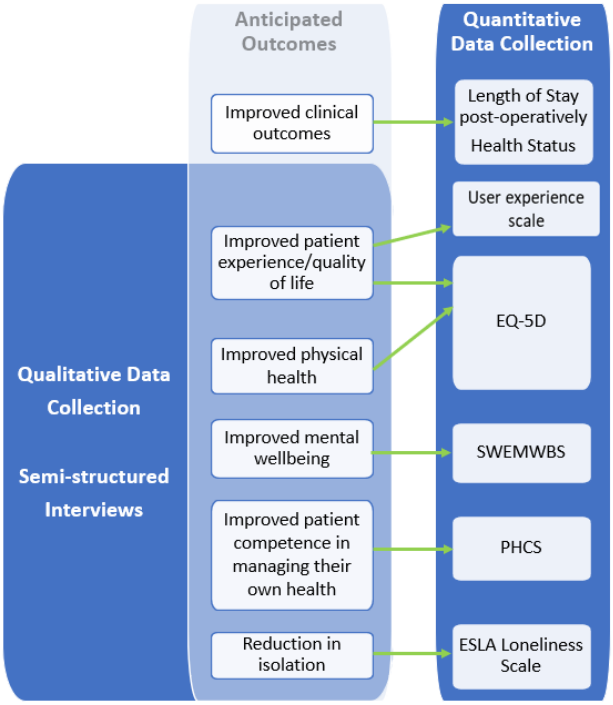
a) Improved clinical outcomes
b) Improved patient experience/quality of life
c) Improved patient competence in managing their own health
d) Improved physical and mental wellbeing
e) Reduction in isolation

To explore the extent to which these outcomes were met by the programme an evaluation was commissioned. A mixed method approach was used to gather quantitative data on the 1) primary outcomes: health status, quality of life, well-being, self-efficacy, and loneliness 2) secondary outcomes: resource utilisation and user experience. To capture the impact of the programme on the primary outcomes a Case Series Design was used. That is a longitudinal uncontrolled observational study with data collected from the same individuals on at least two occasions including pre-and-post intervention (Reeves et al 2008). In addition, a descriptive qualitative approach using semi-structured interviews with referring professionals and participants in the programme was undertaken to explore perceptions around the impact of the programme.

Evaluation Design

A mixed methods evaluation consisting of two strands using quantitative and qualitative data collection methods (see figure 1). The data was collected sequentially with the interviews conducted towards the end of the pilot phase of the programme, to inform the development of the programme in the next stage.

Figure 1: Data collection



Quantitative Strand:

Sample: Patients registered with GPs in the Meridian Primary Care Network and on the waiting list for hip or knee orthopaedic procedures were invited to take part in Worthwhile Waiting. It was anticipated that approximately 220 patients would be referred during the pilot phase of the programme and each patient would be requested to complete an entry assessment for the programme.

Inclusion criteria for the evaluation: Patients aged over 18 years of age under the care of the Worthwhile Waiting Health and Wellbeing Coaches, were invited to complete the validated assessment measures.

Data Collection: At the entry assessment the following demographic data for each participant was recorded: Age, Gender, Ethnicity, Employment Status, Education level, Marital Status, and living arrangements. Validated scales used to collate data on health status, quality of life, wellbeing, and loneliness, provide quantitative assessment of the impact of the programme. This data was collated through the Worthwhile Waiting website and at the first visit to the Health and Wellbeing Coach (HWC) participants were introduced to the web page and asked to complete the tool with the assistance of the Health Coach. The tool was to be completed at the following time points; baseline (pre-intervention), 6 months, 12 months, and 18 months (or immediately pre-surgery) and post operatively (post intervention). At the point of writing this report, data collection had started in November 2021 and was on-going.

The validated scales used were as follows:

The Short Form Warwick and Edinburgh Mental Wellbeing Scale (SWEMWBS) is a short version of the Warwick-Edinburgh Mental Wellbeing Scale and can be used to evaluate interventions which aim to improve mental wellbeing. It is comprised of seven positively worded statements related to functioning. There are five response categories from ‘none of the time’ (score of 1) to ‘all of the time’ (score of 5), with the lowest total score of 7 and highest total score of 35. Higher scores indicate higher wellbeing. These scores are then converted into metric scores (Child Outcomes Research Consortium, 2022).

The English Longitudinal Study of Ageing (ESLA) question on loneliness, a single item measure which is a direct measure of loneliness and indicates the prevalence of loneliness in the population. This was used as an indicator for potential social isolation.

The Perceived Health Competence Scale (PHCS) is a measure of self-efficacy for health-related behaviour. It is comprised of eight statements and there are five response categories from ‘strongly disagree’ (score of 1) to ‘strongly agree’ (score of 5) (Dempster & Donnelly, 2008). Four of the statements are negatively worded and are therefore reverse scored (i.e. ‘strongly disagree’ is scored 5 and ‘strongly agree’ is scored 1) (Polchert, 2015). Higher values indicate a stronger perception of health competence. The scores are summed and averaged (/8) to provide an overall score.

EQ5D5L is a standardised measure of health status (EQ5DL User Guides, 2022). There are five dimensions (5D, mobility, self-care, activity, pain/discomfort, anxiety/depression) and five levels (5L) with response categories from ‘no problems’ (score of 1) to ‘unable to’ (score of 5). Each response for each dimension has a different metric score or ‘index value’ (EQ5DL Index Value Set, 2022). These values are summed and taken away from 1 to provide an index value where 0 is bad health and 1 is good health. The EQ5D5L also enables an individual rating of

health (a health thermometer) in the form of a Visual Analogue Scale score where responses from 0 – represent the worst health you can imagines to 100 –the best health you can imagine.

Where data were missing the average of the participants for that statement and the individual for answered statements were calculated and a value inputted (e.g. if the average for the questions was 3 and the average for the individuals answers was 3, 3 was inputted).

User experience- In addition to the above measures, at the end of the programme the participants were asked to answer questions regarding their experiences of the programme. The questions relate to satisfaction with the programme, and how supported they felt throughout the programme.

Data Analysis: Data from the assessment tool on the website were exported into Excel. Data were scored as per the validated questionnaires guidance. Descriptive statistics, mean, standard deviation (SD), median, mode, minimum and maximum values, kurtosis and skewness were calculated for continuous data. Kurtosis is a measure of tailedness of the distribution (that is the presence of otherwise of outliers), if the number is greater than +1 it is considered peaked. Skewness is a measure of the asymmetry of the distribution, if it is greater than +1 or lower than -1 it is an indication it is substantially skewed. For categorical data, frequencies and percentage frequencies were calculated. The Kolmogorov-Smirnov test was used to test the normality of the data. Where data were normally distributed paired t-tests were used to compare means at baseline and follow up.

Qualitative Strand

The qualitative data was gathered using semi- structured interviews with healthcare practitioners in the network and patients who have completed or are engaged in the Worthwhile Waiting programme. The interview guide was developed through consultation with the funders and programme management team. Practitioners were asked about their understanding of the aims of the programme, perceived patient engagement with and recruitment to the programme, the impact of the programme, and the key factors in the success or otherwise of such programmes. The patients were asked about their referral to the programme perceived impact of taking part in programme, types of interventions experienced and the perceived value of different interventions and programme, as well as the potential barriers to engaging with the programme. Twelve interviews (6 staff members and 6 patients) were conducted using the telephone or Teams depending on the preferences of the participants and ranged from 9 to 45 minutes in length. The interviews were audio- recorded and transcribed verbatim. Data analysis was conducted using thematic analysis (Braun & Clarke, 2006).

Ethical Considerations:

As this is a service evaluation of a quality improvement initiative NHS ethical approval is not required, however, the evaluation was approved by the ARU Faculty Research Ethics Panel.

Results

Of the 34 participants recruited to the Worthwhile Waiting programme 15 were aged 65 or above and 19 were aged up to 64 years (Table 1). There was approximately a 2:1 female to male ratio of participants (n=21, 62% female, n=12, 35% male) and one undisclosed. Most of the participants identified as white (n=24, 71%) or British (n=9, 27%) and one participant identified as mixed race (n=1, 3%). Participants had a variety of employment and education backgrounds. About two thirds of the sample (n=21, 62%) were hardly ever or never lonely.

Table 1: Demographic data of participants

Variables	**Baseline (N=34) N (%)**	**Follow- up (N=13) N(%)**
Age, years		
75-84	6 (18%)	4 (31%)
65-74	9 (26%)	3 (23%)
55-64	10 (29%)	4 (31%)
45-54	6 (18%)	1 (8%)
35-44	1 (3%)	1 (8%)
25-34	2 (6%)	0 (0%)
Gender		
Male	12 (35%)	6 (46%)
Female	21 (62%)	7 (54 %)
Not disclosed	1 (3%)	0
Ethnicity		
White	24 (71%)	8 (62%)
British	9 (27%)	4 (31%)
Other- mixed background	1 (3%)	1 (8%)
Employment status		
Retired	13 (38%)	7 (54%)
Self employed	4 (12%)	1 (8%)
Unemployed	3 (9%)	0
Paid employed	12 (35%)	5 (38%)
Unable to work	1 (3%)	0
Other	1 (3%)	0
Education		
Other	13 (38%)	5 (38%)
NVQ	1 (3%)	1 (8%)
GCSE	4 (12%)	3 (23%)
Apprenticeship	2 (6%)	0
A and AS level	3 (9%)	0
Degree level or higher	10 (29%)	3 (23%)
Not disclosed	1 (3%)	1 (8%)
Marital status		
Married	24 (71%)	8 (62%)
Co-habiting	1 (3%)	0
Single	4 (12%)	2 (15%)
Divorced	1 (3%)	0
Separated	2 (6%)	1 (8%)
Widowed	2 (6%)	2 (15%)
Living arrangements		
Lives with partner	23 (68%)	8 (62%)
Lives with others	3 (9%)	2 (15%)

Lives alone Other Not disclosed	6 (19%) 2 (6%)	2 (15%) 0 1 (8%)
Loneliness Hardly ever or never Often Some of the time	21 (62%) 3 (9%) 10 (29%)	6 (46%) 2 (15%) 5 (38%)

13 participants data were available at follow up. Over half of the participants (n=7, 54%) were aged 65 years or above and were retired. The female to male ratio was about 1:1 (n=7, 54% female, n=6 46% male). ESLA measure of loneliness remained the same for ten participants, three participants loneliness scores increased. Other demographic characteristics were comparable to baseline.

SWEMWBS

Participants mean SWEMWBS metric scores (7 lowest score possible to 35 highest score possible), where higher scores indicate higher positive wellbeing, were 22.74 (SD 3.29, Min – Max 14.75 – 27.03) on entry into the study at baseline (Figure 1). This average score is close (0.87 lower) to the population norm (mean 23.61, SD 3.90) from a health survey in England (Child Outcomes Research Consortium, 2022). Participants mean SWEMWBS metric scores at follow up remained about the same with an average score of 21.93 (SD 3.68). The difference was not statistically significant t=(11) 0.93, p=0.37.

Figure 1 SWEMWBS scores of participants at baseline

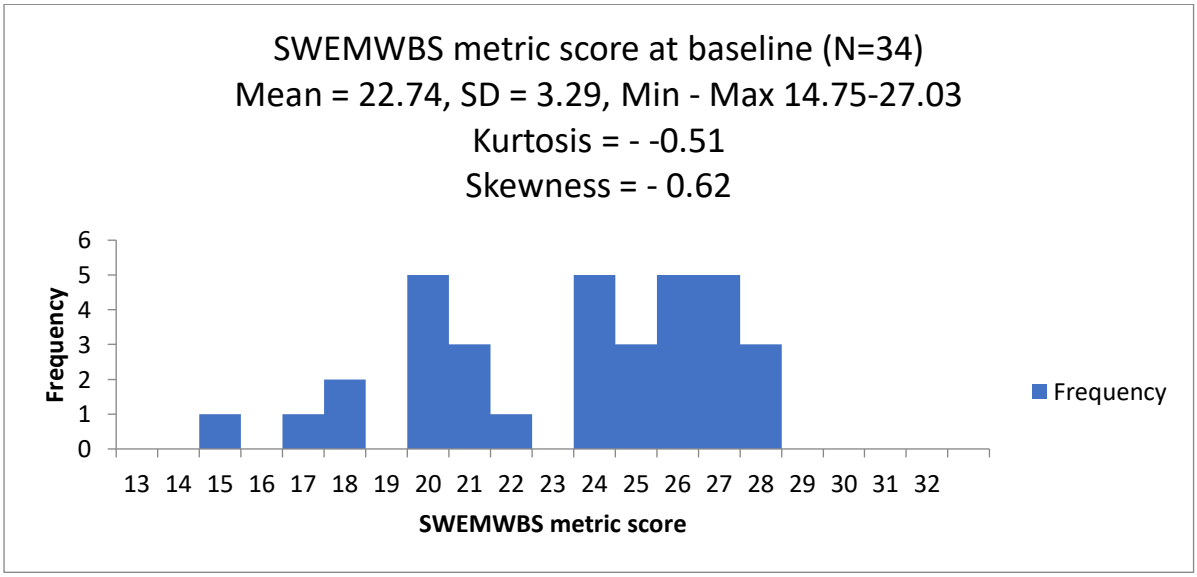
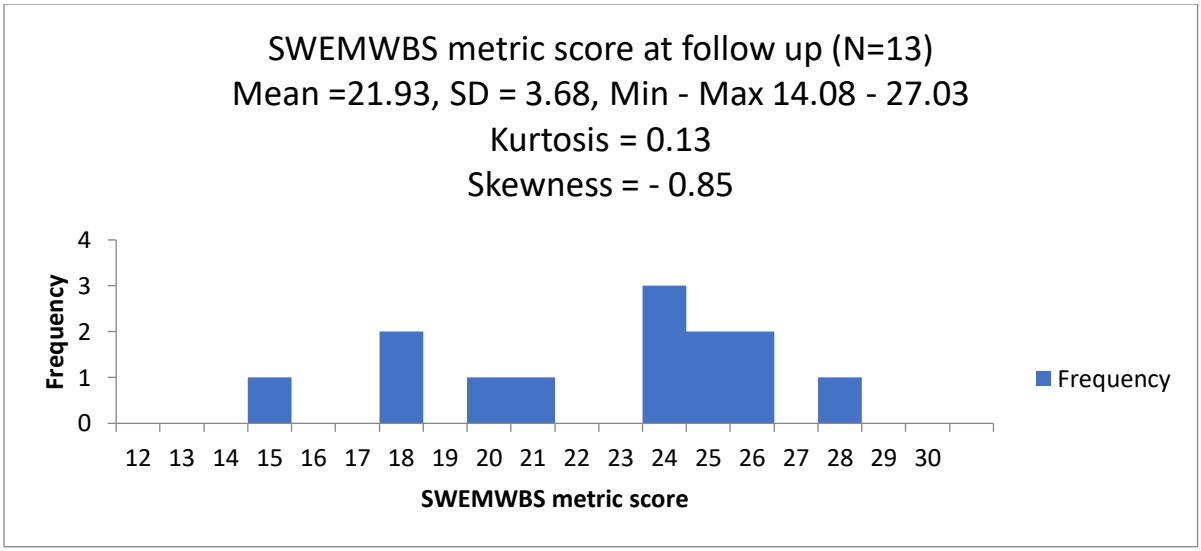


Figure 2 SWEMWBS scores of participants at follow-up



EQ5D5L

EQ5D5L scores at baseline and after Worthwhile Waiting are provided in Table 2. Most notably after Worthwhile Waiting 6 (46%) of the 13 participants who responded at follow up had improved pain levels and four (31%) had improved mobility. A few participants improved in the other domains. The percentages in the table below each figure are the frequency percentage of the sample for each level e.g. 13/34 participants are level 3 (moderate problems) with mobility so this is 38% at baseline.

Table 2 EQ5DL scores at baseline (pre) and after the Worthwhile Waiting programme (post)

	Mobility		Self-care		Activity		Pain / discomfort		Anxiety / depression	
	Pre	Post	Pre	Post	Pre	Post	Pre	Post	Pre	Post
Level 1	5 (15%)	2 (15%)	25 (74%)	9 (69%)	6 (17%)	1 (8%)	0 (0%)	0 (0%)	12 (35%)	4 (31%)
Level 2	5 (15%)	4 (31%)	2 (6%)	2 (15%)	7 (21%)	3 (23%)	6 (17%)	5 (38%)	8 (24%)	4 (31%)
Level 3	13 (38%)	3 (23%)	6 (17%)	1 (8%)	11 (32%)	5 (38%)	14 (42%)	4 (31%)	10 (29%)	5 (38%)
Level 4	11 (32%)	4 (31%)	1 (3%)	1 (8%)	7 (21%)	3 (23%)	11 (32%)	4 (31%)	3 (9%)	0 (0%)
Level 5	0 (0%)	0 (0%)	0 (0%)	0 (0%)	3 (9%)	1 (8%)	3 (9%)	0 (0%)	1 (3%)	0 (0%)
Improved levels	4 (31%)		1 (8%)		3 (9%)		6 (46%)		2 (15%)	
Total	34 100%	13 (100%)	34 (100%	13 (100%)	34 (100%)	13 (100%)	34 (100%)	13 (100%)	34 (100%)	13 (100%)

Legend: Level 1 = no problems; Level 2 = slight problems; Level 3 = moderate problems; Level 4 = severe problems; Level 5 = extreme problems/ unable to do

The mean EQ5D5L VAS health score at baseline for 33 participants was 57.76 (SD 19.13, Min – Max 20-90) out of a possible score of 100 (Figure 3). At follow up these scores improved to 63.75 (SD 20.57, Min – Max 30-90; Figure 4). This difference however was not statistically significant t=(11)-1.76, p=0.11.

Figure 3 EQ5DDL VAS health scores at baseline

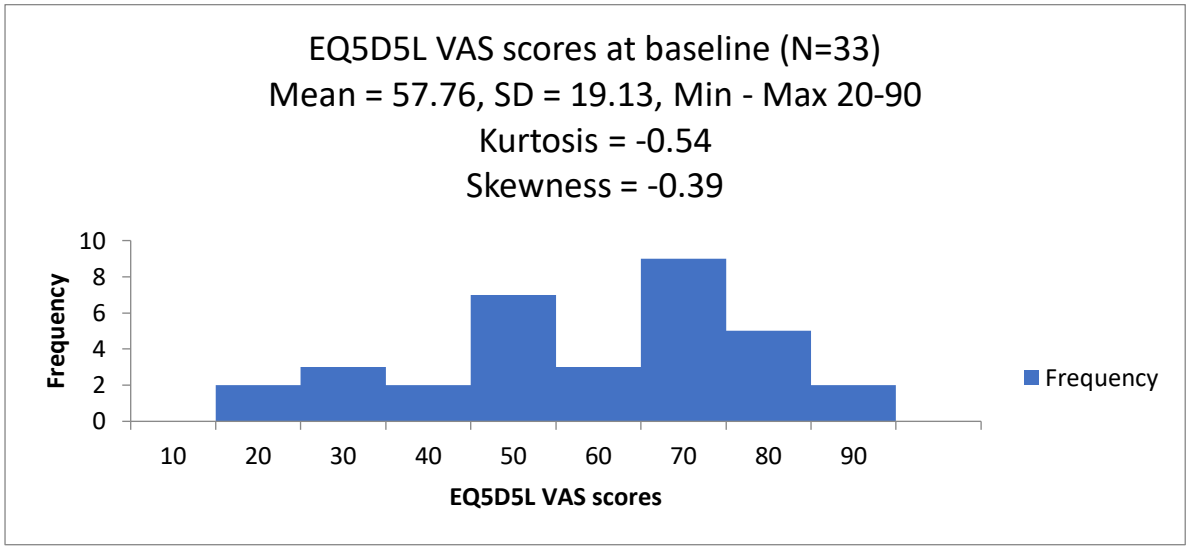
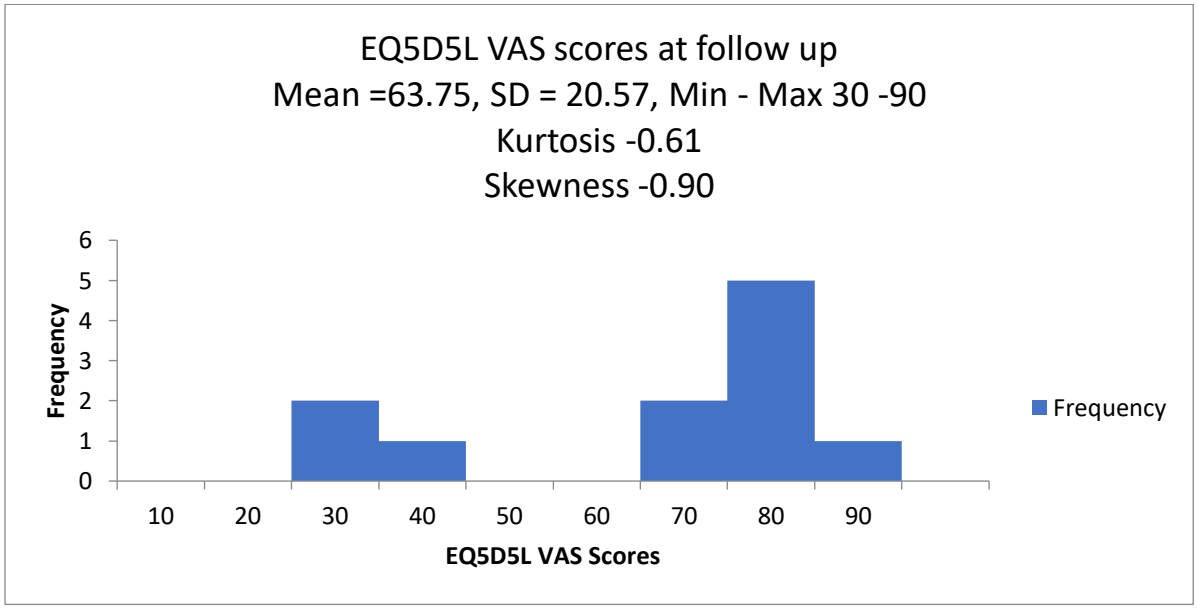


Figure 4 EQ5D5L VAS health scores at follow-up



The EQ5D health index represents a single summary number which reflects how good or bad a health state is according to the preferences of the general population of a country/region. The participants mean EQ5D5L index scores at baseline were 0.54 (SD 0.27, min – max -0.18 – 0.89, Figure 5) these scores are about 60% that of the mean population normative data for EQ5D5L of 0.89 (SD 0.21) scores. The EQ5D5L index scores at baseline and follow up are

categorised by age and compared to normative data (Table 3). At baseline the scores, are about a third of the normative scores for age categories 40 – 49 years. For younger (18 to 29 years) and older age groups (80-89 years) scores are nearer or the same as the normative data, respectively. At follow up, the 70-79 age group scores improved by 25% (0.49 to 0.75). Overall, the mean scores at follow up remained about the same at follow up for the 13 participants (mean =0.59, SD = 0.28, min – max 0.06 – 0.89 Figure 6) and there was no statistically significant difference t=(12)-0.87, p=0.40.

Table 3 EQ5D5L index scores by age at baseline and follow up compared to normative data

Age, years (N)	EQ5D5L index score baseline (SD)	Normative data (SD) (EQ5Dl User Guide, 2022)	Difference to norm at baseline	Age, years (N)	EQ5D5L index score follow up (SD)	Difference to norm at follow up
18-29 (n=1)	0.83 (NA)	0.98 (0.10)	-0.14	18-29 (n=0)	-	-
30-39 (n=1)	0.54 (NA)	0.97 (0.11)	-0.43	30-39 (n=1)	0.54 (NA)	-0.43
40-49 (n=3)	0.27^	0.96 (0.11)	-0.69	40-49 (n=1)	0.17 (NA)	-0.79
50-59 (n=8)	0.45 (0.34)	0.93 (0.17)	-0.48	50-59 (n=2)	0.42 (0.50)	-0.51
60-69 (n=9)	0.86^	0.92 (0.17)	-0.06	60-69 (n=3)	0.76^	-0.16
70-79 (n=9)	0.49 (0.25)	0.87 (0.21)	-0.38	70-79 (n=4)	0.74	-0.13*
80-89 (n=3)	0.75 (0.05)	0.74 (0.32)	+0.01	80-89 (n=2)	0.81 (0.11)	+0.07*

^ median score used because kurtosis was large; *scores decreased for this age group from baseline to follow up; NA = not applicable because n=1.

Figure 5 EQ5D5L index scores at baseline

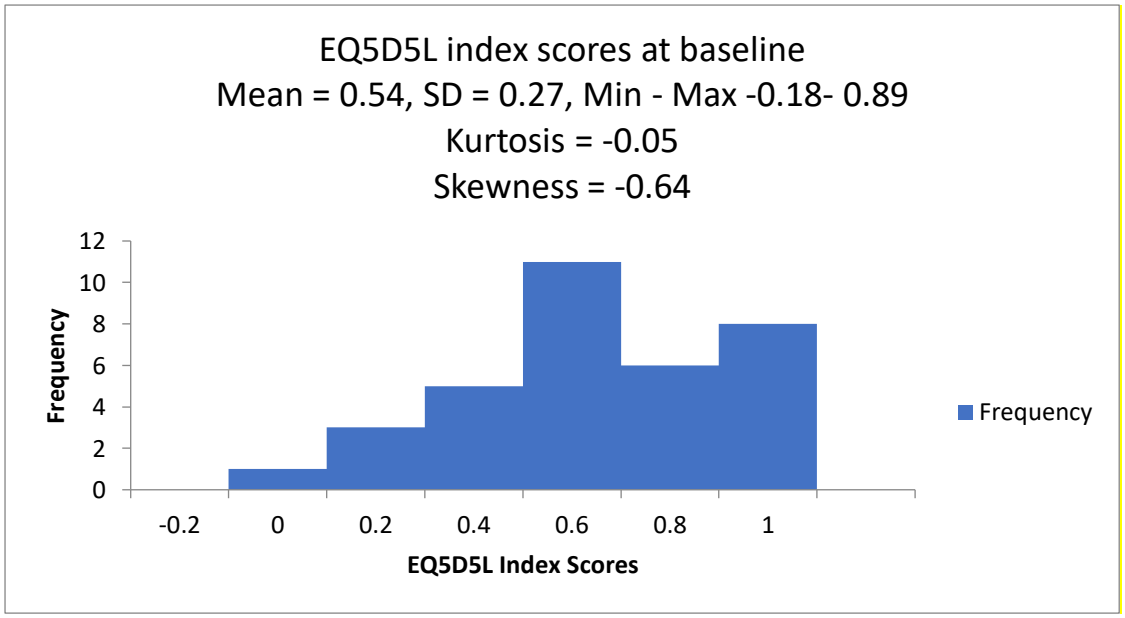
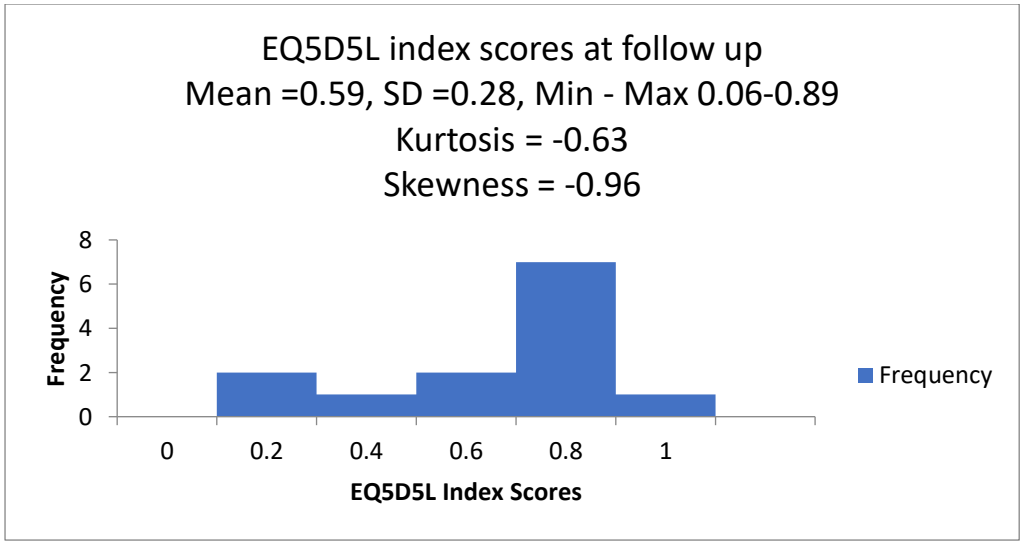


Figure 6 EQ5D5L index scores at follow up



PHCS

The participants mean PHCS at baseline was 3.01 (SD 0.53, Figure 7). This average score is lower than normative data of 3.65 (SD 0.88) in a UK primary health care setting (Dempster and Donnelly, 2008). The PHCS scores at baseline and follow up are categorised by age and compared to normative data (Table 4). At baseline the PHCS scores, particularly for younger age groups, are markedly lower than normative data for that age group. Normative data is not available for older age groups. At follow up, three participants aged 65-74 mean scores improved to exceed the average normative score of 3.65 in a UK primary care setting with scores of 4.04 (Table 4). The participants mean PHCS at follow up as 3.22 (SD 0.66; Figure 8), did not reach statistical significance t=(12)-1.82, p=0.09.

Figure 7 Perceived Health Competency Score at baseline

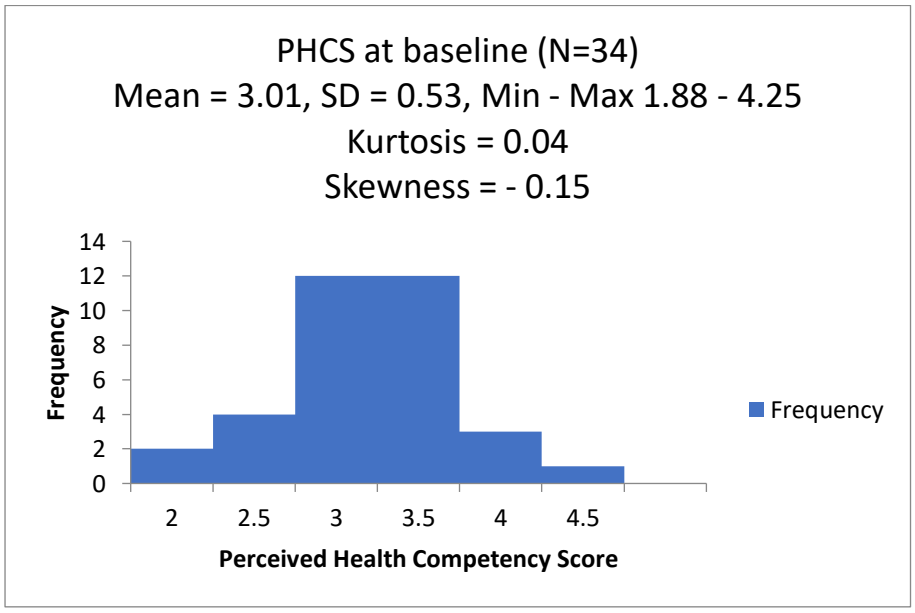
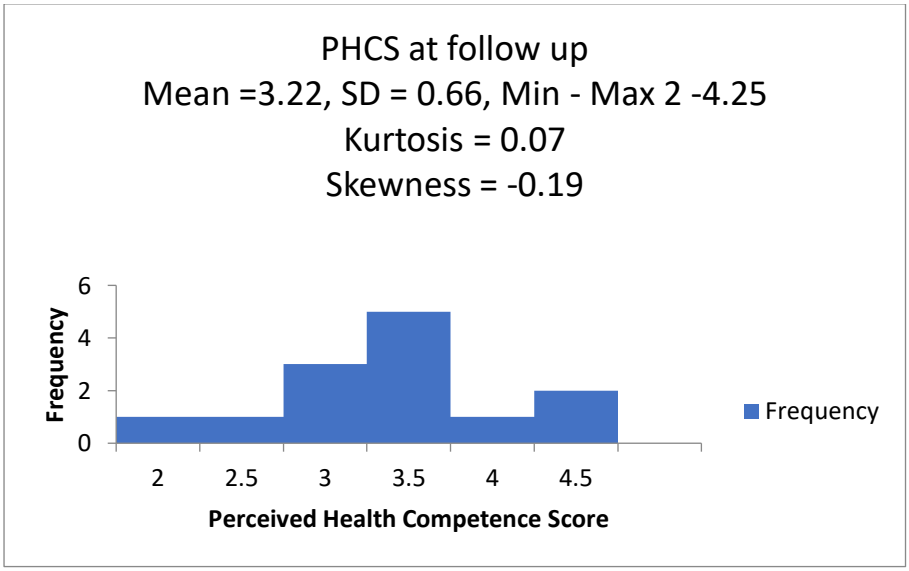


Table 4 PHCS scores by age at baseline and follow up compared to normative data

Age, years (N)	PHCS (SD) baseline	Normative data (Dempster and Donnelly, 2008)	Baseline Difference to norm	Age, years (N)	PHCS (SD) Follow up	Follow up Difference to norm
25-34 (n=2)	3.38 (0.35)	3.92 (0.75)	-0.54	25-34 (n=1)	3.50 (NA)	-0.42
35-44 (n=1)	2.13 (N/A)	3.64 (0.79)	-1.51	35-44 (n=0)	-	-
45-54 (n=6)	2.71 (0.46)	3.34 (0.97)	-0.63	45-54 (n=1)	2.88 (NA)	-0.46
55-64 (n=10)	3.01 (0.62)	3.14 (0.99)	-0.13	55-64 (n=4)	2.56 (0.53)	-0.58
65-74 (n=9)	3.04 (0.24)	Not available		65-74 (n=3)	4.04* (0.36)	
75-84 (n=6)	3.30 (0.43)	Not available		75-84 (n=6)	3.28 (0.21)	

*exceeds the normative UK primary health care setting normative data of 3.65 (Dempster and Donnelly, 2008); NA = not applicable as n=1.

Figure 8 Perceived Health Competency Score at follow up



Programme evaluation

All respondents at follow up (n=13, 100%) were satisfied with the Worthwhile Waiting programme and valued the experience. 46% of respondents (n=6) agreed and 54% (n=7) strongly agreed to both questions.

Over three quarters of the sample (n=10, 77%) either agreed (46%, n=6) or strongly agreed (31%, n=4) that the Worthwhile Waiting programme helped them to achieve their goals (Figure 9). Two respondents (15%) neither agreed or disagreed to this statement and one respondent (8%) disagreed.

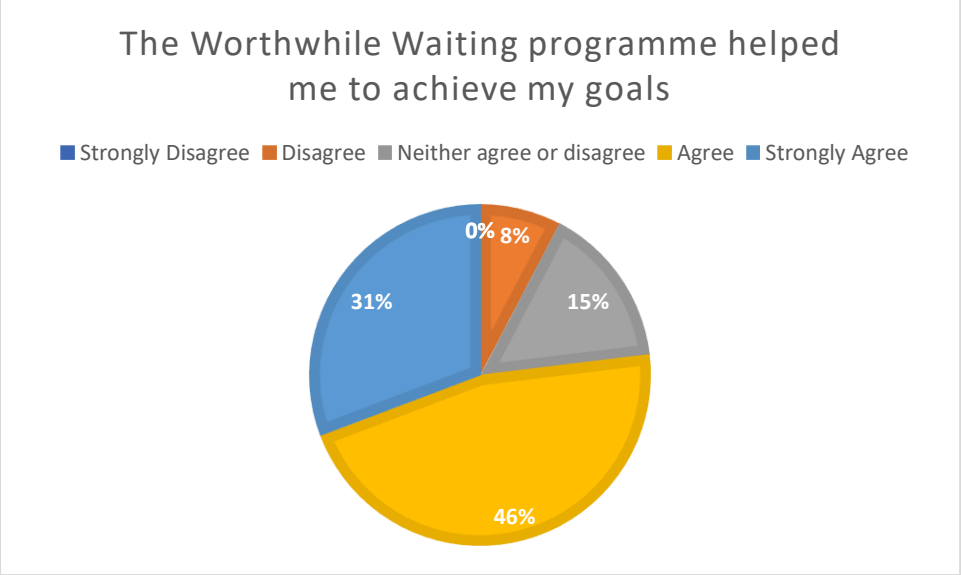


Figure 9 The WorthWhile Waiting programme helped me to achieve my goals (n=13 respondents)

Nine respondents (69%) agreed or strongly agreed (54%, n=7 agreed and 15%, n=2 strongly agreed) the Worthwhile Waiting programme helped them to prepare for surgery (Figure 10). However, three respondents (23%) neither agreed or disagreed with this statement and one respondent (8%) disagreed.

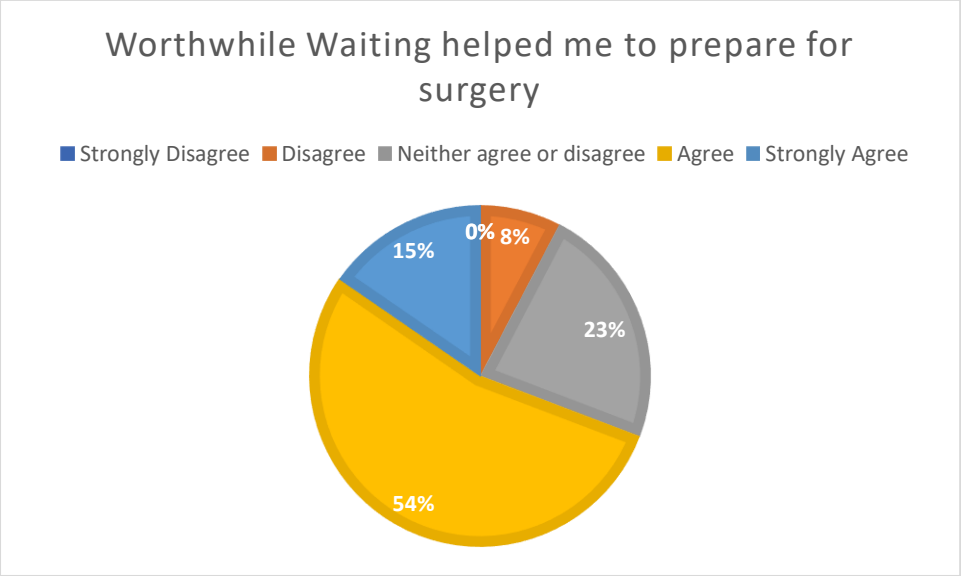


Figure 10: The Worthwhile Waiting programme helped me to prepare for surgery (n=13 respondents)

92% (n=12) of respondents agreed (31%, n=4) or strongly agreed (62%, n=8) help was available from the Health and Wellbeing Coaches if they needed it (Figure 11). Whilst one respondent (8%) disagreed about help being available.

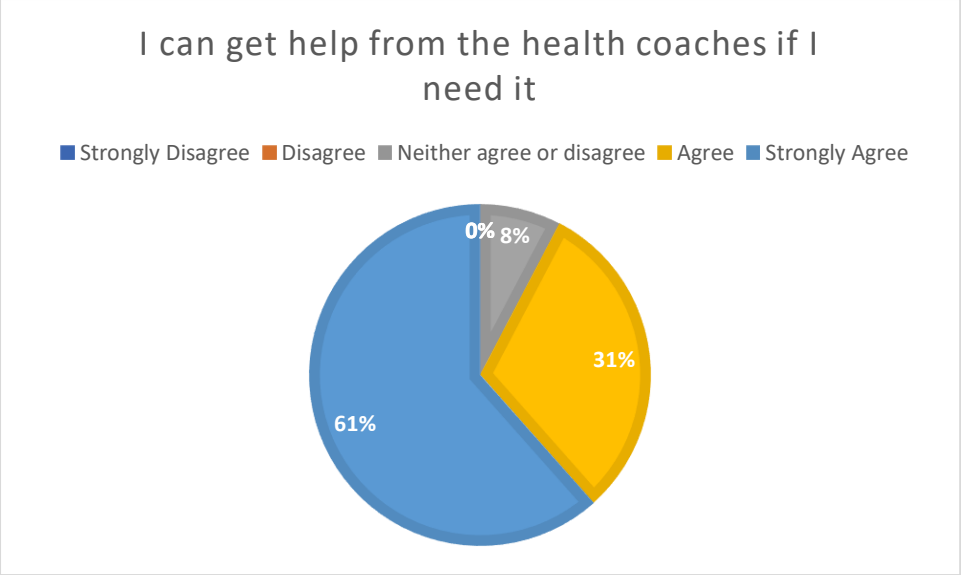


Figure 11: I can get help from the Worthwhile Waiting programme Health and Wellbeing Coaches if I need it (n=13 respondents)

Although only a small number of participants had completed the patient satisfaction ratings overall it was valued by most of the respondents, who particularly valued being able to get help from the Health and Wellbeing Coaches when they need it.

Staff and patient perceptions of Worthwhile Waiting

The recruitment to Worthwhile Waiting was lower than expected with between 10-15% of those referred for MSK signing up. In the following section recruitment is explored from the perspectives of staff and patients. In addition, participants knowledge and understanding of the programme and the perceived impact of the programme on patients and on GP services more widely are also explored. The staff were asked in their interviews about the key factors to the success or otherwise of such programmes and this is considered below, along with perspectives on how Worthwhile Waiting fits with social prescribing and the wider health and social care economy.

What is Worthwhile Waiting?

All the staff interviewed had a good understanding of the overall purpose of Worthwhile Waiting and the challenges faced by patients waiting for surgical procedures or other interventions. Waiting was described as detrimental to both physical and mental health and could lead patients to feel abandoned by the system.

> *…to offer them some health benefits to help them, and perhaps make sure that they were taking the exercise that they were recommended. To generally keep in contact with them, so they didn't feel that they've been abandoned in the system while they were waiting and at the same time improve their mental health. To keep their mental health maintained so that they didn't feel the time was just twiddling their thumbs and putting their life on hold*, (Staff participant 6)

> *I think as in my role as health and well-being coach, if patients are referred to you because they're waiting for surgery, […….] it's important to make sure they have, an*

> *exercise referral or something like that to keep them going until they go. So going through the process of supporting a patient on a one to one basis through that, with the end with the goal to optimize their health and improve their health and work with them to do that.* (Staff participant 2)

Worthwhile Waiting was designed to make the waiting time more palatable through providing structured support, regular contact with a Health and Wellbeing Coach and through signposting to programmes of activities to support mental wellbeing. The programme was described by participants as shifting peoples' experience of passively waiting to one of engagement through empowering them to think about what they could be doing to keep as mentally and physically fit as possible.

> *…being able to provide people who are on a waiting list with structured support or structured support programs, refer them into services or give them opportunities to stay engaged with their health whilst they're waiting for some sort of specialist intervention [….]. The idea was to keep them more proactive (*Staff participant 4)

Whilst it is not surprising that the staff would have a good understanding of the purpose of Worthwhile Waiting, not all patients knew the reason why they had been referred to the programme and hadn't been given a specific reason for referral - one patient on receiving the letter was surprised because he claimed that he was unaware that he had been placed on a waiting list for a surgical intervention and had phoned the GP surgery for more information. Despite this most patients understood the purpose of Worthwhile Waiting and that the intention was to maintain their wellbeing prior to surgery, that it was there to motivate people to help them keep active or to lose weight.

> *to increase wellbeing and to basically to consider things that may help you along to the way towards the point that you might have an intervention or medical treatment* (Patient 1)

The use of resources was mentioned by two of the patients, one with reference to efficiency and a joined-up service possibly to reduce costs, the other while appreciative of the service had initially thought it was a means of making the service as a whole look better through being a waiting list to get on a waiting list.

> *To be honest with you when they first suggested it I thought, "Okay, this is a waiting list to get on a waiting list and it probably makes somebody's numbers look better that they don't have this many people on their list," but [….] I realised this is a damn good idea, we're not just sitting doing nothing and hoping that some sort of magic surgery will happen, we are actually preparing ourselves, doing the necessary things to get us into the situation* (Patient 5)

Overall, the patients' response to the concept of Worthwhile Waiting was positive with people being please to invited to take part. How patients and staff perceive the impact of the programme is presented later.

Recruitment

Patients invited to enrol on Worthwhile Waiting were originally those with a hip or knee condition who had been referred for a MSK appointment in secondary care and the recruitment process was outlined above. To increase recruitment the inclusion criteria were broadened to include any patient waiting for an MSK procedure in secondary care. Recruitment to the

programme was discussed with the staff interviewed and the possible reasons which were given for the slow uptake are now explored.

Firstly, one of the Health and Wellbeing Coaches reported that when contacting patient some reported that they had not seen a letter/email or text from the surgery, another commented that they had feedback from patients for a different project that the message seemed suspicious and so they had contacted the GP surgery for clarification. The point was also made that because the Health and Wellbeing Coaches had been working remotely due to Covid restrictions that some staff in the GP practices didn't know who they were or about the programme so were not able to reassure patients who did phone. The initial letter that was sent to patients came from the patient's GP and the original letter was changed during the programme to encourage greater take up

> *we changed the letter later, so the original invitation letter was quite kind … and we changed it to more of your GP is referring you to this program to help you with your health and well-being while you are waiting. Rather than this is a fluffy offer and it's here, it was changed to more of a quote from [name] or the clinical director which actually recommended that this is what we want you to do next. I think it did get a better uptake [….] Lots of people you call just said. Ohh, I'm OK. I don't need any help. I go on my daily dog walk and I'm fine. Thank you. And you know even though you tried to explain, particularly it was the older population that are fine, they don't want you to get involved.* (Staff participant 1)

Secondly, as indicated here there was reticence from some people contacted, and across the staff participants there were contradictory views about the ages of people who were more likely to take up the offer than others. Whilst staff participant one suggested that older people were less likely to be involved, another thought that it was the younger people who weren't interested because of pressures of work.

> *I think at the very start we either got no answer or we got someone saying it's not for me without letting us tell them about it at all. The normal sort of cohort that we found were most interested was normally someone above the age maybe 60. People below that and they it just thought, this isn't going to fit in with my job. I can't do this while still working.* (Staff participant 5)

Whilst the demographic data from the survey indicates that nearly three quarters (73%) of the participants were aged 55 or above, 47% of the participants were working, therefore the demographic factors in themselves do not help to explain who will take part and who won't. Although over 60% of the sample were female suggesting women are more likely to sign up then men.

Three of the patients interviewed said that they joined the programme as a way of staying on the 'radar' and not being forgotten by or 'lost' in the system

> *… from a personal perspective. It's quite crude actually, it's because if you're not involved in a system, the system forgets you. So, for example, if you're not taking any medication, you have no connection with any of the medical services at all. So by doing something like this, it's a connection.* (Patient 2).

Patients were asked what they thought might influence others to take part and suggestions included having a written plan of what's being offered and what it can or can't achieve and potentially offering taster sessions so people '*can understand what it is about'*.

> *…..maybe a written plan of some sort of what's being offered and what's been taken up. You can positively affect the cause of the path through to treatment. (Patient 1).*

On the other hand, it was also seen as being down to personal preferences and beliefs..

> *You've got to be of the mindset to want to do it yourself, really, and to have the help and the crutches along the way. I don't think you can be forced into doing it. I think the thing is you can discuss with somebody and you can discuss the benefits of it and try to do it. Again, depending on what surgery they are after but I know for myself it helped me thinking about what I was doing and what I was eating and everything else, really. I think having a regimen at the gym may help a lot. (Patient 4).*

The point was also made by staff interviewed that anecdotally the recruitment to prehabilitation programmes and other programmes such as Worthwhile Waiting is low elsewhere, with similar programmes in the region having trouble in recruiting patients to the programme.

Impact

In terms of the quantitative data at follow up only 13 patients had completed a second survey and there was no statistically significant change in the mean score for subjective wellbeing between the baseline point T1 and the score at T2. Although the number of respondents completing the survey a second time was small, the EQ-5D scores did show some improvements in pain levels and in the index scores there was an improvement in the 70-79 age bracket although further research would need to be undertaken before any firm conclusions regarding the impact of the programme could be drawn from this.

The staff were asked what they thought the impact of Worthwhile Waiting was and it was acknowledged that it was too early to tell in terms of the numbers of patients who had been recruited and how long the programme had been running. There was the perception that the Health and Wellbeing Coaches were an alternative source of support for patients, someone they could contact for advice, and this may result in fewer contacts to the GP practice and thus the demand on GPs. However, it was thought that the current software systems would probably not allow this to be readily assessed.

In addition to being a contact point for patients the Health and Wellbeing Coaches have more time than GPs to talk to people as to how they might manage aspects of their physical health such as their blood pressure and weight and to talk through the different options regarding how an individual may make lifestyle changes.

> *You offer them attention and that's what is lacking in the offer at the moment. And so, being interested in them is really what we offer them and that gives an opportunity to nudge them in the direction of better habits and also follow up. You know I said I was going to do it so I should and this person's going to ring me up in a weeks' time and ask me, there's an element of stick and carrots.* (Staff participant 6)

The Health and Wellbeing Coaches therefore support patients though setting long term goals with regular monitoring in the form of follow up calls which helps to motivate people to make lifestyle changes and to maintain any changes made.

> *… people that are involved, are just happy to have someone there that they can let off to or someone they know they can ask about things that might be troubling them with different aspects of their health or their lifestyle. And knowing that they've got someone that they can count on for reliable information or to keep them accountable when they're saying they want to do something, or they want to achieve something. ……. I think it's positive.* (Staff participant 4)

It was further perceived that the support the Health and Wellbeing Coaches provide could have a positive impact on the patients in terms of both their physical and mental health.

> *…most of them you do see them go through a process, you look at their diet, you look at trying to get them to be more physically active, you look at supporting them, their mood, what can they do, in terms of relaxation. In that way, it can really positively impact a patient.* (Staff participant 2)

It was also seen as a way of reassuring patients that they hadn't been forgotten, and this resonates with the accounts of patients who reported joining the programme to avoid being forgotten or lost in the system.

> *Having regular contact with somebody who represents their surgery and their doctors so that they feel, particularly with the pandemic when contact was few and far between and everything was on the phone I think it was just feeling like they mattered, and they hadn't just been forgotten. And in the big mass of everything else, they weren't just a number.* (Staff participant 6)

There was also anecdotal feedback that the GPs like the programme because it gives them something to offer patients who were waiting for procedures. There was also a description of a patient who had lived with chronic pain for 20 years but said that attending the session at the Fitzwilliam was the first time she had been able to be outside of herself enough to stop feeling pain. Staff also reported that patients were grateful that someone was trying to help them, and they were not being forgotten.

This also came out of the interviews with the patients who felt supported through taking part and having the conversations with the Health and Wellbeing Coaches and found the information they received very helpful.

> *I think, again, personally for me, there were things that I needed to do and it's easier to talk to somebody than try to glean all this stuff off the internet and whatever* (Patient 4).

Whilst one patient who had had hip surgery whilst on the programme felt the yoga she had been referred to and helped her with her mobility pre-operatively none of the other patients reported any changes to their physical health, although one patient felt his quality of life had got worse over the past year– not because of being in the programme but rather because of the nature of and deterioration of his condition overall. On the other hand, being encouraged to do more exercise was thought to be a good thing

> *...one of the things that came out of discussions with [name] was to take more exercise putting it bluntly, I suppose. And I've been doing that. So that's a positive benefit out of that.* (Patient 1)

But for another patient whilst they felt the impact of the sessions was neutral in terms of their physical health, they found it a positive experience to have someone to talk to whom they could be honest with as to how their condition was affecting them.

> *…..the kind of outcome is neutral. There is no advantage or disadvantage to it but it's positive. I know it sounds like a contradiction, but when I come off the call, I always that's been positive. I've enjoyed that conversation. It's really positive. Has it actually changed anything physiologically about me? No.* (Patient 2)

Barriers to taking part

The patients interviewed didn't raise issues to participating in Worthwhile Waiting beyond those of access. For example, not being able to attend the Fitzwilliam Museum sessions because they weren't running due to insufficient numbers or difficulty in getting to the museum. There is no disabled parking at the museum and the only carpark is some distance away for people with a disability or mobility issues. The zoom sessions which were run through lockdowns however were enjoyed and provided a distraction from pain.

> *The museum visits have started up again, but they are now in person and it is a bit of a struggle for me to get there because of working and the parking is diabolical for the Fitzwilliam and I can't walk any distance. So, I have politely declined going back in person. If they do restart the Zoom, I would certainly consider doing that again. It was an hour in the week that you didn't have to worry about, it took all the work and pain and household things, everything was taken away and you just had art and music and conversation and friendship, so it was great (Patient 5)*

Transport issues in general were also raised by staff interviewed as a challenge facing people with mobility issues. The physical challenge of attending different activities or interventions can also add to any psychological barriers that people must overcome to participate. This could be due to anxiety but could also be due to the variety of activities on offer. An example given was that some people could be put off by the thought of going to the Fitzwilliam Museum but may attend a similar activity in a garden centre.

> *….barriers would be for people who are not very mobile or don't drive, people that have anxiety and can't leave the home. That is something that you would work with that person to build their confidence up so they can. But yes, I think when somebody hasn't access to transport or there is not a very good bus service for example, or their mobility is so poor that they're going to struggle to even walk to the bus stop* (Staff participant 2)

In terms of joining Worthwhile Waiting and the recruitment to the programme it was suggested that the reason some people refuse to take part is because they find it difficult to see the value of something that is 'touchy feely' and that there is lack of understanding which may be linked to the traditional dominance of the medical model in society.

> *I'm OK. I don't need anything. I know I don't need that. I already do this. I already walk. I already do this and that, and the other. And I don't need any help, and that is very much a barrier. There isn't anything really you can do for me. But I do think that some of that is about the traditional medical model versus what we're trying to do. It's more holistic and a bit more about overall well-being and support, some are just happy to just get on, and don't want to be interfered with as such. I think a lack of understanding plays a bit of a role in that as well and personality. I'm OK. I don't need anything, [….] I know that there's more women and you see that across the board. The health walks and the good mood cafes and all these things. There are always more women happier to be involved than men.* (Staff participant 1)

This quote gives some indication of the challenges facing staff recruiting patients to Worthwhile Waiting. However, staff also reported that there was also reluctance from some clinicians to 'buy in' to the concept and this was seen as an issue more widely.

> *… this is quite a difficult sell for the GPs as well because we have had that all the way along we think they are benefiting from not just Worthwhile Waiting, but also social prescribing. They can understand very clearly that somebody with diabetes might gain from having a diet. They found it much more difficult to understand, that people who feel better are less demanding* (Staff participant 6)

> *…I think from experience of being in this role and talking to clinicians from all over the country, we've got various programmes and that in itself creates a kind of reluctance for clinicians to really buy into what we do as if you have that structure, you can say this is exactly what I'm here to do. So this is exactly what you can send me.* (Staff participant 4)

This is important as patients may ask for advice as to whether to take part in such programmes and without endorsement from a medical practitioner may decide not to take part.

There are also some structural issues which may present barriers to the recruitment to the programme. For example, there are two different electronic systems across the network, and this creates challenges for finding eligible patients. Recruitment relies on the practice secretaries keeping an up-to-date manual record of people who have been referred to secondary care services on a spread sheet and then passing the list onto the Health and Wellbeing Coaches to contact the patients. As the Health and Wellbeing Coaches have got busier over the year with other referrals this has become more challenging for staff to do. Furthermore, as mentioned previously it was also difficult for the Health and Wellbeing Coaches to integrate into the practices because COVID restrictions meant that they worked from home. However, the Health and Wellbeing Coaches were starting to work in the practices more regularly and so this situation should ease.

Key factors which would influence success or otherwise of projects such as Worthwhile Waiting

In the following section the learning from this current project is explored and the key factors that would influence the successful introduction of a similar programmes elsewhere are considered. In answer to patients' reticence in joining the programme it was suggested that people need to be well informed of the value of the programme and the difference it could make to their overall health and wellbeing

> *it's an offer that they would be very well advised to take up. I think it's pretty difficult getting that that shift in people's thinking, I think it would be helpful if people were really I don't know if there was there was sort of .. people were really well informed about it and it was before the moment people get diagnosed and then they're often really in a lot of pain by the time they even get to that point.* (Staff participant 6)

As stated previously there was some disagreement between those interviewed as to whether younger or older patients would be more likely to join Worthwhile Waiting. Regardless of this it was suggested that when setting up a similar programme that it would be important to establish who the target population would be – and this potentially would need to be more specific than by condition because of the need to identify what existing resources and organisations are available in the local area and have a broad range of activities where people could be referred to take account of the different interests.

> *I would say choose the services according to who the population is, who the audience is that you want to target so. I would say that's probably a good starting point and understand what services you have available. So what are the organisations and teams that you can work with? To offer the right service and a wide variety of services, because everyone's different, two people might be on the exact same waiting list and the exact same time, but they want completely different things* (Staff participant 5).

It is also thought to be important to have a 'champion' of the programme, someone who is passionate about the idea and able to engage other staff members too. The Practices overall need to be committed to the programme and the staff who are delivering the programme need to understand the process.

> *I think you need to buy in from the practices and the secretaries. That's absolutely fundamental to just to get the patients. Talking to partner organizations and building those relationships. That would be another key factor. Having a health coaching team who understand the process and the reasons behind it.* (Staff participant 3).

It was commented on by one staff member that because health coaching was such a new role in General Practice that it took time for the Health and Wellbeing Coaches to understand their role because when the roles were first created by NHS England there was no framework in place as to how the new ARRS roles would work.

Discussion

This was a pilot or feasibility project set up to test a model of personalised care for patients who had been referred to secondary care for surgery or other intervention. Based on the existing the literature, the delivery team believed that Worthwhile Waiting had the potential to have the following positive outcomes for patients involved in the programme; improved clinical outcomes in terms of shorter bed stays and enhanced recovery, an improved patient experience/quality of life whilst waiting, improved competence in managing their own health, improved physical and mental wellbeing, and a reduction in social isolation. However, because of the initial difficulties in recruiting patients to the programme as outlined above the sample size is too small to draw any definite conclusions regarding the success of the programme in meetings these objectives. However, what the demographic data does indicate is that more women than men signed up and older people aged over 55 were more likely to join the

programme than others, although fewer than 40% of the respondents described themselves as retired. This is data that will be useful for the project in the future as it develops to consider how best to target people for example the information provided about the programme and in considering the range of activities to offer.

The difficulties around recruitment suggest the need to look at the referral processes and whether alternatives methods of identifying eligible patients could be put in place. This could include an automated system which alerts the Health and Wellbeing Coaches or other project staff when a patient is referred for certain procedures, alternatively a central administrative role could be created to identify patients and make the initial and follow contact with patients. This would alleviate some of the pressures on Health and Wellbeing Coaches whose work loads are increasing with patients referred by GPs for support with weight management, and diabetes management as the role becomes more embedded within the primary care network.

Low recruitment rates to such programmes are not unusual and similar programmes in the region anecdotally report lower than expected recruitment. Furthermore, in the literature there are prehabilitation studies which report issues with recruitment, lack of interest and unwillingness to travel or transport difficulties being cited by patients as reasons for refusal to join (Martin et al 2020, Tew et al 2020). Kulinski & Smith (2020) also reported difficulties with initial recruitment for surgical prehabilitation in their pilot study on a mobile health coaching initiative. They found difficulty in contacting patients using the details provided to the hospital, and that patients stated a lack of interest in taking part. They suggested face to face recruitment during medical appointments could increase likelihood of enrolment, and an opt-out system whereby patients were automatically enrolled onto a programme at the time of booking surgery.

The patients interviewed were very positive and complementary about the programme and the satisfaction survey demonstrated high levels of satisfaction but we were not able to capture the views of those eligible but who had refused to take part. From the staff interviewed those patients who refuse to join the programme did so because they felt they didn't need it or because they were working. However, some of those interviewed were working and the flexibility of the Health and Wellbeing Coaches enabled them to have regular calls with the patients.

The patients interviewed who joined the programme wanted to stay on the 'radar' and wanted to try and stay as well as possible. However, looking at the PHCS data may give some explanation regarding why some patients opted to join Worthwhile Waiting. The perceived health competence scale gives a measure of the degree to which an individual feels capable of effectively managing their health outcomes (Smith et al 1995). Perceived health competence is thought to be relevant to predicting intended or actual health behaviour (Smith et al 1995). Dempster and Donnelly, (2008) reported that those with a lower PHCS score are more likely to find advice on health behaviours and regular health checks helpful whereas those with higher perceived health competence are less likely to desire advice on lifestyle health behaviours. The sample in this evaluation had a mean perceived health competence score below the normative population score. This may contribute to the reasons why some people opted into the programme. A large-scale study where all patients who were referred for surgery or other interventions would be needed to establish whether self-efficacy in relation to managing individual health is a factor in recruitment to Worthwhile Waiting or other prehabilitation programmes.

The baseline data gives an overview of the respondents in terms of their self- reported quality of life, subjective wellbeing and whether people are lonely. The EQ-5D provides a generic measure of health-related quality of life (HRQoL) and the mean index score of the sample was substantially lower than the population normative data. This perhaps is not surprising given that the people were waiting for surgery or interventions in secondary care and 70% of the sample reported moderate or severe problem with mobility at baseline, and over 70% experience moderate or severe levels of pain. The mean SWEMWBS at baseline indicate moderate levels of subjective wellbeing, which is slightly lower than the population norm, but over 60% were above the population norm.

Although loneliness and social isolation are not the same thing the ESLA question on loneliness has been shown to be an indicator of potential social isolation. Whilst 62% of the sample reported feeling lonely hardly ever or never, if we compare this to The Understanding Society Wave 9 (2017-2018) where nearly 90% of people aged over 16 years of age reported hardly ever or never feeling lonely (Karania 2020) it indicates higher levels of loneliness across the sample than perhaps might be expected. Unfortunately, the total sample size is too small to explore any potential correlations with either the demographic data, or with the data from the other measures used in this study. As further participants complete the Worthwhile Waiting programme it is recommended that the statistical analyses are performed again as there will be greater statistical power to be able to pick up any potential differences.

Conclusions

Recruitment to the programme was slower than anticipated and from the interviews reasons for this were linked to a lack of interest and the ages of the eligible population however, it was also noted that the recruitment to other programmes in the region followed a similar pattern. The interviews with staff and patients found most had a good understanding of the purpose of Worthwhile Waiting and how it could have a potential impact on overall health and wellbeing but there were some patients whose main reason for joining was to stay on the radar and have a contact point, so they were not forgotten by the system. There were barriers to taking part identified by both patients and staff and this included access and transport issues, but also and perhaps more important it was felt that there is a lack of understanding in the wider population and amongst health care professionals of the potential value of health coaching and alternatives to the traditional medical model of care. Patients who completed the satisfaction scale in the survey rated the programme highly and those interviewed were very complimentary and felt supported and encouraged to make lifestyle changes through their interactions with the Health and Wellbeing Coaches.

The evaluation has provided some useful insights for the future development of the programme, and further research in this area. At this stage whilst the number of people completing the survey a second time is too small to draw firm conclusions regarding the overall impact of the programme there are some interesting findings which could be explored further as the programme progresses.

From the data the following recommendations for Worthwhile Waiting and other primary care networks planning to implement similar programme can be made

- The Health and Wellbeing Coaches need to be integrated into the individual Practices and ideally -have a greater visible presence on regular basis to raise the profile of Worthwhile Waiting.

- There needs to be dedicated administrative support to take on the role of recruitment to the programme, this would be someone to collate names and to make initial contact with patients to encourage them to consider taking part in Worthwhile Waiting.
- The range of activities offered needs to be considered to take account of a broad range of interests and preferences.
- Accessibility also needs to be considered when offering alternative activities to patients.
- Other primary care networks considering similar programmes need a ‘champion’ in post to engage people in the process and raise awareness of the programme more widely.

References

Braun, V. & Clarke, V. 2006, Using thematic analysis in psychology. *Qual Res Psychol* 2006;3(2):77–

British Medical Association 2022 NHS backlog data analysis at https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/nhs-backlog-data-analysis (accessed 19th October 2022)

Campaign to end loneliness (https://www.campaigntoendloneliness.org/the-facts-on-loneliness/)

Carr, T., Teucher, U. and Casson, A.G., 2017. Waiting for scheduled surgery: a complex patient experience. *Journal of Health Psychology*, *22*(3), pp.290-301.

Child Outcomes Research Consortium (2022). Short Warwick- Edinburgh Mental Wellbeing Scale (SWEMWBS). Available at: https://www.corc.uk.net/outcome-experience-measures/short-warwick-edinburgh-mental-wellbeing-scale-swemws/ (Accessed 22 October 2022)

Cohen, D.J., Clark, E.C., Lawson, P.J., Casucci, B.A. and Flocke, S.A., 2011. Identifying teachable moments for health behavior counseling in primary care. *Patient education and counseling*, *85*(2), pp.e8-e15.

Dempster, M and Donnelly, M (2008). Validity of the Perceived Health Competency Scale in a UK primary care setting. *Psychology, Health and Medicine* 13(1) 123-127.

EQ5D (2022). EQ5DL User Guide. Available at: https://euroqol.org/publications/user-guides/ (Accessed 21 October 2022)

EQ5DL Index Value Set (2022). Available at: https://euroqol.org/wp-content/uploads/2020/12/ENG_value-set_SPSS.txt (Accessed 21 October 2022)

Gagliardi, A. R., Yip, C.Y.Y., Irish, J., Wright, F., Rubin, B., Ross, R., Green, R., Abbey, S., McAndrews, M.P., Stewart, D.E. 2021, The psychological burden of waiting for procedures and patient-centred strategies that could support the mental health of wait-listed patients and caregivers during the COVID-19 pandemic: A scoping review *Health Expectations 00: 1-13*

Karania, V., 2020, Measuring the prevalence of loneliness in England, Age UK, available at https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/loneliness/loneliness-measure-for-england.pdf

Kulinski, K. and Smith, N.A., 2020. Surgical prehabilitation using mobile health coaching in patients with obesity: a pilot study. *Anaesthesia and Intensive Care*, *48*(5), pp.373-380.

Levett, D.Z.H., & Grimmett, C. 2019 Psychological factors, prehabilitation and surgical outcomes: evidence and future directions, *Anaesthesia* 74(Suppl.1) 36-42

Martin, D., Besson, C., Pache, B., Michel, A., Geinoz, S., Gremeaux-Bader, V., Larcinese, A., Benaim, C., Kayser, B., Demartines, N. and Hübner, M., 2021. Feasibility of a prehabilitation program before major abdominal surgery: a pilot prospective study. *Journal of International Medical Research*, *49*(11), p.03000605211060196.

Moran, J., Guinan, E., McCormick, P., Larkin, J., Mockler, D., Hussey, J., Moriarty, J. and Wilson, F., 2016. The ability of prehabilitation to influence postoperative outcome after intra-abdominal operation: a systematic review and meta-analysis. *Surgery*, *160*(5), pp.1189-1201.

NHS England (2019). Universal personalised care: Implementing the comprehensive model available online: https://www.england.nhs.uk/publication/universal-personalised-care-implementing-the-comprehensive-model/

NHS England (2020). Next Steps on NHS Response to COVID-19: Letter from Sir Simon Stevens and Amanda Pritchard. NHS England and NHS Improvement Coronavirus. 2020. Available online: https://www.england.nhs.uk/coronavirus/publication/nextsteps-on-nhs-response-to-covid-19-letter-from-simon-stevens-and-amanda-pritchard/

NHS England (2021). Statistical Press Notice NHS Referral to Treatment (RTT) Waiting Times Data October 2021. 2021. Available online: RTT-statistical-press-notice-Oct-21-PDF-421K-03857.pdf (england.nhs.uk)

NHS England 2020 Health Coaching: Implementation and quality summary guide. Available online https://www.england.nhs.uk/wp-content/uploads/2020/03/health-coaching-implementation-and-quality-summary-guide.pdf

O'Dowd, A., 2021 NHS waiting list hits 14 year record high of 4.7 million people *BMJ 2021:373:n995 http://dx.doi.org/10.1136/bmj.n995*

Oudhoff, J.P., Timmermans, D.R.M., Knol, D.L,. Bijnen, A.B., van der Wal, G., 2007 Waiting for elective surgery: impact on health-related quality of life and psychosocial consequences. *BMC Public Health,* 7: 164

Polchert, M (2015). Cross cultural exploration of the Perceived Health Competency Scale. *Open Journal of Nursing* 5, 632-641.

Reeves, B.C. Deeks, J.J. Higgins J.P.T. and Wells, G. A. on behalf of the Cochrane Non-Randomised Studies Methods Group 2008 *Including non-randomized studies* in Cochrane Handbook for Systematic Reviews of Interventions Cochrane Book Series Eds by Higgins, JPT and Green S, Wiley Blackwell

Shaughness, G., Howard, R., & Englesbe, M. (2018). Patient-centered surgical prehabilitation. *The American Journal of Surgery*, *216*(3), 636-638.

Sheard, S. (2018). Space, place and (waiting) time: reflections on health policy and politics. *Health Economics, Policy and Law*, *13*(3-4), 226-250.

Smith, M.S., Wallston, K.A. and Smith, C.A., 1995. The development and validation of the Perceived Health Competence Scale. *Health education research*, *10*(1), pp.51-64.

Tew GA, Bedford R, Carr E, et al. Community-based prehabilitation before elective major surgery: the PREPWELL quality improvement project. BMJ Open Quality 2020;9:e000898. doi:10.1136/ bmjoq-2019-000898

Wynter-Blyth and Moorthy 2017 Prehabilitation: Preparing patients for surgery BMJ 2017;358:j3702 doi: 10.1136/bmj.j3702