Title

Consistent approach on the management of patients on a waiting list with reluctance to engage with hospital treatment (face-to-face OPA, diagnostics and or treatment).

Issued

3 June 2021- by **Lesley Law Planned Care Policy Manager Welsh Government (Lesley.Law@gov.wales**

This guidance should be read in conjunction with the Rules for Managing Referral to Treatment waiting times guidance, published in October 2017.

Principles:

- Patients should only be on a waiting list if they are actively waiting to be reviewed / treated.

For patients waiting for a first outpatient appointment:

Situation 1:
The patient invited for a virtual appointment, but has declined, as they want a face-to-face appointment,

ACTIONS

- The patient to be advised :
- Virtual appointments are now part of the normal way patients care is reviewed and that their consultant believes they can be effectively assessed this way.
- In addition, understand the reasons why they should engage, and that currently face-to-face reviews are being prioritised for patients where a virtual review is not possible. (This will include patients who may have difficulties hearing for telecom and or access issues with Video if visual review is required).
- If the patient still declines, they should be advised that unless there is a clinical need to remain on a waiting list (assessed by the clinician) they would be removed from the waiting list and referred back to their GP.
- If their clinician feels there is a clinical reason to remain on the waiting list, their waiting time in line with RTT guidance will be reset.

Situation 2:
The patient has been invited for a face-to-face appointment but refuses due to concerns around attending, either due to a clinical reason, (such as immunity issues), or has a COVID fear risk of attending.

ACTIONS

- Phone the patient to discuss their fears and to provide assurance, through a conversation undertaken by a clinician (Nursing, AHP or medical). This should also explain that they might be removed from the waiting list if they do not wish to be seen now. .
- If fears cannot be resolved by reassurance or with appropriate support and the patient refuses to come into a hospital setting for their care, they should be discharged back to their GP.
- The discharge needs to be clinically agreed, and followed-up by a covering letter explaining what may be triggers for escalation and return to the system. If their clinician feels there is a clinical reason to remain on the waiting list, their waiting time in line with RTT guidance will be reset.

OPA 52 week validation process:
For those patients that have been on the waiting list for over 52 weeks, there is an on-going validation process

There is an option on the validation letters asking if patients want to remain on the waiting list, but do not want to attend hospital sites currently due to the COVID risk.

ACTION:

- Phone the patient to discuss their fears and assess their clinical risk through a conversation undertaken by a clinician (Nursing, AHP or medical);
- Assess the reasons for their reluctance to engage at this time;
- Options: demonstrable clinical risk or COVID fear: follow appropriate action as summarised above (scenario A or B2)

For all other patients waiting for stages 2 to 4:

Patients will fall into one of two categories:

A. those who have a demonstrable clinical reason that informs their decision not to attend, and
B. those with COVID risk fears (but not specific clinical risk)

For those patients where there is a **demonstrable clinical reason** why admission / face-to-face review should not take place due to ongoing COVID risk e.g. immunity issues.

ACTION:

- If the patient and clinician agree there is a continued clinical need for review / treatment, the patient would come off an RTT reportable waiting list and put on a review waiting list. This is classified as active monitoring, as set out in the RTT guidance.
- Clinician and patient would agree the review interval, together with how the review will take place. (SoS or PIFU may be a suitable option to encourage the patient self-managing their condition)
- When appropriate, a new RTT clock will commence when the clinician and patient agree the time is suitable to plan for their next stage of their pathway (diagnosis and or treatment).
- The clinician would agree the most appropriate place for the patient to join the waiting list, based on clinical priority of everyone on the waiting list.

Patients with **COVID risk fears (but with no specific clinical reason not to attend)**

ACTION:

- Phone the patient to discuss their fears and to provide assurance, through a conversation undertaken by a clinician (Nursing, AHP or medical). This should also explain that their current waiting time would stop if they do not accept reasonable offers when given.
- If fears cannot be resolved by reassurance or with appropriate support and the patient refuses to come into a hospital setting for their care, discharge them back to their GP.
- The discharge needs to be clinically agreed, and followed-up by a covering letter explaining what may be triggers for escalation and return to the system.

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