Monitoring of Allied Health Professions Waiting Time Targets

Data Definitions and Guidance Document

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Monitoring of AHP Waiting Time Targets  
Data Definition and Guidance Document |
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1. Context

1.1 Introduction

On the 27th April 2007 Chief Executives of Boards and Trusts were informed that the Minister had identified the improvement of access to Allied Health Professional (AHP) services as one of the key priorities for 2007/2008. To this end the Priorities for Action included the following principle:

By May 2007, Boards and Trusts must submit to the Department for approval and monitoring, proposed targets and associated reform plans for March 2008 and beyond.

Six AHP services were to be included in the target:

- Dietetics
- Occupational Therapy
- Orthoptics
- Physiotherapy
- Podiatry
- Speech and Language Therapy

For the purpose of this document reference to AHP is inclusive of the above professions.

In response to the Departments directive, Boards and Trusts submitted an agreed regional target for ministerial approval, which was subsequently confirmed on the 9th July 2007 as:

1. No patient to wait more than 26 weeks from referral to treatment by March 2008
2. No patient to wait more than 13 weeks from referral to treatment by March 2009
This document provides guidance on data collection, which will be used to gather the data necessary for official reporting, to measure progress towards the 13 week target for all AHP services in 2008/09.

The overriding principle is that each patient’s / client’s identified treatment needs for AHP services should be commenced within the agreed targets.

1.2 Current Practice

Allied Health Professionals work with all age groups and conditions, and are trained in assessing, diagnosing, treating and rehabilitating people with health and social care needs. They work in a range of settings including hospital, community, education, housing, independent and voluntary sectors. A synopsis of the roles of the six AHP professions is outlined in Appendix 1. Further details are available on the DHSSPS website at: www.dhsspsni.gov.uk/ahp

Within AHP services there are specialties and also sub specialties. Each service, including the specialties and sub specialties, has developed waiting lists.

A regional scoping exercise was undertaken in May 2007 to explore the extent of AHP waiting times and as a result of this data collection exercise the following issues were highlighted:

- Inconsistent and varied systems for data collection are being used e.g. *Manual, PARIS, LCID, PAS, COMWISE, CLINICAL MANAGER, AND SOSCARE*;
- Lack of a regional approach to data definitions;
- No consistent approach to data definitions;
- Variation in the currency used to collect waiting times e.g. weekly versus monthly;
- Reporting frequencies vary e.g. quarterly waiting list information from Trusts and Boards (information may be up to a quarter in arrears), contact
information from Boards and DHSSPS (KORNER) and adhoc reports to Boards and DHSSPS; and,

- Uncertainty around the extent of “hidden waiting lists”, i.e. multidisciplinary team referrals and consultant led clinics.

### 1.3 Delivery of Targets

The waiting time targets are based on the worst case scenario and reflect the minimum standards with which every Trust must comply.

The expectation is that these targets are factored into plans at Trust, Board, divisional, specialty, and Departmental levels as part of the normal business and strategic planning processes.

It is expected that Trusts will develop robust information systems to support the delivery of these targets.
2. Collection of waiting time data

2.1 What to report?

Waiting times for the following AHP services should be reported:

- Dietetics
- Occupational Therapy
- Orthoptics
- Physiotherapy
- Podiatry
- Speech and Language Therapy

For all AHP Services Count:

- Total numbers waiting to be seen from referral to first treatment (Definition of treatment outlined in 3.4)
- Total number of patients /clients waiting in excess of the 13 week target

2.2 Who to include?

Include all patients / clients waiting for treatment for which the Trust manages, facilitates on site(s) and/or the Trust has responsibility for providing an AHP service.

This includes all referrals, irrespective of the referral source or location of the service, including AHP services provided by staff in GP clinics.

2.3 Who should be accountable for data collection?

Data collection will be Trust based.

Trusts will be responsible for all monitoring returns for AHP services provided by them, including those provided in a non-HSC setting and in GP clinics.
Multiple / Inter Provider Pathways

If a patient / client is referred from one Trust (referring Trust) to another Trust (receiving Trust) for treatment by an AHP, a new waiting time clock should start on the date the onward referral was received by the receiving Trust until first definitive treatment by the appropriate AHP within the receiving Trust.

The Trust who is providing the AHP service(s) will be responsible for reporting the referral to treatment time. Trusts must have steps in place to ensure that delays in making onward referrals are kept to a minimum.

2.4 Reporting

The aim is to automate weekly monitoring for the six AHP categories outlined from September 2007. To facilitate this monitoring, the preferred option for the DHSSPS is for all waiting lists to be recorded and managed in electronic format. Where this is not the case, Trusts must stipulate the system(s) they intend to use to manage this information and ensure that they can provide validated downloadable monitoring data.

Community Information Branch (CIB) will collect information on a quarterly basis and will be responsible for reporting and publishing the official DHSSPS information to monitor these targets. CIB will develop and issue quarterly information returns that HSC Trusts must complete. The returns will be used to monitor both incomplete and completed waits for first definitive treatment by an AHP.

Incomplete waits refers to the number of people waiting for the first definitive treatment of their identified / assessed needs by an AHP at a specific point in time.

Completed waits, for CIB’s monitoring return, refers to the number of people who had the first definitive treatment of their identified / assessed needs by an AHP during the requested accounting period.

In addition to the official quarterly return submitted to CIB, the weekly monitoring return should continue to be sent to SDU.
3. Definitions

3.1 What is a referral?

Referrals to Allied Health Professionals

A referral is a request for an assessment of need for treatment. Referrals may be initiated in many ways, for example, in writing, by fax, by email, verbally, occasionally by telephone or via a self-referral. A self-referral is a request for assessment by a patient / client or by their advocate (e.g. parent / guardian / carer).

All types of referrals, with the exception of incomplete and inappropriate referrals, should be counted in monitoring of waiting times.

Written confirmation may not be required for referrals from teachers, if the AHP is based in the school.

Multiple Referrals

Trusts should ensure that adequate systems are in place to deal with multiple referrals for the same patient regarding the same condition from a number of sources.

Special Schools

Allied Health Professionals should record the date of referral as the time of their first contact with the child / young person at which time the need for an AHP service is identified. If a need is identified and treatment is required, this first contact should start the clock. In some cases referral and first definitive treatment may occur on the same day, and should be included in the appropriate waiting time band on the completed waiting times information return.
Do not record the date of referral as the date on which the AHP receives a list of children / young people who will be attending the school in the incoming year. At this stage the needs of these children / young people have not been identified, and it may be a further period of time before the AHP first contact with the child / young person.

Children / young people seen for the first time and / or who were not previously on the caseload of the relevant AHP service in a Trust in which the special school is located, should be recorded as a new referral.

**Example 1:**
A child may be receiving AHP services in Trust A prior to attending a special school in Trust B, and as such will not be known to the AHP service in Trust B. These cases should be treated as new referrals for Trust B, as per guidance on inter provider pathways on page 8.

**Example 2:**
If a child is on a waiting list for AHP services in Trust A prior to attending a special school in Trust B, Trust A must ensure that the child is treated in line with the AHP waiting time target.

### 3.2 Referral Triage

All referrals must be triaged or assessed to make a clear decision on the next step of a referral. Trusts must ensure that there are no unnecessary delays at this stage of the process. Where there is insufficient information for the professional to make a decision, they should contact the originating referrer in the first instance to access the necessary information. If this cannot be gained, the referral should be returned to the originating referrer requesting the necessary information and a new referral should be initiated.
Triage Outcomes can be:

- Advice only (episode complete)
- Referral Incomplete (unresolved)
- Referral Incomplete (resolved)
- Patient clinically or socially unfit
- Inappropriate Referral
- Referral Accepted

If at the referral stage the patient / client is identified as being clinically or socially unfit (page 20) to receive the necessary service the referral should not be accepted (not added to a waiting list) and returned to the originating referrer with a request that they re-refer the patient / client when they are clinically or socially fit to be treated.
# Referral Triage Outcomes

<table>
<thead>
<tr>
<th>Triage Outcome</th>
<th>Action</th>
<th>Clock Status</th>
<th>Next Step</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advice only</td>
<td>The referral is returned to GP or originating referrer with written advice. Episode is completed.</td>
<td>Clock stops.</td>
<td>The referral is closed.</td>
</tr>
<tr>
<td>Referral incomplete (unresolved)</td>
<td>Insufficient information prevents triage decision being made and so the referral is returned to the GP or originating referrer. If a new referral is received with the added information, this is processed as a new referral from the date on which it was received.</td>
<td>Clock stops</td>
<td>The referral is closed. A new referral may be generated upon receipt of the additional information.</td>
</tr>
<tr>
<td>Referral incomplete (resolved)</td>
<td>If the query relating to the incomplete referral is minor and can be resolved quickly by contacting GP or originating referrer, the additional information can be added and the referral proceeds.</td>
<td>Clock continues</td>
<td>Dependent upon triage decision.</td>
</tr>
<tr>
<td>Patient clinically or socially unfit</td>
<td>A decision to refer the patient for treatment / further assessment / intervention cannot be taken as the patient / client is deemed clinically or socially unfit at the time of triage. Similarly, if the patient / client becomes clinically or socially unfit for treatment after referral their waiting time clock should stop and the referral returned to the originating referrer.</td>
<td>Clock stops</td>
<td>The referral is closed. A new referral may be generated when the patient / client becomes clinically or socially fit.</td>
</tr>
<tr>
<td>Inappropriate referral</td>
<td>Referral deemed inappropriate on the basis of information received. Written notification sent to GP or originating referrer.</td>
<td>Clock stops</td>
<td>Referral closed and returned to originating referrer.</td>
</tr>
<tr>
<td>Referral accepted</td>
<td>A decision to refer the patient for treatment / further assessment / intervention is taken. At this stage it is known which AHP service(s) the patient / client requires and whether they can be provided concurrently or sequentially.</td>
<td>Clock continues</td>
<td>Patient / client is added to the appropriate AHP waiting list.</td>
</tr>
</tbody>
</table>
3.3 Patients / Clients Discharged without Treatment

There are instances when a patient / client can be discharged without treatment. These include:

- The patient / client fails to attend their appointment (DNA), and the AHP agrees that the patient / client be discharged to the care of the originating referrer;
- The patient’s / client’s clinical or social condition changes and they no longer require the service originally referred for; or,
- The patient / client does not provide any response to correspondence issued by the Trust to determine if the condition originally referred for still exists.

3.4 What is Treatment?

For monitoring purposes, treatment commences when the identified or assessed needs of the patient / client, begin to be addressed by the appropriate AHP(s).

The first definitive treatment may be:

- The provision of the component(s) of an agreed care plan;
- The provision of definitive advice intended to manage / treat the patients / clients condition; or,
- Therapeutic intervention where the aim is managing the patient’s / client’s disease condition or injury or to avoid deterioration. This includes the provision of aids and adaptations.
4. Guidance on Counting Waiting Times

4.1 How to count waiting time

Trusts should count the length of time waiting in completed weeks from the date of receipt of referral into the service. A week should be counted as a block of seven completed days. See example below:

<table>
<thead>
<tr>
<th>Time Band (Weeks)</th>
<th>Number of Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Up to 1 Week</td>
<td>Up to and including 7th day</td>
</tr>
<tr>
<td>&gt;1 – 2 Weeks</td>
<td>From 8 up to and including 14 days</td>
</tr>
<tr>
<td>&gt;2 – 3 Weeks</td>
<td>From 15 up to and including 21 days</td>
</tr>
<tr>
<td>&gt;3 – 4 Weeks</td>
<td>From 22 up to and including 28 days</td>
</tr>
<tr>
<td>&gt;4 – 5 Weeks</td>
<td>From 29 up to and including 35 days</td>
</tr>
<tr>
<td>&gt;5 – 6 Weeks</td>
<td>From 36 up to and including 42 days</td>
</tr>
<tr>
<td>&gt;6 – 13 Weeks</td>
<td>From 43 up to and including 91 days</td>
</tr>
<tr>
<td>More than 13 Weeks</td>
<td>92 days or more</td>
</tr>
<tr>
<td>&gt;13 – 21 Weeks</td>
<td>From 92 up to and including 147 days</td>
</tr>
<tr>
<td>&gt;21 – 26 Weeks</td>
<td>From 148 up to and including 182 days</td>
</tr>
<tr>
<td>More than 26 Weeks</td>
<td>183 days or more</td>
</tr>
</tbody>
</table>

Please note that the time bands listed above are for reference only and may not correspond to time bands requested in subsequent information returns.

Example:

if the referral to start of treatment clock starts on 1st January 2008 and a snapshot is taken on 15th January 2008, the length of time waiting for treatment will be 14 days and the patient / client should be reported in the >1 – 2 weeks time band, whilst on the 16th January, the length of time waiting for treatment will be 15 days and the patient / client should be reported in the >2 – 3 weeks time band.
4.2 Clock Starts

The waiting time clock starts on the date the Trust receives notice of the patient’s / client’s referral. All referrals should be date stamped / logged on receipt into the service, irrespective of the means of delivery.

Trusts must ensure that protocols are in place to prevent unnecessary delay from date stamping / logging of referrals to forwarding to the AHP department responsible for referral triage and/or initiation of treatment.

Clock starts when a new condition is recognised

When an AHP treating a patient / client identifies a condition other than that for which the patient / client was originally referred, a new referral should be made to the appropriate AHP service. The new clock should start at the date that the referral for the new condition is received by the Trust.

Clock starts in relation to transfers

If a patient / client transfers to the waiting list of another AHP / Trust for the same condition to which they were originally referred, their waiting time clock should continue.

Clock starts for referrals to Multi-Disciplinary Teams

For multi-disciplinary team referrals, the waiting time clock starts on the date the Trust receives notice of the patient’s / client’s referral.

In some instances the original referral may not detail the particular AHP service required, and this may only be identified following the referral triage. Similarly in this case, the waiting time clock will start upon receipt of the original referral.
The outcome of the referral triage will determine the AHP services required and whether these will be provided; concurrently (Pathway 2, page 18) or sequentially (Pathway 3, page 19).
4.3 Clock Stops

The waiting time clock stops when the first definitive treatment has commenced or when a decision is made that treatment is not required. Please refer to examples 1, 2, and 3 for illustration of clock starts / stops for the range of patient / client pathways:

**Pathway 1:- Patients / Clients requiring only 1 AHP service**

For patients / clients who require only 1 AHP service, the clock stop date is the date of the first definitive treatment or when a decision is made that treatment is not required.
Pathway 2:- Patients / Clients requiring more than 1 AHP Service (Including Multi-Disciplinary Team Referrals)

Concurrent cases refer to patients / clients referred to more than one AHP service. Each service has its own waiting time clock and each clock is stopped upon provision of the first definitive treatment by the appropriate AHP. There is no ordering or dependence on the provision of one AHP service before commencement of another.

Current cases refer to patients / clients referred to more than one AHP service. Each service has its own waiting time clock and each clock is stopped upon provision of the first definitive treatment by the appropriate AHP. There is no ordering or dependence on the provision of one AHP service before commencement of another.
Pathway 3: Patients / Clients requiring more than 1 AHP Service (Including Multi-Disciplinary Team Referrals)

**Sequential** cases refer to patients / clients referred for more than one AHP service; although, each AHP service has their own waiting time clock, these will start and stop depending on commencement and completion of respective elements of the treatments required;

**Example:**
An occupational therapy intervention might not be appropriate until a course of physiotherapy has finished and the patient / client is deemed clinically or socially fit. In this case, the OT clock will not start until there is a clinical decision that the patient / client is ready to commence OT treatment (Clock start date should be the date of the inter-professional referral). The physiotherapy clock will have stopped upon receipt of the first definitive physiotherapy treatment.
4.3.1 Clock stops for patients / clients deemed clinically unfit

If a patient / client is already on a waiting list for treatment / intervention by an AHP, but becomes clinically or socially unfit for treatment, their clock should be stopped and the referral returned to the GP or originating referrer. When they become clinically or socially fit to receive treatment they will be re-referred and a new clock will start on the date the re-referral is received by the Trust. The referrer should advise the Trust of any previous accrued wait so that this may be taken into consideration. Please note that the previous wait is passed on for information only.

4.3.2 Do Not Attends or Patient / Client Cancellations

The waiting time clock should be reset for all DNAs and CNAs irrespective of the booking method used to appoint the patient. The management of such patients, i.e. whether to discharge or re-book, should be made in line with the guidance in section 5 of the Integrated Elective Access Protocol (IEAP).

Do not attend (DNA)

Any patient / client who fails to attend their appointment without giving prior notice will be treated as a DNA and will have their waiting time clock reset to the date that they failed to attend their booked appointment.

Failed contacts / negative visits in which the patient / client is not at home for an agreed pre-arranged appointment by an AHP, should be treated as a DNA.
Cannot attend on the day (CND)

Patients / clients who could not attend and informed the AHP service on the day on which the appointment was scheduled, will have their waiting time clock reset to the date that they failed to attend their booked appointment.

Cannot attend (CNA)

Patients / clients who cancel their appointment in advance will have their waiting time clock reset to the date that the service was notified of the cancellation.

4.4 Further guidance on the management of waiting lists

Further guidance on the effective management of waiting lists can be found in the Integrated Elective Access Protocol (IEAP) available on Trust intranets.
5. Contact details / Further information

This document will be reviewed and updated periodically. If you have any comments on the document or any queries, please contact:

<table>
<thead>
<tr>
<th>Dr Eugene Mooney,</th>
<th>Kieran Taggart,</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Information Branch</td>
<td>Community Information Branch</td>
</tr>
<tr>
<td><a href="mailto:eugene.mooney@dhsspsni.gov.uk">eugene.mooney@dhsspsni.gov.uk</a></td>
<td><a href="mailto:kieran.taggart@dhsspsni.gov.uk">kieran.taggart@dhsspsni.gov.uk</a></td>
</tr>
</tbody>
</table>
### Appendix 1

**Roles of the six AHP Professions**

<table>
<thead>
<tr>
<th>Profession</th>
<th>Main function</th>
<th>Patient/client groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dietitians</td>
<td>Translate the science of nutrition into practical information about food. They work with people to promote nutritional wellbeing, prevent food related problems and treat disease.</td>
<td>All age groups with special dietary requirements or those needing advice and education on nutrition</td>
</tr>
<tr>
<td>Occupational Therapists</td>
<td>Assess, rehabilitate and treat people using purposeful activity and occupation to prevent disability and promote health and independent function.</td>
<td>All age groups where physical or mental functioning impact on everyday life, especially health and independent function</td>
</tr>
<tr>
<td>Orthoptists</td>
<td>Assess, diagnose and treat eye movement disorders and defects of visual function and binocular vision.</td>
<td>All age groups but mainly children and older adults</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>Assess, diagnose and treat people with physical problems caused by accident, ageing, disease or disability, using physical approaches to maximise the patients recovery and alleviate pain</td>
<td>All age groups, especially those with neuromuscular, musculoskeletal, cardiovascular or respiratory problems</td>
</tr>
<tr>
<td>Podiatrists</td>
<td>Assess, diagnose and treat abnormalities of the foot. They give professional advice on prevention of foot problems and on proper care of the foot.</td>
<td>All age groups, mainly older adults and those with chronic disease e.g. vascular or diabetes.</td>
</tr>
<tr>
<td>Speech and Language Therapists</td>
<td>Assess, diagnose and treat people with communication and/or swallowing difficulties.</td>
<td>All age groups, especially children and those with neurological or cancer related problems.</td>
</tr>
</tbody>
</table>
Appendix 2

Frequently Asked Questions (FAQ’s)

It is expected that this FAQ document will be revised and re-issued in the light of presenting questions and is intended to support the Data Definitions and Guidance Document.

Do self-referrals start the clock?
Yes, the receipt of all referrals starts the waiting time clock.

Are inappropriate referrals counted for monitoring?
Inappropriate referrals will not be counted for monitoring.

What about referrals to special schools?
Accepted referrals to Allied Health Professionals working in special schools are counted for monitoring.

Do we treat referrals to special schools as new patients?
Only children / young people not currently on a waiting list or being treated by the Trust AHP service should be counted as new patients.

Does the receipt of a new list of children / young people attending special school start the clock?
Obtaining a list of children / young people who will be attending the school in the incoming year does not start the waiting time clock. The clock starts only when the needs of the child / young person have been identified and they have been referred for treatment by the appropriate AHP.

Do we only include Multi-Disciplinary Teams which are AHP led?
Include all referrals to multi-disciplinary teams where there is an identified / assessed need for the provision of an AHP service(s), regardless of the professional leading the team. For further details see page 15.
**What happens with an incomplete referral?**

Where a decision cannot be made whether or not to treat because of the lack of information, reasonable steps should be taken to elicit the missing information from the referrer in the first instance.

If this is not possible the referral should be returned to the referrer and the waiting time clock would stop.

**Do we include Consultant led clinics for monitoring?**

AHP’s supporting a consultant led clinic will not be counted in monitoring of AHP targets as the wait will already be counted as part of the consultant led waiting time. However, those referred from a Consultant to an AHP should be treated as a new referral and counted for monitoring of AHP targets accordingly.

**When does the clock stop?**

The clock stops when the first definitive treatment has commenced or when a decision is made that treatment is not required.

**How do we deal with patients / clients for whom it is clinically inappropriate to have their first definitive treatment within the maximum waiting time?**

Patients / clients who are clinically unfit should have their waiting time clock stopped and the referral returned to the originating referrer. The patient / client should be re-referred when they become clinically fit for treatment. *For further details see page 20.*