Waiting Times FAQ

When do we have to send data to the DAT?

Data should be sent to the DAT no later than the 14th of the following month. For example: April's data should be sent to the DAT by the 14th of May.

How often will we have to update the spreadsheet?

It is really up to you whether you update the spreadsheet on a daily, weekly or monthly basis as long as all contacts made during the month are added before the deadline for sending to the DAT. I would advise that you don't leave data entry to the last minute, as it may be difficult to locate the necessary information if the contact happened 6 weeks ago.

Do we only send new clients and updates to the DAT?

No. The whole spreadsheet (including previous months data) is sent to the DAT on a monthly basis. This is to simplify the process for the service. DATs have been issued with an Access database to enable them to process the data. The system will compare this month's data with the previous months and automatically update fields as necessary.

What do we do if the DAT sends us an error report?

The DAT system will check the data you send for basic errors such as invalid dates or out of sequence appointments and, if it finds any error, will generate an error report that the DAT will forward to you for correction. The report will contain the client id and information about which field contains the error and what type of error it is. You should correct all the errors listed in the report and then send the DAT an updated copy of the entire spreadsheet.

What if we can't find the errors?

In the first instance double-check that the report is for your service (The name of the extract you sent to the DAT should appear at the top – for clarity I recommend that you use your service name followed by the date when you save the spreadsheet to send). If the error has a row reference rather than a client id ask the DAT to check that row on their csv file and provide you with the client id.

If you have the correct report but you can't find the client id referred to in the error report it is possible that someone has changed the client id on your spreadsheet since the data was sent to the DAT. In this situation you may have to search though the data you originally sent to find the correct client record. You will then have to find the matching record on your 'live' spreadsheet, correct the error and restore the original client id. This is not easy to do and is the main reason we ask

you not to change any of the client identifying data (service id and client id) once the information has been sent to the DAT

What if a client uses our service and someone else's at the same time?

It is important to note that you only collect information on the treatments / interventions that your service provides for the client. If a client is receiving treatment at another service their details will appear on that services spreadsheet as well. For example: if you provide a counselling program for a client but they receive substitute prescribing from a different service you would enter details of how long they waited for counselling at your service and the other service would enter details of how long they waited for substitute prescribing.

What if we offer an appointment and the client can't make it?

For both assessment and treatment / intervention you should record the first appointment date offered to the client. This is a true reflection of how long an individual would have to wait to be seen by your service. If you recorded the date the client actually attended the service then your waiting time would be inflated due to non-attendance.

What if we want to offer an appointment but can't contact the client?

For this client you would log their client id and referral date on the system. If you cannot contact them to give them an appointment date (and as a consequence they are dropped from your waiting list) you would then discharge them as 'unplanned' using the date that the decision was made that they were uncontactable.

What about alcohol clients?

If your DAT has decided to collect waiting times for alcohol clients or your service would like this information then it is possible to collect this data using the framework. However, as alcohol clients are not included in the Scottish Government reports they need to be distinguished from the drug clients. The simplest way of doing this is to add an 'A' to the to the service id for all clients with a *primary referral* of alcohol. For Example:

Service ID	Client ID	Date referral received/ first contact
Service B – A	X106	06/08/2003
Service B	X107	11/07/2003
Service B	X108	06/08/2003

We need to link all visits by one client together – so we have a client history. How can we do this if we have to record each client with a unique id?

If you want to link –up all records for your clients or your existing client id is not unique the simplest way of doing this is to add the referral date to the client id. Alternatively you can add '-1', '-2' etc to the client ID to make it unique.
For example:

Service ID	Client ID	Date referral received/ first contact	First appointment date offered for assessment
Service B	X101-210703	21/07/2003	
Service B	X102-060803	06/08/2003	
Service B	X105-060803	06/08/2003	
Service B	X101-060803	06/08/2003	
Service B	X107-110703	11/07/2003	
Service B	X108-060803	06/08/2003	
Service B	X107-070803	07/08/2003	

Service ID	Client ID	Date referral received/ first contact	First appointment date offered for assessment
Service B	X101- 1	21/07/2003	
Service B	X102	06/08/2003	
Service B	X105	06/08/2003	
Service B	X101- 2	06/08/2003	
Service B	X107- 1	11/07/2003	
Service B	X108	06/08/2003	
Service B	X107- 2	07/08/2003	

However, please note that the client ID should not contain apostrophes as these interfere with data processing at the Drug Action Team.

What about the clients already waiting?

You only need to enter data for clients referred after the 1st of April 2004. Clients currently waiting will not be added to the spreadsheet.

How do we decide a discharge date?

The discharge / referral on date is the date that the service or key-worker decides that a client is no longer on their books / receiving treatment either because they have completed treatment (planned), been referred to another service (planned) or have missed several appointments (unplanned). It is down the individual

services to decide how many appointments a client can miss before they are discharged and must be re-referred.

What's this second treatment about?

The second treatment section of the spreadsheet need only be filled in if the client requires more than one treatment intervention.
Treatments can occur in sequence, where a client must complete the first intervention before they can move on to the second. For example: the client must complete methadone tolerance testing (1) before they can begin a prescribed drug program (2). In this case the 'date client ready for treatment' would be the day their first intervention, tolerance testing, was completed and would be added to the spreadsheet as follows:

Date care plan is agreed/decision on treatment is made	Treatment required	First appointment date offered	Date client ready for treatment	Treatment required	First appointment date offered
11/07/2003	1	22/07/2003	25/07/2003	2	30/07/2003

Treatments can occur in parallel, where the client is ready to start both interventions on the same day. In this case the 'date client ready for treatment' would be the same as the 'date care plan is agreed / decision on treatment is made'. The first appointment dates offered for treatments one and two do not have to be the same date – just because someone is ready to start two treatments doesn't mean they will get appointments for them both on the same day. The examples below show a client who is ready for both a prescribed drug treatment program (2) and a group-work program (3) on the same day. In the first record he is able to start both his group-work and his prescribed drug treatment on the same day. In the second, he receives an early appointment for his group-work but has a longer wait for his prescribed drug treatment.

Date care plan is agreed/decision on treatment is made	Treatment required	First appointment date offered	Date client ready for treatment	Treatment required	First appointment date offered
11/07/2003	3	22/07/2003	11/07/2003	2	22/07/2003
11/07/2003	3	22/07/2003	11/07/2003	2	30/08/2003

When should treatment required codes be entered?

The treatment required codes should be entered as soon as the 'date care plan agreed/decision on treatment is made' or 'date client ready for treatment' fields are complete. The first appointment date offered should then be added once it has been assigned.

For example, while a client is waiting for their first intervention the spreadsheet will look like this:

Date care plan is agreed/decision on treatment is made	Treatment required	First appointment date offered	Date client ready for treatment	Treatment required	First appointment date offered
11/07/2003	1				

While they are waiting for their second intervention it will look like this:

Date care plan is agreed/decision on treatment is made	Treatment required	First appointment date offered	Date client ready for treatment	Treatment required	First appointment date offered
11/07/2003	1	22/07/2003	25/07/2003	2	

If they are waiting for two interventions simultaneously it will look like this:

Date care plan is agreed/decision on treatment is made	Treatment required	First appointment date offered	Date client ready for treatment	Treatment required	First appointment date offered
11/07/2003	2		11/07/2003	3	

Can a client receive two blocks of treatment with the same code?

When developing the system we decided to keep things as simple as possible and only record the broad treatment categories rather than each specific intervention. As such, if a client receives two interventions from a single treatment category, for example: groupwork and employability training from the community support / rehabilitation category (3), we would record this as one continuous burst of treatment rather than two distinct interventions.

What is ‘Structured preparatory and motivational intervention’?

This is a planned intervention that stabilises the client or prepares them for further interventions. For example: this could be methadone tolerance testing prior to substitute prescribing, harm reduction work or a brief counselling intervention intended to stabilise a client prior to further treatment. It is important to note that these interventions must be structured and have agreed goals. Adhoc information and advice should not be recorded.

Which code should I record counselling under?

Counselling can be recorded as either 'structured preparatory and motivational intervention' or 'community support / rehabilitation'.
If the counselling offered to the client is a short-term intervention where the aim is to stabilise the client and/or prepare them for further treatment interventions then it should be recorded as 'structured preparatory and motivational interventions'.
If the counselling offered to the client is a longer-term intervention (ie: a course of six weekly sessions) then it should be recorded as 'community support / rehabilitation'.
In both cases the interventions should be structured and have agreed goals.

What counts as 'prescribed drug treatment'?

Prescribed drug treatment includes any drug used in the treatment of drug addiction, i.e. substitute prescribing, drugs to treat withdrawal symptoms, anti-depressants and anti-psychotics. The prescribing of drugs used to alleviate the medical effects of drug misuse, e.g. TB, abscesses, Hep C etc should not be recorded as prescribed drug treatment.

What about people who are clients, but are not substance misusers?

Data should only be recorded for drug (or alcohol) using clients who are receiving structured interventions. Adhoc advice and information, drop-in group sessions and family support work should not be included.
If a client attends a drop-in session and is then offered further interventions at your service (eg: a program of weekly group work sessions) then their data should be recorded.

Which discharge code should I use?

Planned (1) – used for clients who successfully complete their treatment intervention or have been referral on to another service for further treatment.
Unplanned (2) – used for clients where the treatment intervention has been cut short due to circumstances out with the control of the service, e.g. non-attendance of scheduled appointments or death.
Disciplinary (3) – used for clients where the treatment intervention has been cut short due to problematic behaviour, e.g. verbal or physical abuse of staff or other clients.

What will happen with this data?

Data will be sent to the DAT on a monthly basis and will be loaded into a data processing system that validates the information and produces standard reports for the DAT. The DAT is able to produce a number of reports in different formats including waiting times for assessment and the different treatment types. They will also be able to monitor discharges from services and the length of time

clients are engaged with a service. These reports will be used to highlight bottlenecks in the local treatment process and identify areas where initiatives could be put into place to improve the situation for both clients and services.
On a quarterly basis the DAT will send a summary report to ISD who will collate all these summaries into a Scotland report. The Scottish Government will therefore only receive aggregate data and will not be able to identify problems occurring at a particular service. The emphasis is on the DATs to monitor and act on this information at a local level.

What is a csv file? How do I produce one?

A csv file is a basic text file that can be produced easily from most windows based applications where the data items are separated by commas. This is how to produce a csv file from the data collection spreadsheet:

- Select and delete the first two lines of the spreadsheet (ie: the column headings)
- Click: File => Save As
- Select CSV (Comma Delimited) from the drop down list
- Name the file something appropriate eg: Service B – March04
- Save the file the specified input area.

How do I record the fact that I see clients from different DAT areas?

The simplest way of recording this is to add an identifier to the end of the service id. For example TDPS in Tayside, who see clients from Perth and Kinross, Dundee City and Angus DAT areas, could record their clients as follows:

Service ID	Client ID	Date referral received/ first contact
TDPS–PK	X101	
TDPS–PK	X102	
TDPS-DC	X105	
TDPS-AG	X106	
TDPS-DC	X107	
TDPS-DC	X108	
TDPS-PK	X109	
TDPS-DC	X110	
TDPS-AG	X111	

We're a residential service, should we collect data from all our clients or just the ones referred through NHS service?

You are required to collect data from all your clients. However, if you wish to distinguish between NHS and private clients you can add 'N' or 'P' to the service id as follows:

Service ID	Client ID	Date referral received/ first contact
N-Service B	X101	21/07/2003
N-Service B	X102	06/08/2003
P-Service B	X105	06/08/2003
N-Service B	X106	06/08/2003

Can I use the spreadsheet to collect additional data items?

This is fine, however additional columns (new data items) must be added to the end of the spreadsheet (column 'm' onwards) or the built-in validation will be disabled. If you do add additional columns to the spreadsheet, please inform your DAT so that they can take account of this when processing the data.

A note on naming files before sending them to the DAT:

When you are ready to save your spreadsheet and send it to the DAT, please note that the file name should not contain the word 'add' or any full stops. For example the following file names would cause the data to be rejected by Access:

Add Service – Apr07.xls
Service X.Apr07.xls