

National Waiting Times Information Framework

November 2003

Introduction

The following data items, guidance and definitions have been produced to provide a consistent structure for specialist drug agencies and DATs to monitor local waiting times for drug treatment and care.

Any queries regarding the guidance and definitions or the waiting times template should be referred to:

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1. *Who should information be collected on?*

Information should be collected on every **new** problem drugs user who attends the agency.

New

An individual attending the agency for their drug misuse problem:

a) for the first time ever

or

b) who attended the agency previously but was discharged (planned or unplanned).

Problem drug user

Problem drug user refers to any person who experiences social, psychological, physical or legal problems relating to intoxication and/or regular excessive consumption and/or dependence as a consequence of his/her own use of drugs or chemical substances

The information collected about the client should relate to the time that he/she is engaged with the agency and does not relate to interventions that have taken place with a previous agency or with agencies he/she may be referred onto.

2. When should information be recorded?

Waiting times data should be recorded by agencies on an on-going basis. It is essential that the key data items are recorded routinely and that individual client records are kept up to date. It is of particular importance that the discharge/referral-on date is entered as soon as agreement has been reached that the client is no longer attending the service in order to exclude clients not waiting for assessment or treatment from the waiting times statistics.

It is for agencies to develop the most efficient way of recording the data items, in liaison with the local Drug Action Team, and in line with local information development.

3. *What information should be collected?*

3.1 Service ID

- a) the ISD agency code,
- or
- b) the name of the agency.

Note: If the agency returns SMR24 forms to the Scottish Drug Misuse Database, it will have an agency code. This code can be used as the service ID. The agency should ensure that the DAT are aware of the service ID being used and the same service ID should be used thereafter.

3.2 Client ID.

Number, name or code that identifies the client.

Note: If the agency does not use a number or code for client ID then the SMR24 rules for returning client ID details should be used e.g. first initial of first name and first and fourth initial of surname.

3.3 Date referral received /first contact

The date that:

- a) the referral notification is received by the agency,
- or
- b) the date that the client first made contact with an agency as a result of problem drug use, including written, face-to-face and telephone contact.

3.4 First appointment date offered for assessment.

The date of the first appointment offered to a client to identify their needs and aspirations with a view to establishing a clear statement of the type and level of treatment, care and support required.

The data item should relate to the first date the client was offered an appointment for assessment, **not** the date the client actually attended which might be later.

An assessment may take place over a number of appointments, but for the purposes of monitoring waiting times only the date of the first assessment appointment should be recorded.

3.5 Date care plan is agreed/decision on treatment is made

The date that:

a) A client's care plan is signed off by client and staff

or

b) In the absence of a care plan, the date that agency staff and the client agree the type and level of treatment, care and support to be provided.

In some cases the date that an assessment is started and the date that a care plan is agreed or decision on treatment is made may be the same date. If this is the case the same date should be entered in both fields.

3.6 First treatment – Treatment required

The type of structured care initially required by the client as stated in the care plan or agreed with the client.

One of the following code numbers should be chosen and entered into the treatment required field.

| Code | Treatment Type | Definition* |
|------|-------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1. | Structured preparatory and motivational intervention. | Planned intervention that stabilises the client or prepares them for further interventions. It must be structured and have agreed goal(s). |
| 2. | Prescribed drug treatment (including detoxification, maintenance or reduction programme). | The prescribing of a substitute drug, (e.g. methadone, lofexidine, subutex) for facilitating the complete cessation of the use of illicit drugs, controlling withdrawal symptoms or reducing illicit drug use. |
| 3. | Community based support and/or rehabilitation. | Interventions that have the purpose of tackling the social and psychological problems faced by the client (such as debt / benefit / relationship and family problems, relapse prevention or employability and training issues) e.g. structured day programmes, counselling, group work. Clients may be in receipt of other treatment interventions in parallel with community based support and rehabilitation (e.g. substitute prescribing). |
| 4. | Residential Detoxification and rehabilitation. | Detoxification and/or rehabilitation that involves the client being admitted to a residential facility or hospital. |

**The definitions for code one has been developed from the National Treatment Agency's Making the System Work guidance in consultation with members of the Scottish Executive Waiting Times Working Group.*

Notes: If a number of treatment interventions have been identified as a priority for the client then the one which is **required** to start first should be recorded e.g. in the case of a client who needs to receive prescribed drug treatment but requires tolerance testing for methadone first then code one (structured preparatory or motivational intervention) should be used in the first treatment box while code two (prescribed drug treatment) should be entered in the second treatment required field.

For the purpose of monitoring waiting times **un-structured care should be excluded**. In order to ensure consistent reporting, interventions such as ad-hoc provision of advice and information or harm reduction services should not be considered as 'treatment'. In adopting this definition the intention is not to underestimate the benefit to the client of receiving such interventions but to ensure that all agencies adopt the same approach to monitoring waiting times.

3.7 First treatment - First appointment date offered

The first appointment date offered to a client to initiate the first treatment intervention identified.

The date entered in this field should be the first date the client was offered an appointment **not** the date the client actually attended which may be later.

3.8 Second treatment – Date client ready for treatment

The date that a client is available and prepared for treatment

3.9 Second treatment - treatment required

The second type of structured care required by the client as stated in the care plan or agreed with the client.

See section 3.6 for codes and definitions

3.10 Second treatment - First appointment offered

The first appointment date offered to a client to initiate the second treatment intervention identified.

The date entered in this field should be the first date the client was offered an appointment **not** the date the client actually attended which may be later.

Note: If a service provides only one form of treatment (eg: community rehabilitation) they are not required to enter information in the fields relating to second treatment.

3.11 Date of discharge/referral on

The date that:

a) the case is closed,

or

b) the date that agency staff agree that the client is no longer on it's books.

or

c) the date that a client is referred to another agency

3.12 Discharge Code

The type of discharge.

One of the following codes should be chosen:

| Code | Definition |
|--------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Planned | The client has been referred onto another agency or discharged at the end of their treatment with the agreement of the client and the agency. |
| Unplanned | The client was referred and did not attend a number of assessment or treatment appointments. In this case the discharge date should be entered as soon as agency staff agree that the client is no longer on its books or would be viewed as a new client if they re-presented at the agency. |
| Disciplinary | The client has been discharged due to misconduct. |