

July 2013

**UPDATED GUIDANCE FOR
ALCOHOL & DRUG PARTNERSHIPS (ADPs)
ON
PLANNING & REPORTING ARRANGEMENTS
2013-15**



1. Introduction

Alcohol & Drug Partnerships (ADPs) are responsible for developing local strategies to deliver improved core and local outcomes on the basis of local need, and for making investment decisions to achieve these. They also have a key role in delivering the national policy initiatives, the *Alcohol Framework* and *The Road to Recovery*.

The Scottish Government's 2012-13 and 2013-14 allocation letters for earmarked alcohol and drug funding identified nationally agreed core outcomes which all ADPs are expected to deliver against. These allocation letters indicated that ADPs should develop plans setting out how they will use the funding available to them (from both earmarked and additional resources) to deliver both improved core outcomes and local outcomes. Strengthening joint accountability for planning and delivering shared outcomes is essential to improving local delivery of alcohol and drug prevention, treatment and support services which support person-centred recovery.

The 2013-14 alcohol and drug funding letters indicated the Scottish Government would write to ADPs on the development of a quality improvement framework for alcohol and drug services. This was issued to ADPs on 3 July 2013 and includes information on integrated commissioning, local improvement goals & measures, national support and the potential to integrate and rationalise the functions of the existing Scottish Drugs Misuse Database (SDMD) and Drug and Alcohol Treatment Waiting Times Database (DATWTD) while including new data on alcohol treatment and recovery outcomes, as proposed in the draft Drug & Alcohol Information System (DAISy) dataset.

This ADP Planning and Reporting Guidance aims to support the embedding of outcomes based planning and reporting at local level, helping ADPs to self-assess their performance (including benchmarking against other ADPs) and to articulate their contribution to their local SOA, as well as contributing to a national picture of our overall progress in supporting alcohol and drug prevention, support and treatment. Improved information flows and visibility of ADPs will also help inform national strategies and decision-making by Scottish Government and CoSLA.

Scottish Government is grateful to members of the Short-Life Working Group on ADP Governance & Accountability for their work in developing and refining this guidance and to ADPs themselves for their feedback on the draft guidance and to the Short-Life Working Group which has helped to shape this revised documentation.

The **key principles** on which this guidance is based are to:

- strengthen local partnership working & joint accountability;
- reinforce outcomes based approaches;
- support ADPs to improve accountability to their CPP and demonstrate their contribution to their local SOAs by building on good practice;
- provide local flexibility but within a national framework to enable benchmarking;
- help build the national picture of delivery;
- minimise additional reporting requirements on ADPs.

The very nature of the outcomes which ADPs are seeking to deliver requires cross-cutting partnership working. The national outcomes and indicators for ADPs have therefore been developed to take account of, and be consistent with, other relevant

national outcomes and indicators frameworks such as the National Performance Framework, the Quality Strategy, children affected by parental substance misuse (CAPSM), early years and community safety. The Scottish Government Drug & Alcohol Teams will continue to keep these under review as these frameworks develop.

It is recognised that the extensive reform of the public sector is likely to have implications for the operation of ADPs - including the review of Community Planning Partnerships and Single Outcome Agreements, the integration of health and social care, the review of Criminal Justice Authorities and the creation of single forces for the Police and Fire services. For example, some local areas may choose to include alcohol and drugs within the remit of their Health and Social Care Partnership which would impact on ADP governance and accountability arrangements.

The Drug and Alcohol Teams agreed to keep these developments under review and consider any implications as part of continuous monitoring and review of these arrangements. We will keep colleagues informed of developments via the Drug and Alcohol e-Bulletin.

The Guidance to Community Planning Partnerships – Single Outcome Agreements¹ was issued December 2012. This guidance advises Community Planning Partnerships (CPPs) on the scope and content of new Single Outcome Agreements (SOAs) and on the timetable for agreement of these with the Scottish Government.

This guidance advises that new SOAs should continue to be developed and delivered within the context of the National Performance Framework. However, the National Community Planning Group has agreed that all CPPs should have a common and sharp focus on some key priorities where the aim should be to achieve transformational, not incremental, performance improvement. These key priorities are:

- Economic recovery and growth;
- Employment;
- Early years;
- Safer and stronger communities, and reducing offending;
- Health inequalities and physical activity; and
- Outcomes for older people.

2. Resource and Investment

One of the aims of this guidance is to reinforce the key role of ADPs in directing how earmarked and additional resources are utilised locally.

Scottish Government provides earmarked funding to ADPs to help them deliver against agreed outcomes. While this funding is routed for administrative purposes

¹ www.scotland.gov.uk/Resource/0040/00409273.doc

via NHS Boards, it is a partnership resource and, as such, investment decisions should be made on a partnership basis.

It is also expected that this resource will be supplemented by investment from partners' core funding and that the Partnership will be responsible for determining how all the available resource is invested. ADP Plans and Reports (2012) demonstrated that additional investment across Scotland was provided from partners' core budgets to support alcohol and drugs interventions. Some ADPs also shared that resources in kind were often provided to supplement the SG funding. ADPs should seek to identify investment from both earmarked and core funds as part of their plans and reports.

The nature of problem alcohol and drug use means that the total resources used within localities are often greater than those provided to ADPs via the specific allocations from Scottish Government. ADPs should therefore over time aim to map out the total resource utilised in preventing, treating or dealing with the consequences of problem drug and alcohol use in their locality and seek to reflect this in their future delivery plans and annual reports. This mapping should seek to go beyond direct expenditure by the ADP to identify, where possible, the cost of problem drug and alcohol use in respect of, for example, criminal justice services, hospital admissions, sexual health and BBV interventions, and child protection services. This mapping will provide a fuller picture of the full costs of problem drug and alcohol use for local partners and will help inform long term strategic planning and service redesign to support early intervention and prevention.

Partners are jointly accountable for delivery of the ADP outcomes within this financial framework.

3. Guidance on Planning & Reporting and Core Indicators

The attached updated **Guidance on ADP Planning & Reporting Arrangements for 2013-2015** outlines what each ADP should include a) in their ADP Delivery Plan, and b) in their ADP Annual Report on progress against that Plan.

As requested by ADPs a standard reporting template has been developed for Reporting in September 2013. Use of this template is not mandatory, it is intended to act as a tool to support your local processes. ADPs can continue to adopt their own formats which can also meet local planning and reporting requirements and therefore reduce the need for separate and additional documentation.

ADPs are asked to self-assess against their 3 year delivery plans. Honest self-assessment is a crucial. This will help determine national support for 2013-14.

The ADP Planning and Reporting short life working group and Scottish Government is grateful to ADPs involved in developing and shaping the standard reporting template.

The standard reporting template takes account of the evolving delivery landscape and includes opportunities to align with:

- alcohol & drug quality improvement framework
- review of Community Planning and new SOAs
- health & social care integration

There is no requirement for ADPs utilising the standard reporting template to share supporting documents other than the 3 areas requested which are:

- Needs assessment on New Psychoactive Substances (if available) or information on work carried out locally in response to NPS.
- ADP Commissioning Plan or strategy (if available)
- Outcomes for all individuals within your alcohol and drug treatment system for 2012/13 (if available).

It is anticipated that CPPs will be able to draw from the ADP Delivery Plan and Annual Report to populate their SOA submission.

As under previous Spending Reviews, Scottish Government has confirmed funding allocations for 2013/14 and provided indicative allocations for the final year in the current spending review period (2014/15), to facilitate local planning. We recognise that ADP Planning is on a three yearly rolling programme. ADPs are therefore asked to provide a summary page when submitting Annual Reports, which identifies priorities including key milestones planned for the next 12 months. This is included in the standard reporting template. **Annex C2** sets out the reporting schedule for both delivery plans and annual reports.

In response to feedback on timescales we have moved the date by which ADPs should share their Annual Report. The next Annual Report – which will cover the period April 2012 to March 2013 – should be shared with Scottish Government by 16 September 2013.

As ADP accountability is via CPPs (and for HEAT targets/standards via Health Boards), rather than directly to Scottish Government. The Scottish Government will offer light feedback to individual ADPs on 2012-13 Annual Reports.

The role of Scottish Government is to ensure that the contents meet the requirements set out in this Guidance and where it does not, agree with ADPs how this might be achieved. Scottish Government will also seek to disseminate good practice identified from the Plans and Reports through a range of methods, including the Alcohol and Drugs e-bulletin and facilitated events.

National Support

We would encourage ADPs to use the national support available to them as well as utilising local expertise.

A team of specialist ADP Delivery Advisors are in post to support capacity building and sharing of learning and good practice amongst ADPs. The team is in post until late 2014 with the aim of supporting ADPs around agreed priority areas including:

- improving skills to use data for evidencing progress against core outcomes
- delivering recovery-oriented systems of care through system redesign (including the transition from prison back to community and the importance of ensuring effective pathways are in place to support through-care arrangements)
- implementing a whole population approach to addressing problem alcohol use

- strengthen the Scottish Government's engagement with the social work/care sector in relation to drug and alcohol policy objectives and drug and alcohol workforce development.

Scottish Government officials have been working with NHS Health Scotland and national drug and alcohol support organisations to develop a more cohesive approach to national support for ADPs. The National Drug and Alcohol Agencies (NADA) Network has been established to foster collaboration and plan jointly to effectively respond to national policy and strategy on alcohol and drugs and appropriately respond to the needs of ADPs.

In addition to seeking support from national agencies, ADPs are encouraged to exploit opportunities to access local expertise and resources, for example, in analysing and interpreting data and in building workforce capacity. Utilising wider networking partnerships, for example via the Joint Improvement Team's supported activities, could provide valuable peer support to ADPs.

Information Services Division

Information Services Division (ISD) has a specific role in supporting ADPs, particularly in relation to reporting on core indicators and in benchmarking. For the Annual Report, due 16 September 2013, ISD have provided data on the core indicators in a spreadsheet to each ADP in May 2013.

Detailed Guidance

Annex A sets out the **2012-15 Planning and Reporting Arrangements** which we expect ADPs to follow.

Annex B provides a **schematic** of how the Planning and Reporting process will work in practice.

Annexes C (1) & (2) outline the **planning and reporting cycle** and the **reporting schedule**.

Annex D contains the **Core Outcomes**, previously agreed and continuing for 2012/13.

Given the importance of providing evidence of progress towards outcomes, the **Core Indicators** are included at **Annexes E (1) & (2)**. Their development has sought to ensure consistency of approach to outcomes and indicators with the revised National Performance Framework, the Healthcare Quality Strategy and other key policy frameworks such as early years and reducing offending and will keep changes under review. It is recognised that some of the indicators are proxy measures and that some data might not be available annually but these are intended to be both pragmatic and aspirational. Annual reports should set out this data in such a way that makes it clear what data is new and what is repeated from previous years (for example, italicised, bold text or box shading).

A list of possible **Local Indicators** is attached at **Annex F**. It should be noted that these are suggestions only. ADPs may identify others depending on their own local circumstances. Some ADPs are working together to develop joint local indicators (for example, the ADPs within the NHS Greater Glasgow and Clyde Board area). Some

may wish to collaborate on joint data collection surveys. In addition, it may be that some of these local indicators could supplement national data and/or could be developed into national indicators. The latter will be kept under review as part of the continuing assessment of this process.

Annex G details the Draft Recovery Indicators, which formed part of the Information Services (ISD) consultation on Drug & Alcohol Information System (DAISy). This consultation closed 12 July, ISD are currently considering the feedback.

Annexes

- Annex A –Planning and Reporting Arrangements for 2012-2015
- Annex B – Overview of Proposed Planning and Reporting Arrangements for Alcohol and Drug Partnerships
- Annex C – (1) ADP Funding, Planning and Reporting Cycle and (2) ADP Planning and Reporting Schedule
- Annex D – Core Outcomes for Alcohol and Drug Partnerships (ADPs)
- Annex E – (1) Core Indicators and (2) Core Outcomes and Core Indicators
- Annex F – Possible Local Indicators
- Annex G – Draft recovery indicators included in ISD consultation on draft Drug & Alcohol Information System (DAISY) dataset
- Annex H – Standard Reporting Template – which includes some examples of evidence in part 2.
- Annex I – Blank Standard Reporting Template

PLANNING & REPORTING ARRANGEMENTS FOR 2013-2015

These planning and reporting arrangements aim to:

- strengthen local partnership working & joint accountability;
- reinforce outcomes based approaches;
- support ADPs to improve accountability to their CPP and demonstrate their contribution to their local SOAs by building on good practice;
- provide local flexibility but with degree of consistency to enable benchmarking;
- help build the national picture of delivery;
- to minimise additional reporting requirements on ADPs.

This Guidance is split into two sections:

- a) ADP Delivery Plan: The next ADP Delivery Plan is due by **31 March 2015** and should cover the period April 2015 to March 2018;
- b) ADP Annual Report: This should be submitted by **16 September 2013, 15 September 2014 and 14 September 2015**. ADP Annual Reports should contain a summary page which identifies priorities including key milestones ADPs are planning to achieve over the next 12 months (i.e. April 2013 – March 2014). This is included in the standard reporting template

Both your Plan and Report should be agreed by all your ADP partners. It is anticipated that both Plans and Reports will contain a combination of quantitative and qualitative information and are likely to be around 10-20 pages in length. You may have existing plans or reports which you currently produce for your ADP and/or CPP that contain the elements outlined below, and which will cover the required planning or reporting time periods. In that instance, those documents will suffice and there is no need to produce bespoke documents. However, it would be useful if you could share with us (if available) your commissioning strategy, the outcomes for all clients within your system and your needs assessment on new psychoactive substances or information on work carried out locally - even if you do not use the standard reporting template.

A standard reporting template has been developed in consultation with ADPs for 2012-13 ADP Reporting. This template is included at Annex I. *Use of this template is not mandatory, it is intended to act as a tool to support local processes.*

a) ADP Delivery Plan

Your ADP Delivery Plan should reflect the goals of your local ADP Strategy and be agreed by all ADP partners. ADPs are no longer required to share annual updates on ADP Delivery Plans by 31 March 2013 and March 2014. The next ADP Delivery Plan is due by **31 March 2015** and should cover the period April 2015 to March 2018.

The format of your Plan is for your ADP to determine in light of local management and reporting requirements but it should include:

- **ADP Partner Organisations**

Note: Plans should be agreed by all your partner organisations. These would normally include at a minimum: the local NHS Board, local authority, police and the Third Sector. Additional partners may reflect local priorities. The names of the organisations directly engaged in preparing the Plan should be listed.

- **A high-level summary of key changes to be achieved over the duration of the Plan**

Note: This summary should identify a small number of strategic changes which your ADP intends to achieve during the three years of the plan period which will help deliver the Alcohol Framework² and The Road to Recovery³, and how these will contribute to your SOA. These could be outcomes or outputs but will contribute to preventing alcohol and drug harm and/or improving person-centred recovery services and support. The summary should also identify key milestones for the coming year.

- **Core & Local Outcomes to be achieved**

Note: Core Outcomes for 2012/13 are attached at Annex D. These remain the same as the Core Outcomes for 2011/12. Your ADP may have local outcomes in addition to these (including any contained in your Single Outcome Agreement). These should also be outlined in your Plan.

- **Financial Investment (including earmarked Scottish Government funding and partners' core funding)**

Note: Your plan should identify both the designated drug and alcohol funding from Scottish Government which the ADP receives (via their NHS Board) to enable you to deliver your local Plan. Where appropriate, you should also separately identify any other resource (e.g. financial, staffing as well as in kind) which impacts on alcohol and/or drug prevention, treatment and support activities locally – the source of this resource should also be specified.

² Changing Scotland's Relationship with Alcohol: A Framework for Action, March 2009:
<http://scotland.gov.uk/Publications/2009/03/04144703/0>

³ The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem, May 2008:
<http://www.scotland.gov.uk/Publications/2008/05/22161610/0>

- **Priority Actions & Interventions to Improve Outcomes**

Note: This section of your Plan should outline priority actions for investment including the increasing emphasis on preventative spend as well as on ensuring treatment and support services are person-centred and recovery-oriented. The Alcohol Logic Model (and supporting evidence)⁴, the Quality Alcohol Treatment & Support Services report⁵ and the Alcohol & Drugs Workforce Statement⁶ should be helpful in identifying your priorities. You should indicate arrangements for strengthening service user engagement. The distribution of resources between acute or specialist services, support services (typically Tier 1 and 2) and community-based support for Recovery should be clear and transparent. (The Audit Scotland Self-Assessment Checklist will be helpful in this regard, see “Drug & Alcohol Services in Scotland”, pp37-41, Appendix 4, http://www.audit-scotland.gov.uk/docs/health/2009/nr_090326_drugs_alcohol.pdf)

All actions and interventions identified should clearly link to delivery of improved national core and local outcomes.

- **Core & Local Indicators to enable progress to be measured**

*Note: This section should outline how you are monitoring performance and can demonstrate that the investment in alcohol and drugs delivery is making a direct impact in your area. Core indicators, as set out at **Annex E (1) & (2)**, should be included in Delivery Plans and Reports. In addition, your ADP may have local indicators of progress towards core and local outcomes which should also be outlined in your Plan. Examples of possible local indicators are attached at Annex F.*

For all indicators, you should include baseline figures (for the start of the reporting period, or the most up-to-date available figures), as well as your targets for the end of the three year planning period. However, wherever possible, ADPs should present trends as far back as possible to enable more robust assessments of the longer-term direction of travel. This will also help you to consider appropriate targets for the 3 year planning period.

- **Governance & financial accountability arrangements**

Note: Your Plan should briefly outline the local governance arrangements for developing and overseeing delivery of the plan, including how decisions are made on investment of the available financial resources (both earmarked and from partners’ core funding). It should also indicate through what route and with what frequency your ADP reports to your CPP.

⁴ Health Scotland Alcohol Logic Model:

http://www.healthscotland.com/OFHI/alcohol/logicmodels/lm_01.html

⁵ Quality Alcohol Treatment & Support report, March 2011:

<http://www.scotland.gov.uk/Publications/2011/03/21111515/3>

⁶ Supporting the development of Scotland’s Alcohol and Drug Workforce, December 2010:

<http://www.scotland.gov.uk/Publications/2010/12/AandD>

- **Request for National Support**

Note: Scottish Government seeks to support ADPs to deliver high quality person-centred prevention, treatment and support services through the work of the Alcohol and Drugs Delivery Units as well as through our funding of the commissioned organisations (Health Scotland, Information Services Division, Alcohol Focus Scotland, Scottish Training for Drugs and Alcohol (STRADA), Scottish Drugs Recovery Consortium, Scottish Drugs Forum, Scottish Families Against Alcohol and Drugs).

Set out any issues/areas of support required to help deliver your Plan.

b) ADP Annual Report

As with your Delivery Plan, your ADP Annual Report should be agreed by all ADP partners. It should be published by 16 September 2013, 15 September 2014 and 14 September 2015, with a copy forwarded to Scottish Government. For the report prepared for 16 September 2013, this should cover financial year 2012/13. ADP Annual Reports should contain a summary page which identifies Priorities including key milestones ADPs are planning to achieve over the next 12 months (i.e. April 2013 – March 2014). This is included in the standard reporting template

As requested by ADPs a standard reporting template has been developed for Reporting in September 2013. Use of this template is not mandatory, it is intended to act as a tool to support your local processes.

The standard reporting template takes account of the evolving delivery landscape and includes opportunities to align with:

- alcohol & drug quality improvement framework
- review of Community Planning and new SOAs
- health & social care integration

There is no requirement for ADPs to share supporting documents other than the 3 areas requested which are:

- Needs assessment on New Psychoactive Substances (if available) or information on work carried out locally in response to NPS.
- ADP Commissioning Plan or strategy (if available)
- Outcomes for all individuals within your alcohol and drug treatment system for 2012/13 (if available).

ADPs are asked to self-assess against their 3 year delivery plans. Honest self-assessment is a crucial.

ADPs can continue to adopt their own formats which can also meet local planning and reporting requirements and therefore reduce the need for separate and additional documentation.

• General overview

Note: A concise summary of your ADP's key achievements and issues over the previous year, linking back to the priorities identified in your Plan, should be included. This should highlight any significant progress towards core or local outcomes and how these link to your SOA. This section is likely to contain both qualitative and quantitative elements

• Expenditure (including earmarked Scottish Government funding and additional funding sourced from partners and others)

Note: Your Report should identify both the earmarked drug and the earmarked alcohol funding from Scottish Government which the ADP has received (via your local NHS Board) and spent in order to deliver your local plan. It should separately identify any other expenditure/support in kind on drugs and/or alcohol

prevention, treatment or support which each ADP partner has contributed from their core budgets to deliver the Plan. It should also highlight the main actions and activities in which you have invested. You should also highlight any underspend and proposals on future use of any such monies.

- **Actions/activities to achieve targets and deliver improved outcomes**

Note: Highlight the key actions and activities which, as a result of ADP investment and leadership, have contributed to progress towards your core and local outcomes over the previous year. It would be helpful if you could include case studies/learning examples which help demonstrate the impacts of ADPs on people's lives and which other ADPs may find useful for example around service user engagement or CAPSM.

- **Core and Local Indicators**

Note: Your report should include an assessment of performance against the targets you identified for each indicator in your Plan, including the core indicators attached at Annexes E. This should include a combination of narrative and quantitative data. On the core indicators you should, where possible, consider how your ADP performance benchmarks against other ADPs.

- **Governance and financial accountability arrangements**

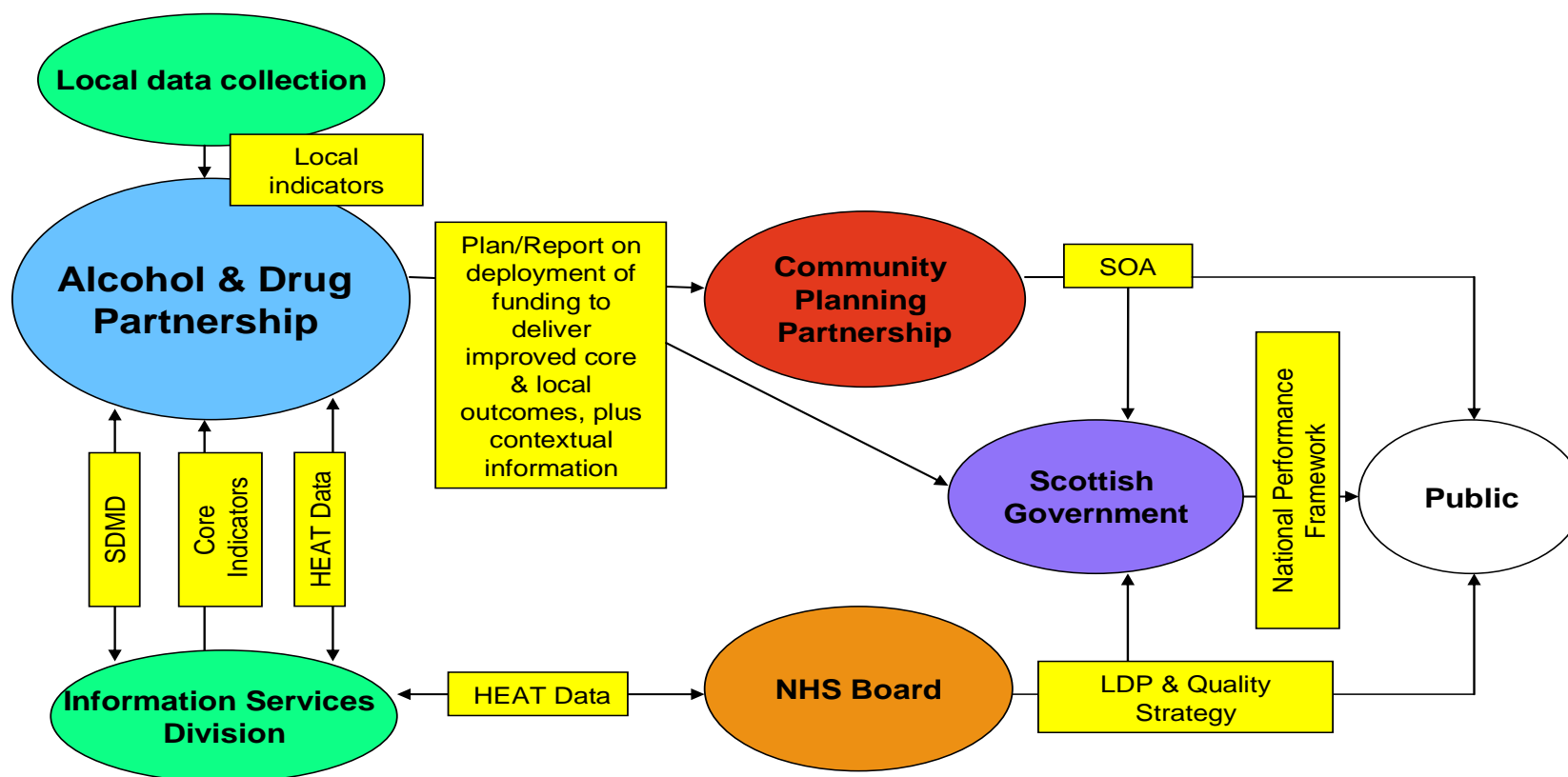
Note: Your report should demonstrate how effectively the partnership is working. It should also outline how decisions on investment of the available funding are made. It should also outline how links with your CPP, in particular reporting arrangements and feedback, have worked in practice.

It would be helpful if you could also include feedback on how these ADP planning and reporting arrangements have operated in practice.

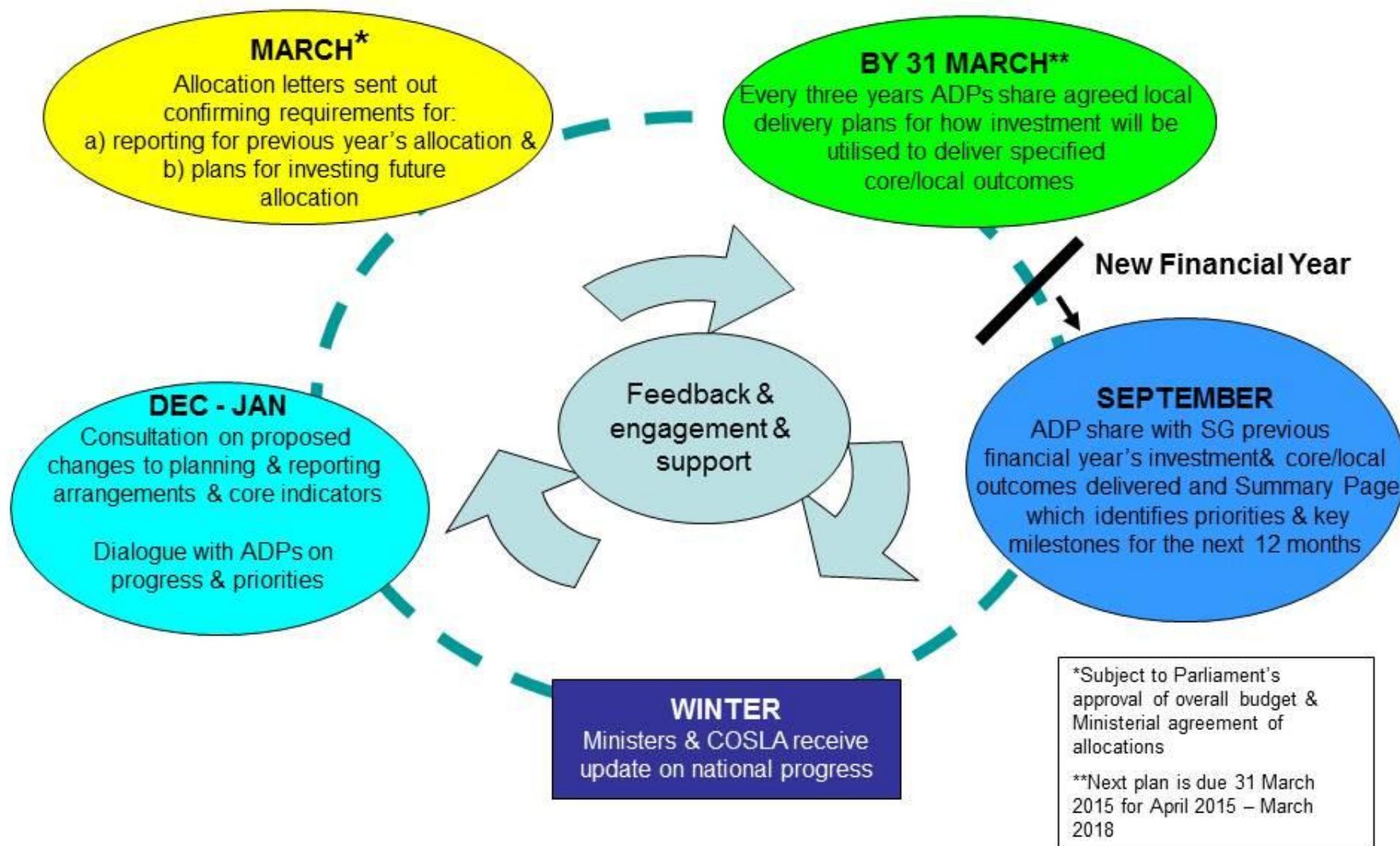
- **National Support**

Note: Your feedback on the National Support provided by Scottish Government and the commissioned organisations (Health Scotland, Information Services Division, Alcohol Focus Scotland, Scottish Training for Drugs and Alcohol (STRADA), Scottish Drugs Recovery Consortium, Scottish Drugs Forum, Scottish Families Against Drugs), over the previous year would be welcome.

OVERVIEW OF PROPOSED PLANNING & REPORTING ARRANGEMENTS FOR ALCOHOL & DRUG PARTNERSHIPS



ADP FUNDING, PLANNING & REPORTING CYCLE



ADP Planning and Reporting Schedule

Period	Deadlines		
	3 year Delivery Plan	Annual Report and Summary Page identifying priorities & key milestones for next 12 months	ISD Indicators & Benchmarking Report
2013/14		16 September 2013 (on 2012/13 activities)	End May 2013
2014/15		15 September 2014 (on 2013/14 activities)	End May 2014
2015/16	31 March 2015	14 September 2015 (on 2014/15 activities)	End May 2015

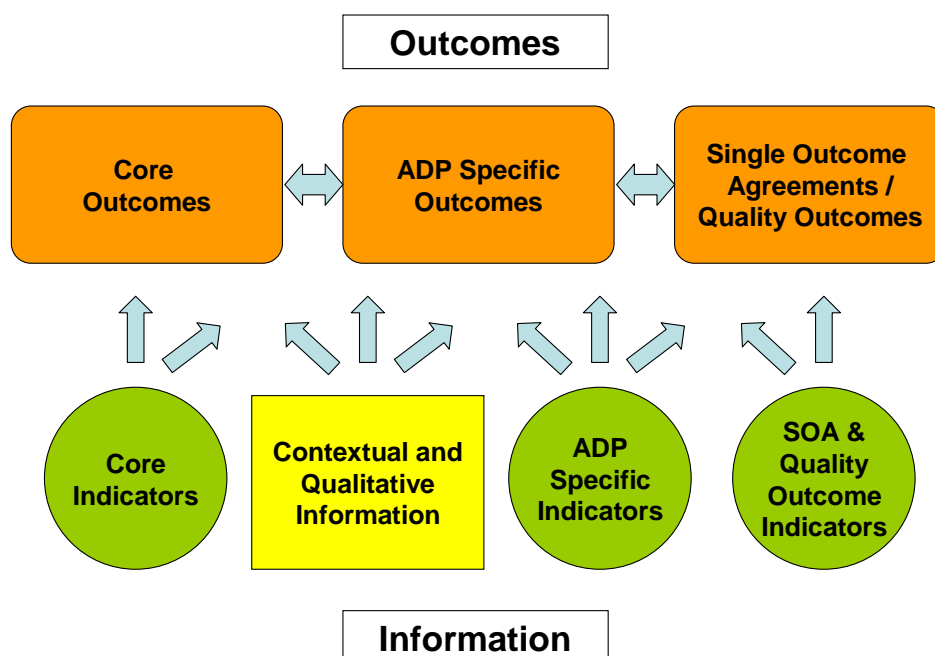
CORE OUTCOMES FOR ALCOHOL & DRUG PARTNERSHIPS (ADPs)

1. **HEALTH: People are healthier and experience fewer risks as a result of alcohol and drug use:** a range of improvements to physical and mental health, as well wider well-being, should be experienced by individuals and communities where harmful drug and alcohol use is being reduced, including fewer acute and long-term risks to physical and mental health, and a reduced risk of drug or alcohol-related mortality.
2. **PREVALENCE: Fewer adults and children are drinking or using drugs at levels or patterns that are damaging to themselves or others:** a reduction in the prevalence of harmful levels of drug and alcohol use as a result of prevention, changing social attitudes, and recovery is a vital intermediate outcome in delivering improved long-term health, social and economic outcomes. Reducing the number of young people misusing alcohol and drugs will also reduce health risks, improve life-chances and may reduce the likelihood of individuals developing problematic use in the future.
3. **RECOVERY: Individuals are improving their health, well-being and life-chances by recovering from problematic drug and alcohol use:** a range of health, psychological, social and economic improvements in well-being should be experienced by individuals who are recovering from problematic drug and alcohol use, including reduced consumption, fewer co-occurring health issues, improved family relationships and parenting skills, stable housing; participation in education and employment, and involvement in social and community activities.
4. **FAMILIES: Children and family members of people misusing alcohol and drugs are safe, well-supported and have improved life-chances:** this will include reducing the risks and impact of drug and alcohol misuse on users' children and other family members; supporting the social, educational and economic potential of children and other family members; and helping family members support the recovery of their parents, children and significant others.
5. **COMMUNITY SAFETY: Communities and individuals are safe from alcohol and drug related offending and anti-social behaviour:** reducing alcohol and drug-related offending, re-offending and anti-social behaviour, including violence, acquisitive crime, drug-dealing and driving while intoxicated, will make a positive contribution in ensuring safer, stronger, happier and more resilient communities.
6. **LOCAL ENVIRONMENT: People live in positive, health-promoting local environments where alcohol and drugs are less readily available:** alcohol and drug misuse is less likely to develop and recovery from problematic use is more likely to be successful in strong, resilient communities where healthy lifestyles and wider well-being are promoted, where there are opportunities to participate in meaningful activities, and where alcohol and drugs are less readily available. Recovery will not be stigmatised, but supported and championed in the community.
7. **SERVICES: Alcohol and drugs prevention, treatment and support services are high quality, continually improving, efficient, evidence-based and responsive, ensuring people move through treatment into sustained recovery:** services should offer timely, sensitive and appropriate support, which meets the needs of different local groups (including those with particular needs according to their age, gender, disability, health, race, ethnicity and sexual orientation) and facilitates their recovery. Services should use local data and evidence to make decisions about service improvement and re-design.

CORE INDICATORS

1. As shown in Figure 1, the core indicators are intended to be one type of a range of information that can help indicate progress towards both the core outcomes and locally specific outcomes. They sit alongside indicators which are specific to individual ADPs and their local needs and priorities, indicators contained in single outcome agreements, and a range of contextual and qualitative information. The latter can add much more depth and meaning (e.g. through case-studies and individuals' recovery stories) and help to explain – or even challenge – the picture shown by quantitative indicators.

Figure 1



2. There are limitations to what can be considered as core indicators. Some good potential indicators may only be collected in a few ADPs, but core indicators need to be available consistently for every ADP. The core indicators will evolve and change over time as new data becomes available. There are some outcomes, such as Community Safety, where, for historical reasons, more core indicators are available. For others - notably Recovery - there is clearly room for further development. The selection of these initial core indicators therefore focuses on what data is currently available, but the clear aspiration is to improve these indicators going forward. We have also sought to ensure consistency of approach to outcomes and indicators with the revised National Performance Framework, the Quality Strategy and other key policy frameworks such as early years and reducing offending and will continue to do so. For these reasons, the core indicators provided here should be seen as a starting point.

3. It is recognised that indicators are just that – they are intended to be indicative of progress towards outcomes, but inevitably provide a partial picture of that progress. All indicators are proxy measures of real outcomes, but some will be more direct than others. In the short-term it may be necessary to use less ideal proxies and even output data to indicate progress towards outcomes. These indicators, while efficient to use, may not always get to the heart of an outcome or an ADP's contribution. Locally specific indicators and contextual and qualitative information will also be vital in interpreting indicators and outcomes and in providing a credible account of the contribution of local partners to observed outcomes (examples of possible local indicators are provided at Annex F).

4. A number of these indicators are only currently available at national or Health Board level and cannot be broken down by ADP. For some indicators, particularly those based on survey data, it is unlikely that samples can be expanded in the current financial climate in order to obtain ADP level data.

5 It will be for ADPs to determine locally for each indicator what direction of travel represents a positive outcome. This may require agreement with local partners. For instance, an increase in the "Number of Child Protection Case Conferences where parental drug and/or alcohol abuse has been identified" may be due to an increase in prevalence in an area and/or an increase in detection rates due to the efforts of local services and professionals. In this case, the ADP will need to discuss and agree both the actions to be taken and the expectations around the impact of these on the indicator with the local Child Protection Committees.

ANNEX E (2): CORE OUTCOMES AND CORE INDICATORS

Outcome	National Indicators	Rationale for indicator	Source and availability
1. HEALTH People are healthier and experience fewer risks as a result of alcohol and drug use A range of improvements to physical and mental health, as well wider well-being, should be experienced by individuals and communities where harmful drug and alcohol use is being reduced, including fewer acute and long-term risks to physical and mental health, and a reduced risk of drug or alcohol-related mortality.	Rate of drug-related hospital discharges (three year rolling average over last 5 years)	Overdoses and other acute drug-related health problems are key risks of drug use. The reduction in health risks due to the prevention of drug use, the recovery of drug users, and the reduction of health risks for those continuing to take drugs, should be reflected in fewer hospital admissions in an area.	Source: ISD Scotland – SMR-01 Frequency: Annual <ul style="list-style-type: none"> • Last: May 2012 • Next: May 2013 Breakdowns available: <ul style="list-style-type: none"> • National <input checked="" type="checkbox"/> • NHS Board <input checked="" type="checkbox"/> • Local Authority <input checked="" type="checkbox"/> • Other: gender, age group, SIMD
	Rate of alcohol-related hospital discharges (three year rolling average over last 5 years)	The reduction in health risks due to the prevention of alcohol misuse and the recovery of people with problematic use should be reflected in fewer hospital admissions in an area.	Source: ISD Scotland – SMR-01 Frequency: Annual <ul style="list-style-type: none"> • Last: May 2012 • Next: May 2013 Breakdowns available: <ul style="list-style-type: none"> • National <input checked="" type="checkbox"/> • NHS Board <input checked="" type="checkbox"/> • Local Authority <input checked="" type="checkbox"/> • Other: gender, age group, SIMD
	Rate of alcohol-related mortality (three year rolling average over last 5 years)	Direct measure of the level of alcohol-related harm in a given area. The reduction in health risks due to the prevention of alcohol misuse and the recovery of people with problematic use should be reflected in fewer alcohol related deaths in an area.	Source: NRS (ISD analysis) Frequency: Annual <ul style="list-style-type: none"> • Last: Aug 2012 (2011 data) • Next: Aug 2013 (2012 data) Breakdowns available: <ul style="list-style-type: none"> • National <input checked="" type="checkbox"/> • NHS Board <input checked="" type="checkbox"/> • Local Authority <input checked="" type="checkbox"/> • Other: gender, age group, SIMD
	Prevalence of hepatitis C among people who inject drugs	A decrease in this indicator will reflect a lower risk from injecting drugs and mean fewer injecting drug users are infected with hepatitis C	Source: HPS Frequency: 2 years <ul style="list-style-type: none"> • Last: 2011

Outcome	National Indicators	Rationale for indicator	Source and availability
			<ul style="list-style-type: none"> • <i>Next: April 2013</i> Breakdowns available: <ul style="list-style-type: none"> • National <input checked="" type="checkbox"/> • NHS Board <input checked="" type="checkbox"/> • Local Authority <input checked="" type="checkbox"/>

Outcome	Indicators	Rationale for indicator	Source and availability
2. PREVALENCE Fewer adults and children are drinking or using drugs at levels or patterns that are damaging to themselves or others A reduction in the prevalence of harmful levels of drug and alcohol use as a result of prevention, changing social attitudes, and recovery is a vital intermediate outcome in delivering improved long-term health, social and economic outcomes. Reducing the number of young people misusing alcohol and drugs will also reduce health risks, improve life-chances and may reduce the likelihood of individuals developing problematic use in the future.	<p>Estimated prevalence of Problem Drug Use Amongst 15-64 year olds in Scotland, by age group.</p> <p>Estimated prevalence of injecting drug use amongst 15-64 year olds in Scotland.</p>	<p>The reduction in the prevalence of problematic drug use as a result of both prevention and recovery should be directly reflected in reduced estimates of adult problem drug use and injecting drug use.</p>	<p>Source: ISD study <i>Estimating the National and Local Prevalence of Problem Drug Misuse in Scotland</i>. Frequency: 3 yrs approx</p> <ul style="list-style-type: none"> • Last: Nov 2011 (2009-10 prevalence) • Next: mid 2014 (2012/13 data, TBC) <p>Breakdowns available:</p> <ul style="list-style-type: none"> • National <input checked="" type="checkbox"/> • NHS Board <input checked="" type="checkbox"/> • Local Authority <input checked="" type="checkbox"/> • Other: Community Justice Authority Area, Police Board
	<p>Percentage of 15 year old pupils who usually take illicit drugs at least once a month (areas with larger prevalence).</p> <p>Percentage of 15 year old pupils who have taken an illicit drug in the last year (areas with lower prevalence).</p>	<p>Reducing the number of young people misusing alcohol and drugs will be reflected in a reduction in both frequent use and any use amongst 15 year old school pupils.</p>	<p>Source: ISD Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) Frequency: 2 years*</p> <ul style="list-style-type: none"> • Last: December 2011 (2010 data) • Next: October 2014 (2013 data) <p>Breakdowns available:</p> <ul style="list-style-type: none"> • National <input checked="" type="checkbox"/> • NHS Board <input checked="" type="checkbox"/> • Local Authority <input checked="" type="checkbox"/> • Other: ADP <p>* Local authority and ADP level data being collected in 2013, a year earlier than originally planned</p>

Outcome	Indicators	Rationale for indicator	Source and availability
	The proportion of individuals drinking above daily and/or weekly recommended limits	<ul style="list-style-type: none"> Drinking above recommended limits is associated with an increased risk of developing a range of health conditions. A reduction in population consumption is a prerequisite to delivering many of the core outcomes. 	Source: Scottish Health Survey Frequency: <ul style="list-style-type: none"> Last: Sept 2012 Next: Sept 2013 Breakdowns available: <ul style="list-style-type: none"> National <input checked="" type="checkbox"/> NHS Board <input checked="" type="checkbox"/> Local Authority <input type="checkbox"/> Other: Gender, age, SIMD <p>* Health Board level data available for all Boards every 4 years; every 2 years for larger Boards.</p>
	The proportion of individuals drinking above twice daily ("binge" drinking) recommended limits	"Binge" drinking is associated with increased risk of acute harm and is linked to a range of anti-social behaviours.	Source: Scottish Health Survey Frequency: <ul style="list-style-type: none"> Last: Sept 2012 Next: Sept 2013 Breakdowns available: <ul style="list-style-type: none"> National <input checked="" type="checkbox"/> NHS Board <input checked="" type="checkbox"/> Local Authority <input type="checkbox"/> Other: Gender, age, SIMD <p>* Health Board level data available for all Boards every 4 years; every 2 years for larger Boards.</p>

Outcome	Indicators	Rationale for indicator	Source and availability
	The proportion of individuals who are alcohol dependent	Reducing the number of individuals who are alcohol dependent will lead to a range of positive individual and societal outcomes	<p>Source: Scottish Health Survey CAGE questionnaire (screening tool used to identify potential alcohol dependence)</p> <p>Frequency:</p> <ul style="list-style-type: none"> • Last: Sept 2012 • Next: Sept 2013 <p>Breakdowns available:</p> <ul style="list-style-type: none"> • National <input checked="" type="checkbox"/> • NHS Board <input checked="" type="checkbox"/> • Local Authority <input type="checkbox"/> • Other: Gender, age, SIMD <p>* Health Board level data available every 4 years (every 2 years for larger Health Boards).</p>
	Proportion of 15 year olds drinking on a weekly basis (and their mean weekly level of consumption)	Drinking in childhood is associated with increased risk of a range of potential harms (as evidenced by SALSUS). There is also some evidence that drinking patterns learnt early in life stay with the individual into later life.	<p>Source: Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS)</p> <p>Frequency: 2 years*</p> <ul style="list-style-type: none"> • Last: December 2011 (2010 data) • Next: October 2014 (2013 data) <p>Breakdowns available:</p> <ul style="list-style-type: none"> • National <input checked="" type="checkbox"/> • NHS Board <input type="checkbox"/> • Local Authority <input checked="" type="checkbox"/> • Other: <p>* Local authority and ADP level data being collected in 2013, a year earlier than originally planned</p>

Outcome	Indicators	Rationale for indicator	Source and availability
3. RECOVERY Individuals are improving their health, well-being and life-chances by recovering from problematic drug and alcohol use A range of health, psychological, social and economic improvements in well-being should be experienced by individuals who are recovering from problematic drug and alcohol use, including reduced consumption, fewer co-occurring health issues, improved family relationships and parenting skills, stable housing; participation in education and employment, and involvement in social and community activities.	Percentage reduction in daily drugs spend during treatment Reduction in the percentage of clients injecting in the last month during treatment Proportion of clients who abstain from illicit drugs between initial assessment and 12 week follow-up	People who are recovering from problematic drug use are likely to show reductions in the level of drug use and, for those who inject, a reduction in injecting. While this indicator is restricted to those in treatment it provides a robust indicator of treatment assisted recovery in an area.	Source: Service submissions to <i>ISD Scottish Drug Misuse Database</i> (SMR-25b) Frequency: Annual • Last: Dec 2012 • Next: Dec 2013 Breakdowns available: • National <input checked="" type="checkbox"/> * • NHS Board <input checked="" type="checkbox"/> * • Local Authority <input checked="" type="checkbox"/> * • Other: * No data available this year due to low levels of data completeness
	Proportion of clients receiving drugs treatment experiencing improvements in employment/ education profile during treatment	People who are recovering from problematic drug use are likely to show improvements in their wider well-being, including their social profile. While this indicator is restricted to those in treatment it provides a robust indication of treatment assisted recovery in an area.	Source: Service submissions to <i>ISD Scottish Drug Misuse Database</i> (SMR-25b) Frequency: Annual • Last: - Dec 2012 • Next: Dec 2013 Breakdowns available: • National <input checked="" type="checkbox"/> * • NHS Board <input checked="" type="checkbox"/> * • Local Authority <input checked="" type="checkbox"/> * * See above

Outcome	Indicators	Rationale for indicator	Source and availability
4. CAPSM/FAMILIES Children and family members of people misusing alcohol and drugs are safe, well-supported and have improved life-chances This will include reducing the risks and impact of drugs misuse on users' children and other family members; supporting the social, educational and economic potential of children and other family members; and helping family members support the recovery of their parents, children and significant others.	Rate of maternities recording drug use (three year rolling average)	A reduction in the number of maternities recording drug use means that fewer children are likely to be born into households where the mother is a drug user which, in turn, makes it less likely they will be affected by parental substance misuse.	Source: ISD, SMR-02 Frequency: <ul style="list-style-type: none"> • <i>Last:</i> April 2012 (data for 2004/05-2006/07 to 2007/08-2009/10) • <i>Next:</i> April 2013 (data for 2010/11, 2011/12, 2012/13) Breakdowns available: <ul style="list-style-type: none"> • National <input checked="" type="checkbox"/> • NHS Board <input type="checkbox"/> • Local Authority <input checked="" type="checkbox"/>
	Rate of maternities recording alcohol use (three year rolling average)	A reduction in the number of maternities recording alcohol use means that fewer children are likely to be born into households where the mother misuses alcohol. Heavy alcohol use during pregnancy increases the risk of Foetal Alcohol Spectrum Disorder (FASD).	Source: ISD, SMR-02 Frequency: <ul style="list-style-type: none"> • <i>Last:</i> 2011/12 • <i>Next:</i> April 2013 (data for 2010/11, 2011/12, 2012/13) Breakdowns available: <ul style="list-style-type: none"> • National <input checked="" type="checkbox"/> • NHS Board <input checked="" type="checkbox"/> • Local Authority <input checked="" type="checkbox"/>
	Number of Child Protection Case Conference where parental drug and alcohol abuse has been identified as a concern/risk	To provide an indication of number of children identified by local authorities as at significant risk due to parental drug and alcohol abuse.	Source: Scottish Government Child Protection statistics Frequency: Annual <ul style="list-style-type: none"> • <i>Last:</i> March 2013 (2011/2 data) • <i>Next:</i> March 2014 Breakdowns available: <ul style="list-style-type: none"> • National <input checked="" type="checkbox"/> • NHS Board <input type="checkbox"/> • Local Authority <input checked="" type="checkbox"/>

Outcome	Indicators	Rationale for indicator	Source and availability
	Proportion of positive ABI screenings in ante-natal setting	Highlights the number of pregnant women where problematic drinking has been identified. Possible risks to baby and existing children.	Source: NHS Board Frequency: Annual <ul style="list-style-type: none"> • <i>Last: Local data collection</i> • <i>Next: Local data collection</i> Breakdowns available: <ul style="list-style-type: none"> • National <input type="checkbox"/> • NHS Board <input checked="" type="checkbox"/> • Local Authority <input type="checkbox"/>

Outcome	Indicators	Rationale for indicator	Source and availability
5. COMMUNITY SAFETY Communities and individuals live their lives safe from alcohol and drug related offending and anti-social behaviour Reducing alcohol and drug-related offending, re-offending and anti-social behaviour, including violence, acquisitive crime, drug-dealing and driving while intoxicated, will make a positive contribution in ensuring safer, stronger, happier and more resilient communities.	Percentage of new clients at specialist drug treatment services who report funding their drug use through crime	Communities will be safer where there is less drug-related acquisitive crime and this should be reflected in fewer reports of crime-funded drug use by clients entering drugs treatment	Source: Service submissions to <i>ISD Scottish Drug Misuse Database</i> (SMR-25a) Frequency: Annual <ul style="list-style-type: none"> • Last: March 2013 (2011-12) • Next: March 2014 (2012-13) Breakdowns available: <ul style="list-style-type: none"> • National <input checked="" type="checkbox"/> • NHS Board <input type="checkbox"/> • Local Authority <input checked="" type="checkbox"/>
	One year reconviction frequencies rate (per 100 offenders), for offenders given a Drug Treatment and Testing Order	Communities will be safer where drug-related reoffending is being successfully tackled.	Source: Scottish Government <i>Reconviction Rates in Scotland</i> Frequency: Annual <ul style="list-style-type: none"> • Last: 2012 (2009-10 cohort) • Next: Summer 2013 (2010-11 cohort) Breakdowns available: <ul style="list-style-type: none"> • National <input checked="" type="checkbox"/> • NHS Board <input type="checkbox"/> • Local Authority <input checked="" type="checkbox"/>
	Number of cases of vandalism (or malicious mischief), breach of the peace, assault or anti-social behaviour per 1,000 population	Strong link between alcohol misuse and crime. Individuals, families and communities will benefit for a reduction in offences where alcohol is likely to be a contributory factor.	Source: Police data (Crimefile recording system and the STORM command and control system) Frequency: <ul style="list-style-type: none"> • Last: March 2012 • Next: April 2013 Breakdowns available: <ul style="list-style-type: none"> • National <input checked="" type="checkbox"/> • NHS Board <input type="checkbox"/>

Outcome	Indicators	Rationale for indicator	Source and availability
			<ul style="list-style-type: none"> Local Authority <input checked="" type="checkbox"/> Other: Locus of offence is recorded so potential to identify other geographies. <p>* Data may need to be derived at the local level</p>
	Number of Community Payback Orders issued where alcohol and drug treatment is required, and proportion that are successfully completed	Low level offenders are required to carry out their punishment in the community where they committed the crime. Ensures that offenders receive effective treatment for alcohol and drugs, the community also receives reparation for the offender's crimes. Proportion of Orders completed potentially more of an outcome measure.	<p>Source: Scottish Court Service data Frequency: Annual</p> <ul style="list-style-type: none"> Last: December 2012 Next: December 2013 <p>Breakdowns available:</p> <ul style="list-style-type: none"> National <input checked="" type="checkbox"/> NHS Board <input type="checkbox"/> Local Authority <input checked="" type="checkbox"/>
	Proportion of victims of a crime who reported that the offender was under the influence of alcohol / drugs	Indication of how alcohol and drug related crimes are impacting on communities, and also whether communities are becoming safer.	<p>Source: Scottish Crime and Justice Survey Frequency: Bi annual</p> <ul style="list-style-type: none"> Last: October 2013 Next: October 2014 <p>Breakdowns available:</p> <ul style="list-style-type: none"> National <input checked="" type="checkbox"/> NHS Board <input type="checkbox"/> Local Authority <input checked="" type="checkbox"/>

Outcome	Indicators	Rationale for indicator	Source and availability
6. LOCAL ENVIRONMENT People live in positive, health-promoting local environments where alcohol and drugs are less readily available Alcohol and drug misuse is less likely to develop and recovery from problematic use is more likely to be successful in strong, resilient communities where healthy lifestyles and wider well-being are promoted, where there are opportunities to participate in meaningful activities, and where alcohol and drugs are less readily available. Recovery will not be stigmatised, but supported and championed in the community.	Percentage of young people who have been offered drugs in the last year	Young people are less likely to become involved in drug use when drugs are less readily available and this is likely to be reflected in reductions in the number of school pupils aged 13 and 15 who are offered drugs.	Source: Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) Frequency: 2 years* <ul style="list-style-type: none"> • Last: Dec 2011 (2010 data) • Next: Oct 2014 (2013 data) Breakdowns available: <ul style="list-style-type: none"> • National <input checked="" type="checkbox"/> • NHS Board <input type="checkbox"/> • Local Authority <input checked="" type="checkbox"/> * Local authority and ADP level data being collected in 2013, a year earlier than originally planned
	Percentage of people perceiving drug misuse or dealing to be very or fairly common in their neighbourhood	Communities which are safer as a result of reductions in drug related offending and anti-social behaviour are likely to exhibit fewer signs of drug use and dealing which should be reflected in reductions in both experienced and perceived levels of drug misuse and dealing.	Source: Scottish Household Survey Frequency: Annual <ul style="list-style-type: none"> • Last: Aug 2012 (for years 2009/10 – every LA reported every second year) • Next: Aug 2013 Breakdowns available: <ul style="list-style-type: none"> • National <input checked="" type="checkbox"/> • NHS Board <input checked="" type="checkbox"/> • Local Authority <input checked="" type="checkbox"/> * Larger local authorities each year, and every local authority over a two-year period.

Outcome	Indicators	Rationale for indicator	Source and availability
	Percentage of people spontaneously reporting 'alcohol abuse' as a negative aspect of their neighbourhood	Surveys demonstrate that alcohol is seen as the drug impacting most on Scotland, impacting on too many communities. A positive shift in this indicator is likely to improve individual quality of life and community cohesion.	Source: <i>Scottish Household Survey</i> Frequency: Annual <ul style="list-style-type: none"> • <i>Last:</i> October 2012 • <i>Next:</i> August 2013 Breakdowns available: <ul style="list-style-type: none"> • National <input checked="" type="checkbox"/> • NHS Board <input checked="" type="checkbox"/> • Local Authority <input checked="" type="checkbox"/> <p>* Larger local authorities each year, and every local authority over a two-year period.</p>
	Number of premise and occasional licences in force per annum and the overall capacity of premise licences Number of new applications for premise or occasional licences, and proportion refused on the grounds of overprovision	Strong evidence that reducing the availability of alcohol is a key component of an effective alcohol strategy.	Source: Licensing Boards; routine returns of some data to the Scottish Government Frequency: <ul style="list-style-type: none"> • <i>Last:</i> April 2013/Local data collection • <i>Next:</i> April 2014/Local data collection Breakdowns available: <ul style="list-style-type: none"> • National <input checked="" type="checkbox"/> • NHS Board <input type="checkbox"/> • Local Authority <input checked="" type="checkbox"/> • Other: <p>* Licensing statistics being collected (published April 2013) by the Scottish Government but some data will (e.g. capacity) need to be derived at the local level.</p>

Outcome	Indicators	Rationale for indicator	Source and availability
7. SERVICES Alcohol and drugs prevention, treatment and support services are high quality, continually improving, efficient, evidence-based and responsive, ensuring people move through treatment into sustained recovery Services should offer timely, sensitive and appropriate support, which meets the needs of different local groups (including those with particular needs according to their age, gender, disability, health, race, ethnicity and sexual orientation) and facilitates their recovery. Services should use local data and evidence to make decisions about service improvement and re-design.	The number of screenings (using a validated screening tool) for alcohol use disorders delivered and the percentage screening positive with the breakdown of i) % eligible for ABI and ii) % eligible for referral to treatment services	Identification of those with alcohol use disorders, and potential demand for services. This indicator should be used in conjunction with the indicator below on the delivery of alcohol brief interventions to provide an overall picture of activity.	Source: Health Boards Frequency: Annual <ul style="list-style-type: none"> • Last: Local data collection • Next: Local data collection Breakdowns available: <ul style="list-style-type: none"> • National <input checked="" type="checkbox"/> • NHS Board <input checked="" type="checkbox"/> • Local Authority <input type="checkbox"/>
	The number of alcohol brief interventions delivered in accordance with the HEAT Standard guidance	Strong evidence demonstrating the effectiveness of alcohol brief interventions (ABI) in reducing consumption. Health Boards and partners expected to embed ABI delivery at end of current HEAT target.	Source: Health Boards Frequency: Quarterly (to ISD); published annually (by ISD) <ul style="list-style-type: none"> • Last: June 2012 • Next: June 2013 Breakdowns available: <ul style="list-style-type: none"> • National <input checked="" type="checkbox"/> • NHS Board <input checked="" type="checkbox"/> • Local Authority <input checked="" type="checkbox"/> (ADP delivery to be collected from 2012/13)
	Percentage of clients waiting more than three weeks between referral to a specialist drug and alcohol service and commencement of treatment	Offering person-centred support for recovery from drug and alcohol misuse requires that people are able to access support when they require it. This will be reflected in the reduction in the time people have to wait for this support.	Source: Service submissions to ISD Drug and Alcohol Treatment Waiting Times Database Frequency: Quarterly <ul style="list-style-type: none"> • Last: Mar 2013 (Oct-Dec 2012 data) • Next: June 2013 Jan – Mar 2013 data) Breakdowns available: <ul style="list-style-type: none"> • National <input checked="" type="checkbox"/> • NHS Board <input checked="" type="checkbox"/>

Outcome	Indicators	Rationale for indicator	Source and availability
			<ul style="list-style-type: none"> Local Authority <input checked="" type="checkbox"/> Other: ADP
	Number of treatments drug service clients receive at 3 month and 12 month follow-up (and annually after that)	Highlights the range of services available to client in each ADP at key stages of recovery.	<p>Source: Service submissions to <i>ISD Scottish Drug Misuse Database</i> (SMR-25b)</p> <p>Frequency: Annual</p> <ul style="list-style-type: none"> <i>Last:</i> - Dec 2012 <i>Next:</i> Dec 2013 <p>Breakdowns available:</p> <ul style="list-style-type: none"> National <input checked="" type="checkbox"/>* NHS Board <input checked="" type="checkbox"/>* Local Authority <input checked="" type="checkbox"/>* <p>* No data available this year due to low levels of data completeness</p>

Possible Local Indicators

Local indicators are those which are specific to a particular ADP and their local needs and priorities, and are not at the moment robustly collected at a national level. These local indicators could be supplemented by a range of contextual and qualitative information. They are measures of local practice, particularly in regards to local licensing and policing policy. It would be helpful for ADPs to share any locally-specific indicators that could potentially be worked-up into consistent, nationally-available indicators in the future.

Examples of local indicators include:

Health

- Number of times naloxone has been used by ambulance staff and A&E

Recovery

- See Annex G for draft Recovery Indicators Included in Information Services Division (ISD) Consultation on the proposed Drug & Alcohol Information System (DAISy) Development.

Families

- Number of contacts with Scottish Families Affected By Drugs helpline, and reasons for contact
- Number of cases of domestic violence

Community Safety

- Rates of drink, driving, drunkenness and drinking in a designated place
- Accidental dwelling fires where impairment due to suspected alcohol/drugs use was a contributory factor
- Number of test purchasing visits and the proportion failed

Services

- Proportion of alcohol and drug services with Investors in People Award (or equivalent)
- Proportion of services where an EQIA had been carried out in the last 3 years
- Proportion of services where an assessment for the National Quality Standards for Substance Misuse Services has been carried out in the last 12 months
- Demographic breakdown of users of services (by gender, age, race, disability and sexual orientation)
- Pathways of different drug services client groups (age, gender, health and type of drug use) as they progress through treatment
- Number of naloxone awareness sessions carried out in the last 12 months in ADP area

Draft Recovery Indicators Included in Information Services Division (ISD) Consultation on the proposed Drug & Alcohol Information System (DAISy) Development

ID Number	Draft Indicators	How will this be measured?
RI 1	Engagement in meaningful activities (leisure, volunteering)	Client's rating of involvement in leisure or volunteering (0=poor; 10=Good)
RI 2	Physical health	Client's rating of physical health status (extent of physical symptoms and bothered by illness) (0=poor; 10=good)
RI 3	Psychological/emotional/mental health	Clients rating of psychological health status (anxiety, depression and problem emotions and feelings), 0=poor, 10=good)
RI 4	Social networks	Client's rating of social networks and relationships (e.g. attendance at mutual aid groups, gets on well with friends, actively engaged in the community) (0=poor; 10=good)
RI 5	Overall quality of life	Client's rating of overall quality of life (e.g. able to enjoy life, gets on well with family and partner) (0=poor; 10=good)
RI 6	Level of motivation and taking responsibility for achieving own goals	Clients rating of energy and motivational level to deal with things and take responsibility for achieving own goals (0=poor, 10=good)
RI 7	Self-care and daily living skills	Clients rating of self-care and living skills (copes well with tasks of daily living, does household chores, etc.), 0=poor, 10=good)
RI 8	Confidence in managing money	Clients rating of confidence in managing money (pays bills on time, budgeting skills, obtaining benefits, etc.), 0=poor, 10=good)
RI 9	Parenting capacity (if appropriate)	Client's rating of their ability to meet the emotional and physical needs of their children (children are regularly attending school, receive appropriate medical care, eat regular meals, spend quality time with parents etc.)

STANDARD REPORTING TEMPLATE – WHICH INCLUDES SOME EXAMPLES OF EVIDENCE

Document Details:

ADP Reporting Requirements 2012/13

- 1 Partnership Details**
- 2 Self-Assessment:**
- 3 Finance Framework**
- 4 Core & Local Indicators and key activities 2012/13**
- 5 ADP & Ministerial priorities for 2013/14**

Appendix 1

- Guidance Notes and Commissioning Diagram**
-

1. PARTNERSHIP DETAILS

Alcohol & Drug Partnership:	
ADP Chair	
Contact name(s): See note 1	
Contact telephone	
Email:	
Date of Completion:	
Date published on ADP website(s)	

The content of this template has been agreed as accurate by the Alcohol and Drug Partnership, and has been shared with our Community Planning Partnership:

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ADP Chair

The Scottish Government copy should be sent to:

Amanda Adams, Alcohol Policy & Delivery Team, Amanda.adams@scotland.gsi.gov.uk

2. ADP Self-Assessment 1 April 2012 – 31 March 2013

	Theme	R A G See 1	Evidence (some examples have been provided) See Note 2
ANALYSE			
1	ADP Joint Strategic Needs Assessment has been undertaken and provides a clear, coherent assessment of need. See Note 3 Include your ADP needs assessment on New Psychoactive Substances or information on any work carried out locally in response to NPS – if available		<ul style="list-style-type: none"> • Strategic Alcohol and Drugs Needs Assessment completed to inform strategy and commissioning plans. • Specific population needs assessment for example ARBD, Homelessness, BME, prisoners, Co-morbidity, hidden populations. • Overprovision Analysis supporting licensing Policy has been undertaken. Consultation across partners including the community has taken place.
2	An outcomes based ADP Joint Performance Framework is in place that reflects the ADP National Outcomes. See note 4		<ul style="list-style-type: none"> • ADP performance framework is outlined in the ADP Delivery plan 2012/15. • Clear baseline data, indicators and targets identified within delivery plan.
3	Integrated Resource Framework - Process Suitable data has been used to scope the programme budget and a baseline position has been established regarding activity,		<ul style="list-style-type: none"> • Baseline data was analysed to support resource transfer across partner agencies. • Mapping of health and social care data undertaken to scope activity, costs and variation in service delivery to inform option appraisal and

	Theme	R A G See 1	Evidence (some examples have been provided) See Note 2
	costs and variation. Note 5		service redesign to support ROSC
4	Integrated Resource Framework - Outcomes Note 5 A coherent approach has been applied to selecting and prioritising investment and disinvestment options		<ul style="list-style-type: none"> Completed a review of inpatient care resulting in reallocation of resources to primary care. Alcohol and Drug Service Review identified resource transfer within core budget to support service redesign and ROSC. Option Appraisal completed to identify prioritising investment and disinvestment options.

PLAN

	Theme	R A G	Evidence
5	We have a shared vision and joint strategic objectives		<ul style="list-style-type: none"> ADP Strategy shared vision ADP Strategic objectives
6	Our strategic commissioning work is clearly linked to Community Planning priorities and processes . See note 6 Include your ADP Commissioning plan or Strategy – if available.		<ul style="list-style-type: none"> ADP Commissioning Plan/Delivery Plan identifies contribution to SOA and details governance arrangements and reporting to CPP and CHCP including feedback on performance. Financial regulations require reference to SOA Outcomes.

PLAN

7	Service Users and carers are embedded within the partnership commissioning processes		<ul style="list-style-type: none"> • Process in place to ensure service user and carer involvement across all stages of local planning, design and delivery of services • Service user and carer consultation on service redesign • Service user consultation and evaluation of service provision • Service user and carers within service level agreement and commissioning plan • Participation within ADP and sub group
8	<p>A person centered recovery focus has been incorporated into our approach to strategic commissioning</p> <p>Please include your outcomes for all individuals within your alcohol and & drug treatment system for 2012/13 if available.</p>		<ul style="list-style-type: none"> • Recovery Orientated System of Care Service Review and Redesign. • Strategic Commissioning Plan for Recovery • Identify and commission against key recovery outcomes. • Recovery outcomes reflected in service specifications • Recovery outcome reporting across drug and alcohol services e.g. outcome star, other. • Recovery champions at both system and service level • Individual recovery plan and review • Strong and active relationship with mutual aid and recovery communities • Individuals can access the range of services and spectrum of support services to move on and into sustained recovery
9	All relevant statutory requirements regarding Equality Impact assessments have been addressed during the compilation of our ADP Strategy and Delivery Plan		<ul style="list-style-type: none"> • ADP Strategy and Delivery Plan Equality Impact Assessment • Alcohol and Drugs Services/Service Development/Service Redesign Equality Impact Assessments • Alcohol and Drug Policy Impact Assessments

PLAN

			<ul style="list-style-type: none"> Equality Impact Assessments completed as part of the governance arrangements for commissioned services.
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DELIVER

10	Joint Workforce plans are in place across all levels of service delivery which are based on the needs of your population.		<p>See link to the alcohol and drugs workforce statement http://www.scotland.gov.uk/Publications/2010/12/AandD</p> <ul style="list-style-type: none"> Alcohol and Drugs Workforce Development Needs Assessment Alcohol and Drugs Workforce Development Strategy Alcohol and Drugs Workforce Delivery Plan Workforce development supported by Performance Review Processes, Personal Develop Plans and supervision arrangements Workforce Development identified within service level agreements
11	A transparent performance management framework is in place for all ADP Partner organisations who receive funding through the ADP.		<ul style="list-style-type: none"> ADP funding regulations require outcome performance reporting. Outcomes are reported and monitored though ADP Executive group every six months.

REVIEW

12	ADP Delivery Plan is reviewed on a regular basis.		<p>Delivery plan is reviewed on a regular basis and report submitted to ADP Committee. Reports include:</p> <ul style="list-style-type: none"> ▪ Systematic recording of progress made, ▪ variance against plans ▪ and remedial actions is in place. ▪ Reporting arrangements which demonstrate the impact of services and aggregate data to inform service-level / strategic adjustments are in place.
13	Outcomes focussed contract monitoring arrangements are in place for all commissioned services.		<ul style="list-style-type: none"> • ADP outcome contract monitoring officer/group or other arrangement through CHCP/Council. • Contract monitoring framework
14	A schedule for service monitoring and review is in place.		<ul style="list-style-type: none"> • Quarterly service outcome performance reporting to ADP Commissioning Group.
15	Service Users and their families play a central role in evaluating the impact of services.		<ul style="list-style-type: none"> • SDF Quality Tool for Service user evaluation (see 16. below) • Service User Evaluations • Service User Focus Groups
16	There is a robust quality assurance system in place which governs the ADP and evidences the quality, effectiveness and efficiency of services. See note 7		<ul style="list-style-type: none"> • Service Self-Evaluation and Quality Improvement Plan Development • SDF Quality Tools for Staff and Service Users providing quality reports and service improvement support: http://www.sdf.org.uk/drug-service-quality/useful-information/

REVIEW

			<ul style="list-style-type: none">Capacity and demand tool from available from SG's Quality and Efficiency Team (QuEST): https://scotlandgov.webex.com/scotlandgov/lsr.php?AT=pb&SP=MC&rID=54686962&rKey=DD0779A39D3D46F8
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3. Financial Framework

Your Report should identify both the earmarked drug and the earmarked alcohol funding from Scottish Government which the ADP has received (via your local NHS Board) and spent in order to deliver your local plan. It would be helpful to identify any other expenditure on drugs and/or alcohol prevention, treatment or support which each ADP partner has contributed from their core budgets to deliver the Plan. You should also highlight any underspend and proposals on future use of any such monies.

Income

Income	Alcohol	Drugs	Total
Earmarked funding from Scottish Government			
Funding from Local Authority			
Funding from NHS (excluding funding earmarked from Scottish Government)			
Funding from other sources			
Total			

Expenditure

Prevention (include community focussed, early years, educational inputs/media young people, licensing objectives, ABIs)

	ADP Budget	NHS	Authority	Other
ABIs LES				

Treatment & Support (include interventions focused around treatment for alcohol and drug dependence)

	ADP Budget	NHS	Authority	Other
Acute liaison nursing				
Integrated Alcohol Service				
Integrated Drug Services				
Prolific Offender Programme				

Recovery

	ADP Budget	NHS	Authority	Other
Recovery Café Project				
Moving on Project				
SMART				
Training on Recovery				

End Year Balance

	Income £	Expenditure £	End Year Balance £
Drug			
Alcohol			
Total			

Underspend

Underspend £	Proposals for future use

Support in kind

Provider	Description

4. Core and Local Indicators 2012/13

Please include progress made re-establishing baselines, local improvement goals/targets and progress using the RAG system for all national and local outcomes.

e.g.

National Outcome: Health: People are healthier and experience fewer risks as a result of alcohol and drug use

Indicators	Baseline	Improvement Goal/Target	RAG	Key actions delivered to support this outcome in 2012/13
e.g. Rate of drug-related hospital discharges (three year rolling average over last 5 years)				
e.g. Rate of alcohol-related hospital discharge rates (three year rolling average over last 5 years)				
e.g. Rate of alcohol-related mortality (three year rolling average over last 5 years)				

5. ADP & Ministerial Priorities in 2013/14

ADP Priorities

Please list your ADP's five key commitments for 2013/14 following this self-assessment.

Ministerial Priorities

ADP funding allocation letters 2013-14 outlined a range of Ministerial priorities. The Quality Improvement letter issued to ADPs on 3 July 2013, asks ADPs to describe in this ADP Report their local Improvement goals and measures for delivering these during 2013/14. Please outline these below.

APPENDIX 1: NOTES

1. Please complete the RAG column for each theme according to the following definitions:
Red: No action is yet underway
Amber: Action is underway but is not yet completed
Green: Action is completed
2. This column should be used to describe the range of evidence used to support the RAG Score. We do not require the source documents to be attached unless specifically requested
3. **Joint Strategic Needs Assessment:** Joint strategic needs assessments (JSNAs) analyse the health needs of populations to inform and guide commissioning of health, well-being and social care services within local authority areas. The main goal of a JSNA is to accurately assess the health needs of a local population in order to improve the physical and mental health and well-being of individuals and communities. (<http://www.nhsconfed.org/Publications/briefings/Pages/joint-strategic-needs-assessment.aspx>)
4. **Joint Performance Framework:** a national assessment process on how effectively local partnerships are achieving these improvements. (http://www.sehd.scot.nhs.uk/publications/cc2004_02.pdf)
5. **Integrated Resource Framework:** this is being developed jointly by the Scottish Government, NHS Scotland and COSLA to enable partners in NHS Scotland and Local Authorities to be clearer about the cost and quality implications of local decision-making about health and social care. The IRF helps partnerships to understand more clearly current resource use across health and social care, enabling better local understanding of costs, activity and variation across service planning and provision for different population groups. (<http://www.shiftingthebalance.scot.nhs.uk/initiatives/sbc-initiatives/integrated-resource-framework/>)
6. **Please indicate in your evidence if you have received feedback on this report from your Community Planning Partnership/ or other accountability route, specifying who that is.** Strategic commissioning is informed by The Commissioning Cycle (the outer circle) which drives purchasing and contracting activities (the inner circle), and these in turn inform the on-going development of Strategic Commissioning. Strategic commissioning is defined as 'term used for all activities involved in assessing and forecasting needs, links investment to desired outcomes, considering options, planning the nature, range and

quality of services and working in partnership to put this in place. Strategic commissioning process is defined by four stages, analyse, plan, deliver and review as presented visually in the diagram below.



7. **Quality Assurance Framework:** A guidance document which sets out the systematic monitoring and evaluation of the various aspects of a project, service, or facility to ensure that standards of quality are being met. Examples of how to improve the quality of your services may be found at <http://www.qihub.scot.nhs.uk/media/458288/efficient%20and%20effective%20cmht%20prototype%20version%201.pdf>

As this is the first self-assessment ADP's are asked to report please describe briefly whether you found the questions asked to be useful in considering your current position.

STANDARD REPORTING TEMPLATE - BLANK

Document Details:

ADP Reporting Requirements 2012/13

- 6 Partnership Details**
- 7 Self-Assessment:**
- 8 Finance Framework**
- 9 Core & Local Indicators and key activities 2012/13**
- 10 ADP & Ministerial priorities for 2013/14**

Appendix 1

- **Guidance Notes and Commissioning Diagram**

1. PARTNERSHIP DETAILS

Alcohol & Drug Partnership:	
ADP Chair	
Contact name(s): See note 1	
Contact telephone	
Email:	
Date of Completion:	
Date published on ADP website(s)	

The content of this template has been agreed as accurate by the Alcohol and Drug Partnership, and has been shared with our Community Planning Partnership:

.....

ADP Chair

The Scottish Government copy should be sent to:

Amanda Adams, Alcohol Policy & Delivery Team, Amanda.adams@scotland.gsi.gov.uk

2. ADP Self-Assessment 1 April 2012 – 31 March 2013

	Theme	R A G See 1	Evidence See Note 2
ANALYSE			
1	ADP Joint Strategic Needs Assessment has been undertaken and provides a clear, coherent assessment of need. See Note 3 Include your ADP needs assessment on New Psychoactive Substances or information on any work carried out locally in response to NPS – if available		
2	An outcomes based ADP Joint Performance Framework is in place that reflects the ADP National Outcomes. See note 4		
3	Integrated Resource Framework - Process Suitable data has been used to scope the programme budget and a baseline position has been established regarding activity,		

	Theme	R A G See 1	Evidence See Note 2
	costs and variation. Note 5		
4	Integrated Resource Framework - Outcomes Note 5 A coherent approach has been applied to selecting and prioritising investment and disinvestment options		

PLAN

	Theme	R A G	Evidence
5	We have a shared vision and joint strategic objectives		
6	Our strategic commissioning work is clearly linked to Community Planning priorities and processes . See note 6 Include your ADP Commissioning plan or Strategy – if available.		
7	Service Users and carers are		

PLAN

	embedded within the partnership commissioning processes		
8	A person centered recovery focus has been incorporated into our approach to strategic commissioning Please include your outcomes for all individuals within your alcohol and & drug treatment system for 2012/13 if available.		
9	All relevant statutory requirements regarding Equality Impact assessments have been addressed during the compilation of our ADP Strategy and Delivery Plan		

DELIVER

10	Joint Workforce plans are in place across all levels of service delivery which are based on the needs of your population.		
11	A transparent performance management framework is in place for all ADP Partner		

PLAN

	organisations who receive funding through the ADP.		
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REVIEW

12	ADP Delivery Plan is reviewed on a regular basis.		
13	Outcomes focussed contract monitoring arrangements are in place for all commissioned services.		
14	A schedule for service monitoring and review is in place.		
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Recovery

	ADP Budget	NHS	Authority	Other

End Year Balance

	Income £	Expenditure £	End Year Balance £
Drug			
Alcohol			
Total			

Underspend

Underspend £	Proposals for future use

Support in kind

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