STANDARD REPORTING TEMPLATE

Aberdeenshire ADP Annual Report 2014-15

Document Details:

ADP Reporting Requirements 2014-15

1. Partnership Details
2. Self-Assessment
3. Finance Framework
4. Performance Framework
5. ADP & Ministerial Priorities

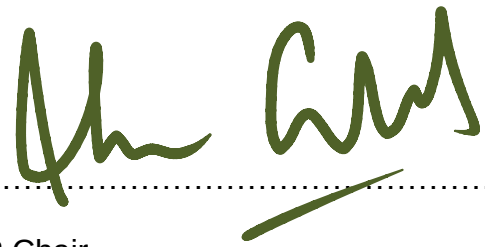
Appendix 1

- Guidance Notes and Commissioning Diagram

1. PARTNERSHIP DETAILS

Alcohol and Drug Partnership	Aberdeenshire
ADP Chair	Adam Coldwells
Contact name(s) *see note 1*	Gillian Robertson
Contact Telephone	01224 558420
Date of Completion	18 Sept 2015
Date Published on ADP website(s)	22 Sept 2015

The content of this Annual Report has been agreed as accurate by the Alcohol and Drug Partnership, and has been shared with our Community Planning Partnership/Integration Joint Board through our local accountability route.



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ADP Chair

The Scottish Government copy should be sent for the attention of Amanda Adams to:

Alcoholanddrugdelivery@scotland.gsi.gov.uk

2. ADP SELF-ASSESSMENT 1 APRIL 2014 – 31 MARCH 2015

ANALYSE – Please evidence your ADPs analysis activities/progress

	Theme	RAG *see note 1*	Evidence *see note 2*
1	**ADP Joint Strategic Needs Assessment has been undertaken and provides a clear, coherent assessment/analysis of need, which takes into consideration the changing demographic characteristics of people (and their families and local communities) affected by problem drug and/ or alcohol use in your area.** Please state when this was undertaken and when it is next planned. **Please also include here any local research that you have commissioned e.g. hidden populations, alcohol related deaths.**	a	Aberdeenshire ADP utilise available Information Services Division Scotland (ISD) information to help form an understanding of need. We also use additional statistical information such as the Scottish Health Survey and Scottish Adolescent Lifestyle and Substance Use Survey (SALSUS). We frequently measure local referral rates and types of referrals to monitor the needs of service users and to develop appropriate plans. We also engage in an annual capacity planning exercise to ensure services are able to provide necessary intervention and support A Health Needs Assessment for Alcohol and illicit drug use was completed in May 2014 using data up to quarter 4 2013/14. This is currently being reviewed and will be expanded to include NPS use. Our Health Intelligence colleagues have been asked to look at wider indicators that could be included to help make our needs assessment more robust and not so health orientated. Analysis of the SALSUS data helped us indicate a need for an increase in early intervention and prevention activity in particular with girls. Aberdeenshire ADP finds this data very useful when examining trends and planning interventions/ education programmes and have funded a sample boost to enable the continuation of provision of Aberdeenshire data. In identifying the need to gather broader information, we are working with Aberdeenshire Community Safety Partnership to fund a specific resource to gather the widest range of data to help inform the needs assessment along with

	See Note 3		our Delivery Plan and other areas of need as they emerge. Our Community Forums have also conducted a range of 'Big and Wee Blether' community consultations. This evaluation of perceived need will also feed into the needs assessment. We would anticipate having an updated strategic needs assessment for the end of 15/16. At the request of our Community Forums we have commissioned a needs assessment to look more in depth at the results from SALSUS and the adequacy of our existing services for children. The results of this and resulting actions will be delivered in 2015/16. We have established a Drugs Related Death group which has looked in depth into every DRD case and helps to identify areas of concern as well as actions to support the reduction of deaths. As a result of this we are looking at using information from SPARRA to help identify those most at risk that might benefit from assertive outreach. There have been three cycles of survey monkey questionnaire to a range of partners to assess NPS risk. This has shown us that the risk appears to be primarily confined to looked after children. This data has helped make the case for a joint ADP and Trading Standards effort to help address the challenges from local Head shops.
2	**An outcomes based ADP Joint Performance Framework is in place that reflects the ADP Local Outcomes and the National Core Outcomes.** See note 4	a	Our performance framework operates at a number of different levels: **a.** Outcome monitoring for strategy outcomes (incorporating the 7 national core ADP outcomes. **b.** Outcome monitoring for operational service delivery (Via ADP service agreement letters). **c.** The function of the Commissioning, Performance and Finance Group (CPF) to manage the ADP's commissioning, performance and finance activity on behalf of the ADP Committee. **d.** The Delivery Plan and tactical group roles – reports received at each ADP meeting from each group highlighting progress

			against action plans. **e.** Evaluation of activities and consultation with providers through self assessment of their work. We continue to work on this as part of our ongoing development of services. In 15/16 one of our main priorities will be to have a new commissioning and performance strategy which will incorporate local recording on measures agreed within the new Delivery Plan. This will develop further our recording of wider and local indicators. We will continue to work with providers and partners to understand the need to measure outcomes effectively. An example of this in 14/15 was in addressing Aberdeenshire's poor waiting time performance. The ADP Support Team provided training and all partners recognised the need to address this issue, improve our performance and ensure recording is accurate and in line with guidance. Whilst we didn't meet the 14/15 target we did improve performance and have consistently hit the 90% target from March 2015.
3	**Integrated Resource Framework Process** **Suitable data has been used to scope the programme budget and a baseline position has been established regarding activity, costs and variation.** Note 5	a	There have been behind the scenes discussions about financial re-engineering of ADP spend. Whilst we did not make the progress hoped, due to intense political sensitivities around statutory partner funding, we have secured commitment across the ADP for financial changes articulated within our new Delivery Plan. Over the next year we will negotiate shifts in expenditure to address the following challenges: • Increase the proportion of spend in prevention and early intervention. • Ensure tier 3 treatment services focus exclusively on their speciality allowing access to a varied range of services in recovery. • A higher proportion of spend directed by communities. Currently the ADP receives a share of funding from NHS Grampian. We have been in negotiation with the other ADPs and NHS Grampian to: • Agree a equitable funding allocation formula to better reflect need across Grampian (an aspiration to use the National allocation formula).

			• Better understand historical spend of ADP monies top sliced at a Grampian level to ensure proper ownership of decision making by ADP partners and equitable distribution across Grampian. We are hopeful that the changes around Health and Social Care integration will help facilitate this. Following deeper analysis of activities as described in 2, we have identified unexplained variations in relation to value for money and best use of resources. This will be addressed further in 15/16
4	**Integrated Resource Framework - Outcomes** Note 5 **A coherent approach has been applied to selecting and prioritising investment and disinvestment options – building prevention into the design and delivery of services.**	a	Currently our spend has been decided on four ways: • Historical Spend – this is mainly for statutory services • New services commissioned as a result of needs assessment • Contingency spend based on emergent operational demands • Community participatory budgeting and piloting work / small tests of change To cope with the varying approaches we have attributed spend to each of the priorities within our Delivery Plan to provide and an objective basis to achieve the financial changes mentioned above. To illustrate this, this section highlights the proportion of current ADP spends on each outcome within our Delivery Plan. Outcome 1 expenditure - Prevention & early intervention Social Marketing £10,000 EPI £40,000 Outcome 2 expenditure – Protection and Harm Reduction CFYP Allocation £50,000 Naloxone £ 8,000

			ORCA £30,000 Outcome 3 expenditure - Treatment and Recovery Total £1,287,160 Outcome 4 expenditure – Community Involvement CLD Workers £61,536 Garioch Family Group £5,700 SUI £53,063 Forum £70,000 Other expenditure ADP Support team £255,570(Core Funding) Admin support £15,838 Contracting Support £5,000 Adhoc, meetings, events etc £6,000 Total anticipated spend for 15/16 £1,897,867 (£123,930 to be allocated) Total anticipated allocation for 16/17 £1,670,556 In planning in this way we have made explicit the need to shift spend.

PLAN - Please evidence your ADPs Planning activities/progress

<table>
<tr><th></th><th>Theme</th><th>RAG
see note 1</th><th>Evidence see note 2</th></tr>
<tr><td>5</td><td>We have a shared vision and joint strategic objectives for people affected by problem substance use & those affected, which are aligned with our local partnerships, e.g child protection committees, violence against women, community safety, prevention including education etc.</td><td>g</td><td>The Aberdeenshire Single Outcome Agreement (SOA) details the priorities community planning partners have agreed to work towards over the coming 10 years. It sets out what we will do together to make Aberdeenshire a better place. Likewise, the Health and Social Care Partnership (HSCP) aims to have a strategic plan to support modernisation and integration of local health and social care. Our Delivery Plan informs the alcohol and drug outcomes for both.
The quality of our partnership is evident in the range of partners contributing to our Delivery Plan and the number of ADP members both receiving and offering information into wider partnerships:

<table>
<tr><th>Services</th><th>Local Partnerships</th></tr>
<tr><td>• Aberdeenshire Council Community Substance Misuse Service
• Aberdeenshire Health and Social Care Partnership
• Housing Services</td><td>• Aberdeenshire Voluntary Action
• Aberdeenshire Youth Council
• Community Planning Partnership
• Community Safety Partnership</td></tr>
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			<table><tr><td> - Job Centre Plus - NHS Grampian Sexual Health Service - NHS Grampian Substance Misuse Service - Partner Voluntary Organisations - Police Scotland, Aberdeenshire and Moray Division - Scottish Prison Service HMP Grampian </td><td> - Employability Partnership - GIRFEC Management Group - Health Inequalities Group - Learning Communities Partnership - Licensing Forums - Managed Care Network for Sexual Health and BBVs - Tackling Poverty and Inequalities Group - Choose Life </td></tr></table> Aberdeenshire ADP has actively contributed to the work of other partnerships such as the Community Learning and Development Strategic plan, the Aberdeenshire physical activity strategy, the Community Safety Partnership, the Community Justice Strategic Outcomes Group, Aberdeenshire Employability Partnership and the recent Care Inspection of Childrens Services. The chair of our Early Intervention and Prevention Group is the head of Community Learning and Development. There are deliberate overlaps within the ADP and CLD Delivery Plans. We jointly fund CLD workers to support ADP activities in communities through our Community Forums. The vision for children in Aberdeenshire is that they are *confident individuals, effective contributors, successful learners and responsible citizens* (Aberdeenshire ICSP 2015). To achieve this we aim to work in a child and family centred way, underpinned by GIRFEC principles, intervening early to offer support to prevent adverse impacts on the wellbeing of our children and young people. The close links are evident when staff development programmes are arranged and expertise from both committees is utilised to provide high quality provision for staff. The ADPs strategic vision of “Healthy, Happy, Safer” supporting people to live rich meaningful and autonomous

			lives free from harm due to alcohol and drugs entirely supports the overall aim for children. The Child and Family protection committee (C&FPC), which form part of the GIRFEC management arrangements, has clear links with the ADP, in particular the ADP Family and Children Task Group, ensuring the agendas are matched and consistency of message and practice across children's and adults services. Another example would be our relationship with the Community Safety Partnership- "The newly structured Community Safety Partnership recognises the key role of the ADP across and within our partnership with representation at our Executive as well as at 3 of our 4 priority theme groups playing different but relevant role - ASB & Violence; Gender-Based Abuse and Unintentional Injuries with a focus on early intervention and prevention around substance misuse and underlying causes of Home, Fire and Water Safety. ADP feeds into relevant policies strategies ensuring joint strategic objectives."
6	**A. Our planned strategic commissioning work is clearly linked to Community Planning and local integrated health and social care plans, preparing to support improved outcomes, priorities and processes jointly.** Please include your ADP Commissioning Plan or Strategy if available.		We have worked closely with the Health and Social Care commissioning team in supporting us to refine our commissioning process in line with the HSCP. This has allowed us to develop a commissioning strategy which is in a final draft form and will be presented at our next full ADP in December. As can be seen from our partnership activity, we are well placed with relevant partners to feed into the Community Planning process. This has allowed us to determine areas of joint work and shared outcomes as well as avoiding duplication of funding and activities. Child Protection The links between the C&FPC and the ADP are made in several ways. • The chairperson of the ADP Families and Children Task Group is a full member of the ADP, C&FPC and the GIRFEC Management Group (GMG). Reports are provided to every meeting of both committees and an annual update to the GMG. This allows cross referencing of issues and ensures that CAPSM 's needs are taken account of in both groups while avoiding duplication of effort/resource. • The L&D group of the C&FPC ,which also considers gender based violence, has

	Please include information on your formal relationship to your local child protection committee. **B. What is the formal arrangement within your ADP for reporting on your Annual Reports/ Delivery Plans/shared documents, through your local accountability route**. Please include information on the level and frequency of feedback you have received through your local accountability route/CPP/ Joint Integration Board. See note 6	G	membership from the ADP families and children task group, and development sessions are planned in a co-ordinated way when this is relevant. • The lead officer of both committees meet on a regular basis to discuss areas of mutual interest. The Chairperson of the ADP and the C&FPC are both members of Aberdeen GIRFEC leadership group. CPP Reporting We are called to account to the Community Planning Partnership Board annually at a face to face meeting where we receive feedback and are able to answer any questions. A subset of indicators from our Delivery Plan is incorporated into the SOA and this is monitored on an exception basis at every CPP executive team meeting once every 2/3 months. Additionally on an ad hoc basis we are invited to provide an update to the 6 area committees in Aberdeenshire. The Aberdeenshire ADP Chair has a seat on the CPP Board and the Lead Officer has an active role on the CPP Executive Team. We submit all strategies and plans to the CPP for comment and agreement. This is the feedback we received from our last presentation at the CPP Board - **"11. SOA FOCUS: ALCOHOL AND DRUGS** There had been circulated a joint report dated 19 May 2015, by the Alcohol and Drugs Partnership Commissioning and Performance Manager and the Strategic Development Officer (Community Planning), which provided the Board with an update on progress made by the Alcohol and Drugs Partnership in delivering the outcomes set out in the Single Outcome Agreement. During discussion, members asked questions about other organisations that could help to support the delivery outcomes; the variation of Alcohol Brief Intervention delivery across Aberdeenshire; the role of the recovery community in prevention; and the impact of the cessation of the bus pass project. After due consideration, the Board **agreed**:- (1) to acknowledge the progress made by the Aberdeenshire Alcohol and Drugs Partnership in delivering the outcomes set out in the Single Outcome Agreement;

			(2) to acknowledge the comments made by partners demonstrating how they were contributing to the alcohol and drugs priority; (3) to acknowledge the information provided on the Partnership's performance to improve outcomes, plan preventatively and join up resources; and (4) to instruct officers to provide further information on the impact of the cessation of the bus pass pilot project."
7	**Service Users and carers are embedded within the partnership commissioning processes**	R	We have two p/t Service User Involvement Coordinators who proactively encourage service users to become more involved in all aspects of Aberdeenshire ADPs work. In addition to this we had an embedded member of staff from SFAAD covering Grampian. One of the SUIC post holders has subsequently included this role for Aberdeenshire in her working week. Aberdeenshire also have three Community Forums with active Service Users and family members. One of the forums has an Ex Service User as vice chair. The forums receive a financial investment from the ADP and decisions on how this is spent are made by community members, many of whom are service users or family members. This is more than involving service users as part of the commissioning process; in this case the community members are the commissioners. The Forums are also represented on our Commissioning Performance and Finance group. Whilst we have not had the need to commission services this operational year we have invested in service developments as a result of Service User feedback.
8	**A person centered recovery focus has been incorporated into our approach to strategic commissioning. Please advise if your ROSC is 'in place'; 'in development' or in place and enhancing further.**	A	We have a ROSC in place but continue to develop this as we continuously review our practice and identify areas requiring further work. We have developed a customer Journey (See 11) which has helped services look at recovery from a person centred perspective. We have made progress against some of the Distinguishing features of a ROSC including: • Being person-centred – We have reviewed service processes and identified the need to make it easier to access services and as a result we have provided funding for Single Points of Access across Aberdeenshire. These will provide advice and assessment before referring people onto the most appropriate service where required.

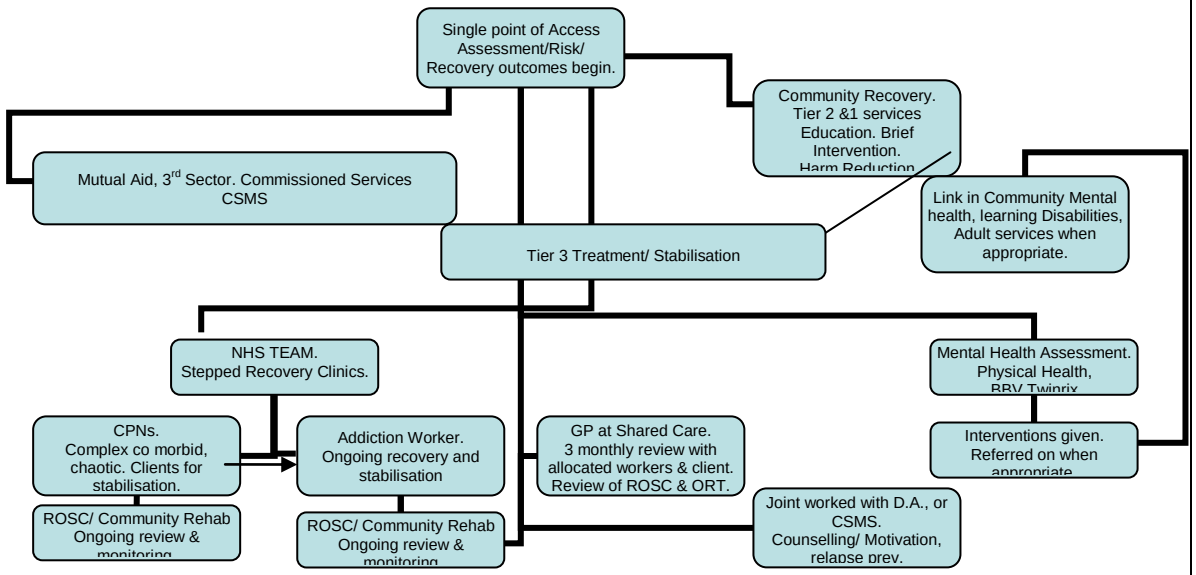
	Describe the progress your ADP has made in implementing a Recovery Oriented System of Care (ROSC), please include what your priorities are in implementing this during 2015-16. This may include: • **ROSC service review and redesign** • **Identify and commission against key recovery outcomes** • **Recovery outcome reporting across alcohol and drug services (Please outline what current/planned recovery tool you are using)**		In some cases we are able to undertake urine testing etc which enables people to access treatment much quicker. We have seen a reduction in our waiting times and service users are getting seen at the most appropriate place at the most appropriate time. During the review it was also identified the capacity of moving on services was insufficient. We have directed additional resources in this area with match funding received from DWP to support more people to move on in their recovery journey. During 15/16 we will review the impact of the Single Points of Access and the expanded moving on service. • Being inclusive of family and significant others – we have embedded within our assessment the need to encourage links and interventions to include this group. We arranged for Family Inclusive Practice workshops to be delivered last year and will continue in 15/16. We have 4 family support groups and will continue to develop these in 15/16. Our service User Involvement Co-ordinators also promote family inclusive practice. Our children Families and Young people Group have undertaken a lot of work on this and ensure that support is given where families would benefit. An example is the work with a residential provider who enables children to accompany their mother in a residential recovery setting. The CFYP group have worked with this service to develop a post that will focus on the child and direct activities in line with GIRFEC and SHINARRI. This will start in 15/16 and will be reviewed by the CFYP in a year's time. The Community Forums also paid for an event in January "Recovery – A family affair" which was extremely well attended by over 145 people. • The provision of individualised and comprehensive services - such as housing, employability and education – through our wider partnership we are working with a range of services including DWP and Housing. We have incorporated employability as part of our recovery offer and plan to look at potential housing related projects in 15/16. • Services that are connected to the community – we have 3 Community Forums which have a wide membership and our services link very closely into these, in particular our third sector services. Finance is available to these groups to fund local community programmes, which support our outcomes, as they see fit. Our single points of access will be delivered in a variety of locations within communities including pharmacies,

- **Individual recovery care plan and review**
- **Involved mutual aid and recovery communities**

Please include your recovery outcomes for all individuals within your alcohol and drug treatment system for 2014/15 if available.

community halls, etc.

The diagram below was agreed as our Recovery and Treatment ROSC and was developed by services with ADP support staff after piloting a redesign.



ORT Shared Care Clinics will have 3 steps of Recovery within them. CPN, Addiction Worker& GP.	3 Monthly Review to meet prescribing guidelines and review of ROSC plan. Recorded goal setting and review being person centred.
These clinics can transfer within each other as to client's stage of recovery.	Within this model there is evidence of supervision and recording will be included. .

Addiction worker pre and post Alcohol Detox. Harm reduction, motivational enhancement. CBT. Family support.	Referred to CPNs for Screening of suitability for Community Detox. Risk Assessment and home environment assessment completed.
Workers identify suitability for detox and refer to CPN. Preportorial counselling for detox. Recovery goals and relapse prevention work.	Request from registered GP for Supervised Home Detox as per protocol.

			<table><tr><td></td><td></td></tr><tr><td>Reducing size of caseloads & improving psycho social interventions. (Heat Target)</td><td>Transfer of skills within multi agency approach to improve choice and opportunities for recovery.</td></tr></table> <table><tr><td></td><td></td></tr><tr><td>Addiction workers support client's family/carer with joint working with CPN during detox and continues recovery and relapse prevention on its completion.</td><td>Specialist CPN input and support to Community Hospitals with Alcohol Detox. And linking back into community supports on discharge.</td></tr></table> Every service user will have a care plan with regular reviews and a sample of these will be reviewed as part of the monitoring process. We were part of the pilot to review the Scottish Government Recovery Outcome Tool and plan to continue to use this. Aberdeenshire ADP is extremely proactive in involving community and mutual aid groups. Our service user involvement coordinators have been employed to ensure genuine service user involvement, which drives our ROSC and redesign of services. Figures for 14/15 2,258 people accessed services – We have seen a 14% increase in people seeking support for Drug misuse and a 3% decrease in people seeking Alcohol support. We had an increase in numbers of people receiving residential support in 14/15 (131 vs 101). Some of our services have provided us with specific service user outcome data but this is in no way consistent or comprehensive across all services. We can make this available if required. We recognise that this is an area we need to improve on and had delayed committing to a particular universal recover outcome monitoring methodology in anticipation of DAISY etc. We have this as one of our 5 key commitments for 15/16.
9	**All relevant**		Due to a number of staffing changes we no longer have this capacity but are currently

	statutory requirements regarding Equality Impact Assessments have been addressed during the compilation of your ADP Strategy and Delivery Plan. Please advise when this was undertaken and is next planned.		recruiting a new member of staff who will be able to undertake this for all aspects of our work. Our Strategy was fully assessed by qualified ADP support team members who have since left post. Our Delivery Plan is currently being health inequality impact assessed by colleagues in public health.

DELIVER - Please evidence your ADPs Delivery activities/progress

	Theme	**R A G** *see note 1*	**Evidence** *see note 2*
10	**Delivery of Joint Workforce plans, as outlined in 'Supporting The Development of Scotland's Alcohol and Drug Workforce' statement are in place across all levels of service delivery which are based on the needs of your population.**		Due to staffing changes we have not progressed this on the systematic basis we would have wished. Fortunately a new member of staff has been appointed to specifically lead on workforce development issues within the ADP. Never the less we have made good progress in a number of areas of obvious workforce development need including: • Family Inclusive Practice • GIRFEC

	see note 7		• NPS • Naloxone • Universal Credit • ABI Workstream 2 of our service delivery group has identified workforce development priorities that will be taken forward in 15/16.
11	**Please provide a bullet point summary of your ADP's Alcohol and Drug Provision, to demonstrate the range of prevention, treatment/recovery & support interventions (including early interventions) commissioned by the ADP which have been delivered in the reporting period.** We recognise there will be overlaps – please use local definitions.		We have designed a local pipeline of services. This is helping everyone understand the widest range of support available, as well as encouraging services to refer to the most appropriate support at the most appropriate time to the service user. A comprehensive listing of services is available in our Service Directory.  ADP Service Directory May 2015.d  Customer Recovery Journey.docx **Prevention** – • Resource to allow ABI to be embedded within criminal justice as part of their daily activities. • Campaigns – Meet the Hendersons, Pregnant Pause, alcohol and older people. • Diversionary activities / Education Group • ABI activities in NHS and Wider settings **Protection and Harm Reduction** • Play Specialist in HMP Grampian • DRD co-ordinator

			• Needle Exchange • Nursery Nurse in hot spot area • ORCA **Treatment and Recovery** **Engagement** • Single points of Access (New service this year) **Treatment** • Substance Misuse Service – CPNs across the area • Community SMS – LA • Various third sector organisations delivering a variety of interventions including shared care **Moving On** • Employment Development Officers • Support to re engage with community activities • REACH – 12 week course • Job Parents – 1-2-1 support to tackle barriers and address employability skills **Inclusion** • Service User Involvement Co-ordinators • Three Community Forums with budgets to allocate to increase community activism and address shortages as well as stigma etc. • Community Development staff to support forums and take forward ideas and projects.
12	**Please provide a brief summary of the interventions your ADP has**	g	Aberdeenshire ADP are proud of the work and developments in Aberdeenshire to support communities. We have three extremely active Community Forums

	delivered to support communities: **a) Prevention of developing problem alcohol/drug use** **b) Community Safety/ violence against women/Reducing Reoffending** **c) Children/ CAPSM** **d) Supporting People in moving on from treatment and care services for ongoing recovery (e.g Self Directed Support, mutual aid/recovery communities)**		covering North, South and Central Aberdeenshire and these are growing in membership and in the activities across each of the areas. The Forums were identifying a number of areas of development but, as members attend on a voluntary basis, were finding it hard to take forward some of the good ideas. The ADPs invested in community support workers to help facilitate new activities and projects and this has resulted in: • New community recovery Cafes – these are held in various locations including a very active one utilising Tescos community room in Inverurie. • New projects covering a diverse range of ideas, issues and customer groups. • Increased attendance at meetings. • Focussed formats of meetings discussing issues at conversation cafes. • A wide range of community events for families and service users. • Presence at a number of local events, combating stigma etc. a) The meet the Hendersons campaign started in 2013 with a radio campaign and website to help parents have conversations with their children about alcohol. In 2014 we modified the website and sent a flyer to parents through every primary school child and S1 &S2 in Grampian. In 2015 we arranged for 10,000 meet the Henderson stickers to be put into primary school childrens home school books. This generated a considerably improved level of traffic to the website. b) ORCA – Opportunities to reduce Criminal Activity, a long standing novel mentoring ADP project delivered by TPS and the Police. This is designed to divert prolific offenders, due to substance use, from anti social behaviour to support services. The following police statement is extracted from the ORCA annual report for 14/15: “Police Service of Scotland continues to work alongside partner agencies, such

			as Turning Point Scotland, assisting in the continued support of the work carried out by them. The work provided by Turning Point Scotland in relation to the ORCA Project provides positive progress and stability for those whose past choices have led them into a chaotic life style and for who without such support would likely continue in this way. This work has proven to reduce recidivism for those willing to engage and provides them with the tools required to enable them to break the cycle." Kevin Fyfe **Antisocial Behaviour Co-ordinator, Police Scotland** c) We have a very proactive children, families and young people group. d) We have agreed to invest more resource in moving on and these services will start in 15/16. Our Community Substance Misuse Service in Aberdeenshire Council operates SDS for our area. We are also a pilot area for looking at third sector involvement in this with IRISS. We continue to work in partnership with a variety of organisations that allow a holistic approach to recovery including DWP, Housing, mutual aid groups etc. There are new peer support groups and CSMS are involved in supporting SMART recovery particularly in Peterhead offering mentoring to 3 peers who have been undertaking their facilitator training.
13	**A. A transparent performance management framework is in place for all ADP Partner organisations who receive funding through the ADP, including statutory provision**	a	Reviews are undertaken with all services. We are well on our way to reviewing how we commission services and this will finalised in 15/16. All services report on outcomes and activities as asked although the recording of these is still not on a common tool. This would be beneficial especially given the large numbers of services we have.

	B. Describe how all ADP Partners contribute to delivering outcomes identified in the Joint Strategic Needs Assessment (box 1) which includes prevention, recovery, treatment, support and throughcare services through ROSC provision, where in place.		Treatment services and health improvement provide quarterly updates on the A11 target and H4 standard and Lead Officers attend quarterly ADP Chairs strategy group meetings to account for performance and agree future actions. We have an ADP Joint Financial Framework in place which requires outcome performance reporting via the development of service specifications/service level agreements.

REVIEW - Please evidence your ADPs Delivery activities/progress in reviewing Strategies/Outcomes

	Theme	**RAG** *see note 1*	**Evidence** *see note 2*
14	**ADP Delivery Plan is reviewed on a regular basis, which includes a review of the provision of prevention activity, recovery, treatment and**	g	Aberdeenshire have recently signed off a comprehensive Delivery Plan. Within this, acytions have been attributed to lead partners overseen by the relevant ADP sub-committee. Each of the ADP groups has a workplan with these actions that they report on and agree actions on at each meeting. This is then fedback to full ADP meetings.

	support services (ROSC).		
15	**Progress towards outcomes focussed contract monitoring arrangements being in place for all commissioned services, which incorporates recommendation 6 from the *Delivering Recovery Report*.** see note 8		• A standardised reporting template has been developed to assist services in producing quarterly reports for the ADP and CPF groups. • Third Sector commissioned services have a SLA that sets out measures for monitoring performance. • CPF (Commissioning, Planning and Finance) Group is developing a Commissioning strategy and will advise the ADP on its introduction and development. This will be key in improving our activity on this as the process will highlight specific outcomes prior to services applying for the funding. • We have received a new funding agreement letter which allows us to be clearer in setting our expectations of services
16	**A schedule for service monitoring and review is in place, which includes statutory provision**.		All services are reviewed every six months and in our new plans they will be required to provide numerical quantities and qualitative information on a quarterly basis. All services are due to be monitored in October 2015. This is done with Aberdeenshire Council contracts team.
17	**Service Users and their families play a central role in evaluating the impact of our statutory and third sector services.**		All services gather service user feedback and include this in their monitoring visits and reports. We have two part time Service User Involvement staff who are proactive in engaging with service users and encouraging them to become involved with a variety of activities. We would like to be in a position where we could have representation on our Commissioning Performance and Finance group but unfortunately we do not have a willing volunteer. Discussions and conversation cafes are held at the Community Forums and anything relevant from here is fed back. We aim to have a service user reference group in operation for 15/16 who can give us feedback on the reviews of our services prior to taking these to the CPF meeting.

18	**A. There is a robust quality assurance system in place which governs the ADP and evidences the quality, effectiveness and efficiency of services.** **B. Please advise when (and how) your ADP has/plans to undertake an assessment of local implementation of the '*Quality Principles: Standard Expectations of Care and Support in Drug and alcohol Services.*** See notes 9 and 10		Through analysing data collected by all services we are now in a position where we can start reviewing services in regards to identifying value for money. This is something we will be taking forward in 15/16. We have also approached SG resources to help with this. Aberdeenshire ADP has started to evaluate the implementation of Quality Principles by conducting a survey of service users. This survey was carried out to obtain views of the service users in order to develop and evaluate the service. 85 responses were received direct from service users and families. The questionnaire was created around the 8 Quality Principles. All responses were recorded by the Scottish Health Council. The final report has not been published yet but early indications are very positive. Once the final report is available the results will be assessed and any actions required will be taken forward by our Service Delivery Group. The implementation of quality Principles also form part of the service monitoring procedures and all services will be asked what they have done to ensure they are adhering to the Quality Principles guidance.
19	**Describe the progress your ADP has made in taking forward the recommendations from the Independent Expert Review of Opioid Replacement Therapies in Scotland. Please include any information around the following:** • **your (updated, if applicable) Key Aim Statement**		Aberdeenshire ADP continues to be committed to providing Opiate Replacement Therapy (ORT) in a safe and effective fashion and following the recommendations of the expert review into Opiate Replacement Therapy. The Opiate Replacement Therapy Service is intrinsically linked with the wider Recovery Orientated System of Care. Opiate Replacement Therapy is primarily delivered by the Health Team within the wider integrated drug service. Those on Opiate Replacement Therapy get ongoing health monitoring and progress is also monitored by other professionals such as Social Work and Voluntary Sector colleagues. Between April 2014 and March 2015 the number of people in receipt of Opiate

	• **a specific update on your progress in implementing it – have you achieved it/when do you plan to do so?** • **Outline the work of your ORT Accountable Officer** • **How many people were in receipt of opiate replacement therapies in your area between 1 April 2014 & 31 March 2015.** • **Information on length of time on ORT and dose** • **Information about any related staff training in ORT provision or recovery orientated systems of care.** • **Detail of any ORT focussed groups operating in the area.** • **GP engagement – how drug and**		Replacement Therapy in Aberdeenshire was 438 patients. Information about length of time on Opiate Replacement Therapy is not routinely collected, neither is dose ranges. Opiate Replacement Therapy is prescribed in line with the National Clinical Guidelines. Any doses out with the guidance would be under review of a Consultant Psychiatrist. The staff from all professional groups receive regular training in Opiate Replacement Therapy provision and recovery orientated system of care. Specific training is provided to members of the NHS in the Addiction Team with regards to safe and effective provision of Opiate Replacement Therapy. There is no specific Opiate Replacement Therapy self care group operating in Aberdeenshire. With regards to GP engagement, there continues to be challenges with several large GP practices not engaging in Opiate Replacement Therapy services. NHS Grampian's Opiate Replacement Therapy Accountable Officer has clinical sessions in Aberdeenshire. Meetings are held regularly with the NHS Grampian Controlled Drug Team to collect health intelligence regarding the use of Opiate Replacement Therapy in Grampian. Guidance is still awaited from Scottish Government about the exact role of the Accountable Officer. The table below shows the numbers of people registered with pharmacies in Jan 2014. This is the most up to date information that we have. Unfortunately collecting this information from Pharmacies along with changes to the Primary Care Contracts Team has meant that we no longer get this information as regularly as we would like. This is something that our specialist substance misuse pharmacist is trying to resolve.

	Methadone Supervised	Methadone Take Home	Buprenorphine Supervised	Buprenorphine Take Home	Total

	alcohol treatment is being delivered in primary care settings. See note 10		<table><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>Aberdeenshire</td><td>300</td><td>171</td><td>45</td><td>41</td><td>557</td></tr></table>
20	**Please describe in brief bullet points how your ADP and partners are contributing to delivery of a Whole Population Approach for Alcohol.**		• Aberdeenshire ADP is represented in each of the three licensing forums in Aberdeenshire, resulting in all three forums being keen advocates of the whole population approach influencing licensing board policy. • Campaigns have been undertaken: Meet the Hendersons and Pregnant Pause. • We have been successful in attracting non heat settings to ABI delivery. • We have been working with our Healthy Working lives colleagues who have delivered support to employers to have alcohol and drug policies in the workplace. • We have undertaken a review of alcohol use in over 65s resulting in planned publication of a targeted alcohol leaflet for older people to be issued when they collect their prescription. • We secured three years funding from Robertson Trust for DA to develop their 'culture changers' youth led community action programme. • ALEC – community classrooms exclusively focussing on substance misuse targeting p1-p7 and S1-2 school age children and providing age appropriate substance misuse education to equip them to make informed lifestyle choices. • Embedded ABI in criminal justice settings as normal day to day procedures.
21	**How many service users are in receipt of prescriptions for problem alcohol use?**		This is not something we normally record in our routine reporting and it would have been an extensive piece of work for all our services to go back through all their records for the year to gather this information. We have however been able to identify the numbers of people who are on

			prescription across Aberdeenshire for the following: • Acamprosate and Disulfiram. Licensed - only used for alcohol patients. • Chlordiazepoxide, diazepam, naltrexone. Licensed - Can be used to treat other, non alcohol related conditions • Baclofen, ondansetron, topirimate. Unlicensed - Can be used to treat other, non alcohol related conditions. • Nalmefene (reduces alcohol intake in dependent patients who do not exhibit physical symptoms of withdrawal) Licensed - Only used for alcohol patients. • Thiamine, oral and parenteral. Vitamin supplementation. Licensed - Potential to be used for other forms of vitamin B deficiency but the majority will be for alcohol The figures we have for the three categories (with key to colouring) are ; 1. Only Alcohol: 279 patients 2. Mainly Alcohol: 2743 patients 3. Other Than alcohol: 17128 patients We are aware that our services need to increase home alcohol detox and work started on this in 14/15 with the intention of having more staff trained and delivering in 15/16.
22	**How many service users are receiving counselling/support through ADP commissioned services?**		We have seen an increase in service users during 2014/2015. 2,258 people have accessed ADP funded services. We have see a 14% increase of people requiring support with Drug issues and a slight decrease of 3% in alcohol related treatment. There is a slight increase in the numbers of people attending for residential treatment. We identified an increase in caseload sizes and on further investigation identified that there were blockages due to lack of moving on services. This has allowed us to identify an area requiring investment and to do this in partnership with new funders.

23	**How many service users have received treatment for ARBD in the reporting period?**		Unfortunately we are unable to give an accurate report on this as we are struggling to get a definition or code that purely counts these cases. We do not feel asking services for this would give an accurate picture. Diagnosis is only made after 30 days of abstinence so most cases will go undiagnosed e.g. we estimate that up to 10% of dementia cases in Aberdeenshire are misdiagnosed ARBD. A significant proportion of these cases would be treated out with substance misuse services. Here is some information from our LA service, which would be most likely to come into contact with these cases: Not treatment, but support. At any one time CSMS will have a very small number actually diagnosed with ARBD, 10 for reporting period. Across CSMS we would then have anything up to 20 individuals who for various reasons cannot access a diagnosis. Many will have acute cognitive impairment but may still be actively drinking. All existing CSMS cases are moving onto new SDS pathway and any new referrals automatically are going on SDS pathway. Any service users requiring commissioned services will from 1st April 2015 have to undergo financial assessment.

3. FINANCIAL FRAMEWORK

Your Report should identify both the earmarked alcohol and the earmarked drug 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/support services or recovery which each ADP partner has contributed from their core budgets to deliver the Plan. You should also highlight any under spend and proposals on future use of any such monies.

N.B. for NHS

1. Costs do not include secondary care costs of dealing with Patients who are treated for conditions related to substance misuse.

2. Costs do not include GP or community service costs of dealing with patients who have substance misuse issues.

3. Costs do not include NHS Grampian overheads (e.g. facilities costs, non-clinical departments, capital charges etc)

Total Income from all sources

Income	Alcohol	Drugs	Total
Earmarked funding from Scottish Government	1,099,057	982,491	2,081,548
Funding from Local Authority	203,000(to 3RD sector)	98,000(to 3rd sector)	301,000 (to 3rd sector)
Funding from NHS (excluding funding earmarked from Scottish Government)	773,180	2,176,540	2,949,720
Funding from other sources- Carry Forward from 13/14	143,591	128,362	£271,953
DWP Funding	10,000	10,000	£20,000
3rd Sector	35,665	35,665	71,330
Total	2,264,493	3,431,058	5,695,551

Total Expenditure from sources

	Alcohol	Drugs	Total
Prevention (include community focussed, early years, educational inputs/media, young people, licensing objectives, ABIs)	194,714	224,714	419,428
Treatment & Support Services (include interventions focussed around treatment for alcohol and drug dependence)	1,688,372	2,824,937	4,513,309
Recovery	229,403	229,403	458,806

Dealing with consequences of problem alcohol and drug use in ADP locality	152,004	152,004	304,008
Total	**2,264,493**	**3,431,058**	**5,695,551**

End Year Balance for Scottish Government earmarked allocations

	Income £	Expenditure £	End Year Balance £
Drug	**1,110,634**	**1,061,197**	**49,437**
Alcohol	**1,243,192**	**941,063**	**302,129**
Total	**2,353,826**	**2,002,260**	**£351,566**

Total under spend from all sources

Under spend £	Proposals for future use
£351,241- ADP Allocation	A substantial amount of this under spend was due to a delay in a decision on developing Single Points of Access and Moving on Services. This accounts for £223k of this under spend. We will also be investing further in the Community Learning Support for our Community Forums £40k. We agree to support an addiction Workers Training programme for 15/16 at £60k and £20k for a joint analytical post with the Community Safety Partnership. The remaining 8k will be spent on small projects such as Conference and support to trading standards work on NPS.

Support in kind

Provider	Description
DA	Quay services – support for people in the sex industry
3RD Sector orgs	Forums – chaired by 3rd sector and supported well
DA	Provides training for a variety of people to help raise awareness and understanding as well as Naloxone etc.

4. PERFORMANCE FRAMEWORK - PROGRESS

Please include progress made re-establishing baselines, local improvement goals/targets and progress using the ScotPHO website for all national outcomes. You may submit your annual update on your performance framework from your Delivery Plan, however please include local indicators, linkage between activities, indicators and outcomes, how you will measure if a ROSC has been successfully implemented in your area.

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

Indicators	Baseline	Local Improvement Goal/Target	RAG	Key actions delivered to support this outcome in 2014/15
Alcohol related hospital stays per 100,000 population e.g. General acute inpatient & day case discharges (EASR) with a diagnosis of alcohol misuse in any position	2013/14 358 2nd lowest in Scotland	300 by 17/18	G	Increased ABI activity Identification of need for home dettox and staff trained

Drug related hospital stays per 100,000 population General acute inpatient & day case discharges (EASR) with a diagnosis of drug misuse in any position	2013/14 41.5 (4th lowest in Scotland)	30 by 2017/18	G	Wider range of services available Quicker access to services
Alcohol Related Deaths per 100,000 population Alcohol-related deaths (underlying cause) (EASR) per 100,000 population; by calendar year (1997-2011)	2013 8.97 Lowest in Scotland	6 by 2017	G	Redesign of services to make them readily available
Drug Related Deaths per 100,000 population	2014 0.04 (n=10) 2013 0.084 (n=21)	To have 0.04 or below	G	Re design of services to make them readily available to all Naloxone training
Prevalence of hepatitis C among people who inject drugs (PWID). Percentage of injecting drug users testing positive for HVC antibody (% is based on all injecting drug users tested)	2011/12 53% (Middle of Scottish range)	Benchmark 2011/12 Scotland 53%;East Dunbartonshire 55.7% Target – to see year on year reduction	G	Increased capacity to undertake testing Awareness raising at Needle exchange and other services

% against target and number of alcohol brief interventions delivered in wider settings.	2014/15 160% (n=797)	Goal 20% of ABIs conducted in wider settings.	G	We have invested in training of a wider range of staff as well as tightened up on our recording processes which have resulted in Aberdeenshire reporting on wider settings for the first time in 14/15.

Local outcomes relating to this

Local Outcomes	Indicators	Baseline	Local Improvement Goal/Target	RAG	Key actions delivered to support this outcome in 2014/15
Risks to alcohol and other drug users are reduced resulting in fewer acute and long-term risks to physical and mental health and a reduction in drug and alcohol-related deaths.	Number of Aberdeenshire SMS clients tested for BBV (Viral Hepatitis C, Hepatitis B and HIV)	2014 Hep C: Offered DBST: 113 Accepted: 68 Positive: 17 (25%)	200 pa by April 2016	A	We have increased the availability of this testing through some third sector organisations. Work with staff to highlight the need to promote this to all service users
	% and number of new drug clients reporting injecting behaviour	2013/14 33% (n=324) (In highest third of Scotland)	25% by April 2017 Benchmark - 2013/14 East Dunbartonshire: 10% Aberdeen City: 26%	A	
	% achievement of take-home naloxone supply target within the community	To 31 March 2015 101% of 2015 25% prevalence target (n=354)	Target 350 (25%) by April 2015 & 420 (30%) by April 2016	G	There have been a number of events highlighting this including training events with our local Community Forums.
	% achievement of	To 31 March 2015	Target 153 (25%)	A	Staff been trained

	take-home naloxone target supplied at liberation from HMP Grampian	22% (n=93)	by April 2015		Need highlighted Overcame barriers within prison setting
	% and number of substance misuse service treatment discharge types	2014/15: Planned- received required support: 30.30% (n=529); Planned- to GP: 3.5% (n=62); Planned- to other service: 9.3% (n=162); Disciplinary: 0.4% (n=7); Unplanned: 56.6% (n=988	Unplanned down to 40% by April 2017	A	Staff training Evaluation of activities
	% and number substance misuse service assessment DNA rate.	2014/15: Drugs – 57.2% (n=396) Alcohol – 54.1% (n=348)	Reduce both to 40% by April 2017	A	Encouraged services to look at current processes of allocating appointments, finding out from Customers what is best for them to help reduce this.
	% and number substance misuse service treatment DNA rate.	2014/15: Drugs – 6.8% (n=52) Alcohol – 2.4% (n=15)	No more than 5% by April 2017		As above
	% of drug related deaths that had been in contact with drug treatment	2013: 65% (n=20)	For all customers who had received treatment that assertive outreach	A	Working towards this and starting with this at Single points of access

	services in the 6 months prior to their death.		had been in place.		

National Outcome - **PREVALENCE: Fewer adults and children are drinking or using drugs at levels or patterns that are damaging to themselves or others.**

Indicators	Baseline	Local Improvement Goal/Target	RAG	Key actions delivered to support this outcome in 2014/15
% Drinking above daily or weekly recommended limits (4 year aggregate 2008-11).	Grampian 2011 41.0% (In best third of Scotland	35% by 2018	G	No change (next data due 22nd September 2015)
% 15 year olds reporting drinking on a weekly basis	2013 11.5% (Mid position within Scotland	5 % by 2017, decline consistently since 2006	G	ALEC – community classrooms exclusively focussing on substance misuse targeting p1-p7 and S1-2 school age children and providing age appropriate substance misuse education to equip them to make informed lifestyle choices Meet the Hendersons Campaign Close working with CLD
% of 15 year olds reporting drug use in last year	2013/14.15% (In best third in Scotland)	12.3% by 2018	G	
Prevalence of problem drug use (Opiates and/or benzodiazepines).	2013 0.67% (n=1,100) (4th lowest in Scotland)	0.60% by 2018	G	
More citizens will be offered an Alcohol Brief Intervention (ABI) where the need and opportunity to do so presents	2014/15 116% (n=2,307; 1790 GP +	Target 1970	G	Whilst the numbers of ABI in NHS settings has reduced in Aberdeenshire we still achieved the target but have identified the need to increase this activity and have

	571 GUM			increased training in this area
% against target and number of alcohol brief interventions delivered in wider settings.	2014/15 160% (n=797)	Goal 20% of ABIs conducted in wider settings.	G	We have invested in training of a wider range of staff as well as tightened up on our recording processes which have resulted in Aberdeenshire reporting on wider settings for the first time in 14/15.

Local Indicators relating to this

Local Outcome	**Indicators**	**Baseline**	**Local Improvement Goal/Target**	**RAG**	**Key actions delivered to support this outcome in 2014/15**
Communities will be better informed to make their own decisions about their use of alcohol and other drugs	Number of campaigns run per year.	2014: 2 (Meet the Henderson's and Pregnant Pause)	3 per year by 2016	G	New approach which increased hits for Meet the Hendersons Website, Working closely with Education colleagues
The ADP will be aware of emerging alcohol and other drug use trends, including new psychoactive substances (NPS) sufficient to inform community interventions and workforce development plans.	Local 'Red Amber Green' (RAG) scores for respondents assessment of the current NPS situation in Shire Red - NPS use is a growing concern Amber - NPS use is a continuing concern Green - NPS use is not a concern	June 2015 Red: 41.7% Amber 50.0% Green: 0% Black: 8.3%	Assess and use quarterly	G	NPS training delivered widely Discussions with trading standards Sharing of information as it becomes available

	Black - We have no information/ we don't know				
Alcohol and other drug related inequalities between communities will reduce.	Difference between alcohol related hospital stay rates in Fraserburgh Harbour & Broadsea and Inverurie North.	2013/14 Difference:579 (Inverurie North 400.2; Fraserburgh Harbour & Broadsea 979.4)	5% reduction year 1 20% reduction year 3	A	Working with partner organisations re wider range of issues

National Outcome -**RECOVERY: Individuals are improving their health, well-being and life-chances by recovering from problematic drug and alcohol use**

Indicators	**Baseline**	**Local Improvement Goal/Target**	**RAG**	**Key actions delivered to support this outcome in 2014/15**
Number of alcohol clients engaged with services as a % of the estimated total alcohol dependant population in Aberdeenshire	14% in 2012 (n=1453)	20% by 2018	A	
Number of drug clients engaged with services as a % of the estimated total problematic drug using population in Aberdeenshire	2013: 58.6% (n =645)	60% by 2018	G	
Number and EASR	2013/14	Maintain Level	G	

(European age and sex Standardised) rate per 100,00 new drug clients in year	136 (n=324) (In lowest third of Scotland)			

National Outcome - **FAMILIES: Children and family members of people misusing alcohol and drugs are safe, well-supported and have improved life-chances**

Indicators	**Baseline**	**Local Improvement Goal/Target**	**RAG**	**Key actions delivered to support this outcome in 2014/15**
Maternities with Drug Use per 1,000 (3 year average)	Aggregate 2010/13 8.9 (Lower third of Scottish range)	Benchmark - 2011 Scotland 19.7; East Dunbartonshire 5.5 Target 7 by 2016	A	
Rate of case conferences for concerns about parental alcohol or drug abuse for children on the child protection register per 10,000 population	2014 Alcohol misuse 1.2, n=7 (lowest in Scotland) Drug misuse 5.1, n=28 (3rd lowest in Scotland)	Alcohol misuse up to 4 by 2018 Drug misuse down to 2 by 2018	A	

Local Outcome	**Indicators**	**Baseline**	**Local Improvement Goal/Target**	**RAG**	**Key actions delivered to support this outcome in 2014/15**
Children and young people assessed to be 'at risk' from alcohol or other drug use can	Substance misuse – alcohol - related pupil exclusion rate per 10,000 pupils.	2013/14: 3.2 (n=11) (Provisional 2014/15 n=6)	2014/15: 2.0	G	Partnership working with Education including CLD Active Childrens Families and Young People group of Aberdeenshire ADP
	Substance misuse	2013/14:	2014/15: 4.0	G	

access positive interventions designed to support and divert them from harm.	– not alcohol - related pupil exclusion rate per 10,000 pupils.	9.3 (n=32) (Provisional 2014/15 n=4)			
	% and number of children referred to the Children's Reporter on the grounds of having misused alcohol.	2013/14 <1.5% (n<5)	Maintain less than 5	G	
	% and number of children referred to the Children's Reporter on the grounds of having misused drugs.	2013/14 <1.5% (n<5)	Maintain less than 5	G	
The risk to children and young people affected by parental or carer substance misuse will be reduced	% and number of children on the Child Protection register who are recorded as being affected by parental alcohol misuse.	As of 30/6/15: 10% (n=8)	Maintain below 13% by Jan 2016	G	Proactive Children Families and Young Peoples group. Place at Child Protection Committee Close link with Social work
	% and number of children on the Child Protection register who are recorded as being affected by parental drugs misuse.	As of 30/6/15: 32.5% (n=26)	Maintain below 30% by Jan 2016	G	
Families affected by a loved one's	Numbers of family support groups in	4	6 by December 2016	G	Increased numbers of groups this year to 4.

substance misuse will experience improved support and where appropriate, greater involvement in recovery planning	Aberdeenshire				Close link to SFAAD worker in Grampian

National Outcome -**COMMUNITY SAFETY: Communities and individuals are safe from alcohol and drug related offending and anti-social behaviour**

Indicators	**Baseline**	**Local Improvement Goal/Target**	**RAG**	**Key actions delivered to support this outcome in 2014/15**
Number of on-sales premises licenses in force per 10,000 population	2013/14 21.7 2014 n= 443 (3.92% of Scotland)	Benchmark 2013/14 Scotland 26.6; East Dunbartonshire 13.90	A	Information is supplied to the 3 licensing forums in Aberdeenshire on a regular basis. Attendance and input at forums Received buy in for whole population approach from all forums.
Number off-sales premises licenses in force per 10,000 population	2013/14 9.6 2014 n= 197 (3.96% of Scotland)	Decrease to 8 by 2018	A	
% of people perceiving rowdy behaviour to be common in their neighbourhood	2013 5.7%	5% by 2018	A	Working with Community Safety Partnership
%15 year olds ever offered drugs	2013 29.3% (In bottom third of Scottish Range)	23% by 2018	A	Steady reduction ALEC – dedicated Substance misuse education in schools
% people perceiving drug misuse or dealing	2013 7.5%	6% by 2018	A	Working with Community Safety Partnership

to be common in their neighbourhood				

Local Outcome	**Indicators**	**Baseline**	**Local Improvement Goal/Target**	**RAG**	**Key actions delivered to support this outcome in 2014/15**
Communities are safe from harmful alcohol or drug related behaviour	% positive test for any illegal drug on reception and liberation from HMP Grampian	HMP Grampian Nov 2014 Reception:72% Liberation: 39%	2013/14 8%	A	
	Reconviction rate for drug related crimes.	2012/13 Aberdeenshire and City Offenders = 533 Reconvicted = 137 (25.7% reconviction)	HMP Grampian Nov 2014 Reception:72% Liberation: 39%	A	
	No of people receiving Through care addiction Service.	2013/14 n=13 (1.17% of Scotland)	2012/13 Aberdeenshire and City Offenders = 533 Reconvicted = 137 (25.7% reconviction)	A	

National Outcome - **LOCAL ENVIRONMENT: People live in positive, health-promoting local environments where alcohol and drugs are less readily available**

Indicators	Baseline	Local Improvement Goal/Target	RAG	Key actions delivered to support this outcome in 2014/15
Proportion of citizens who express positive attitudes towards those in recovery	Jan 2015: 83% agreed we should help people recover from addiction; 74% agreed that anyone can recover from addiction; 72% agreed addicts should be more included in the community; 93% agreed families are important support and should be involved; 60% agreed addiction is an illness that could happen to anyone. 39% of respondents personally knew of someone who has successfully recovered from alcohol or drug addiction.	To have questions included in Citizen's survey, - Included in Viewpoint 40, Jan 2015 on attitudes and knowledge about mutual aid, peer support, family support and recovery	G	Link well with community survey to ensure that relevant questions to our work were included
Number of community involvement events or community surveys conducted per annum.	2014/15 7 events 2 community surveys	Increase each year	G	Increase in number of events arranged through a variety of sources including our Service User Involvement staff and Forums.

Local Outcomes	Indicators	Baseline	Local	RAG	Key actions

			Improvement Goal/Target		**delivered to support this outcome in 2014/15**
2 Marginalised communities and their representatives will develop a powerful voice and have real influence over the decision-making of the Forum, ADP and wider Community Planning Partners and become some of the most active and influential in our community	% of ADP earmarked funds spent on the basis of community decision making.	3.5%	4% by 2017	G	We have recruited Community support workers to support the forums to be able to progress and review more applications for projects within the local communities
Marginalised communities will be helped to get involved and develop the confidence to try things to make things better in their community	Number of people on Forum mailing lists.	June 2015 North: 126 Central: 103 South: 65	5% increase per annum	G	Our forums continue to grow and become more active with an extremely broad reach in the community. We have invested money so that dedicated support can be given to support
	Number of people who regularly attend Forums	June 2015 North: 25 Central: 35 South:15	10% increase per annum	G	
	Number of community members who regularly attend	June 2015 North: 10 Central: 12 South: 5	10% increase per annum	G	

	Forums.				applications, project development and review of impact can be done
	Number of community members acting as office bearers /representatives or leaders at Forum events/groups	June 2015 North: 11 Central: 10 South: 4	10% increase per annum	A	
	Number of funding applications to the Forums	Year 2014/15 North: 9 Central:8 South: 14	NA	A	
	Numbers of mutual aid and recovery groups and projects	June 2015: 11	15 peer support groups or projects	A	

National Outcome -**SERVICES: Alcohol and drug prevention, treatment and support services are high quality, continually improving, efficient, evidence-based and responsive, ensuring people move through treatment into sustained recovery**.

Indicators	**Baseline**	**Local Improvement Goal/Target**	**RAG**	**Key actions delivered to support this outcome in 2014/15**
% of community clients seen within 21 and 42 days from referral to commencement of treatment.	83% within 21 days 98 5% within 42 days	90% within 21 days by Sept 2015 100% within 42 days by Dec 2015	A	Training of staff in services after ADP support team member visited ISD. Monthly monitoring sheets issued. Services with history of poor performance get mid month check also
% of HMPG clients seen within 21 and 42 days from referral to commencement of treatment.	97.5% within 21 days 100% within 42 days	90% within 21 days by Sept 2015 100% within 42 days by Dec 2015	A	HMP Grampian re now recording and within the target. However we have remained this at amber as it is only drug activity that is being recorded. Training ongoing with staff

Local Outcomes linked to this

People in need can readily access the most appropriate local services able to evidence service quality and a proven ability to help people recover to live healthier, happier and longer lives.	% of community drug clients seen within 21 and 42 days from referral to commencement of treatment.	79.1% within 21 days 91.2% within 42 days Full year 14/15	90% within 21 days by Sept 2015 100% within 42 days by Dec 2015	A	Training was delivered with all services and we have seen a marked improvement in the last few months. We still closely monitor this activity
	% of community alcohol clients seen within 21 and 42 days from referral to commencement of treatment.	84.7% within 21 days 93.9% within 42 days Full Year 14/15	90% within 21 days by Sept 2015 100% within 42 days by Dec 2015	A	As above
	% of HMPG drug clients seen within 21 and 42 days from referral to commencement of treatment.	97.4% within 21 days 100% within 42 days	90% within 21 days by Sept 2015 100% within 42 days by Dec 2015	G	As above
	% of HMPG alcohol clients seen within 21 and 42 days from referral to commencement of treatment.	O Reported	90% within 21 days by Sept 2015 100% within 42 days by Dec 2015	A	As above
	% of missing data from SDMD returns	2014/15 16% (mid position in Scotland)	Lower than 10% by April 2016	A	Ongoing Review and training
	% of drug clients	2014/15	75% by April 2016	G	As Above

	with SMR25b review undertaken within 12 weeks	69% (3rd best in Scotland)			
Our commissioning strategy will ensure resources are used effectively and efficiently, gaps in integrated care pathways are filled and service duplication is eliminated	Number of alcohol clients engaged with services as a % of the estimated total alcohol dependant population in Aberdeenshire.	14% in 2012 (n=1453)	20% by 2018	A	
	Number of drug clients engaged with services as a % of the estimated total problematic drug using population in Aberdeenshire.	2013: 58.6% (n =645)	60% by 2018	G	
	Number and EASR (European age and sex Standardised) rate per 100,00 new drug clients in year	2013/14 136 (n=324) (In lowest third of Scotland)	Maintain level	G	

5. ADP & MINISTERIAL PRIORITIES

ADP Priorities 2014/15

Please list the progress you have made in taking forward your ADP's five key commitments for 2014/15.

ADP Key Commitments	What has happened
1. Review and redevelop our financial principles.	We have undertaken a review of spend over the year and had hoped to re-engineer the allocation of resources between the ADP and Local Authority to voluntary organisations. Unfortunately this has not taken place but we continue to develop further work on a Commissioning and Performance strategy with a view to tender for the majority of our larger services. The review did identify some projects that would no longer be funded as they had either moved on or were no longer delivering on our required outcomes. We have met with Local Authority commissioning services to ensure we have the correct processes in place as well as making sure we are in line with the new Health and Social Care Partnership procedures. This area of work will continue to be a major focus during 2015/16 and will see development of a Commissioning and Performance Strategy.
2. Complete a redesign of services across the partnership.	We have made considerable headway in this area and have now agreed funding to develop the Single Points of Access that were being piloted. This has greatly increased services awareness and a positive attitude towards co-production. During the trial it was also identified that there were blockages in our pipeline and that services and service users felt there was a need for moving on services which we have also funded. We had a very successful partnership day in February which discussed wider partnership working and identified three areas for further development and focus. These were: 1. Communication and Marketing – this covered a variety of areas from Single Shared Assessment to Risk Assessment. 2. Workforce Development – All aspects of WD as well as

	looking at processes and procedures. 3. Customer Journey - this discussed needs of providers and understanding ADP and wider services available to SUs. This work has allowed closer working whilst also identifying issues that needed to be addressed as a delivery partnership. This work continues through our service delivery group.
3. Implement a revised monitoring and evaluation system	A full review of our evaluation system has taken place which identified a number of areas that needed to be addressed. This included identifying issues with performance and processes. Monitoring and evaluation is being done across all services although we have still to establish a common electronic recording mechanism. We have identified areas where improvements are required as well as good practices which have been shared with services. Quarterly reports have been established which hold more details including capacity, and additional numerical information on activities. This is an area we feel we would like to develop further in 15/16
4. Continue to build and maximise our resources in the community (co-production; asset).	We have increased activity in this by recruiting p/t support officers for each of the forums. This has resulted in an increase in activities within communities including 'big and wee blethers', new recovery cafes, community profiling etc. Our services are working in a more collaborative way and we have now identified money to have single points of access for easy entry into services or for advice. The forums continue to fund community projects that will benefit those in recovery in the community. An example of this was funding a church to upgrade their kitchen and bathroom facilities. This has led to them looking to start a recovery group as well as offer health eating/ cooking on a budget type courses.
5. Workforce Development	Due to changes in staff we have been unable to move this on as quickly as we hoped. However there have been a number of

	joint training events including Waiting Times events, Family Inclusive Practices, Universal Credit awareness. This is still a priority area for Aberdeenshire ADP and the appointment of a new member of staff starting this month (September 2015) will allow a consistent focus on this area and further development of actions from the working group mentioned in 2. above.

ADP Priorities in 2015/16

Please list your ADP's five key commitments for 2015/16 following this self-assessment.

1. Developing and implementing a Commissioning and Performance strategy which includes further evaluation on most appropriate spend whilst ensuring value for money.

2. Workforce Development - Mapping of learning opportunities offered across agencies and to volunteers so resources can be shared, analysis of existing skills and knowledge completed, that will inform the development of a workforce development strategy.

3. Increase impact and access to services able to increase peoples recovery capital, e.g. Employability and Housing.

4. Full implementation of a common Recovery Outcome Tool.

5. Achieve a further increase in proportion of ADP spend on prevention activities.

Ministerial Priorities

ADP funding allocation letters 2015-16 outlined a range of Ministerial priorities and asks ADPs to describe in this ADP Report their local Improvement goals and measures for delivering these during 2015/16. Please outline these below.

- **Implementing improvement methodology at local level, including implementation of the *Quality Principles*: *Standard Expectations of Care and Support in Drug and Alcohol Services* and responding to the recommendations outlined in the independent expert group on opioid replacement therapies**;

We have started monitoring of the implementation of Quality Principles and these are all included within our funding agreements/ contracts. Aberdeenshire ADP has also conducted a survey with Service Users based on the Quality Principles. This will be published and, although initial information looks positive, any actions from this will be taken forward in 2015/16. Quality Principles will be embedded in all our work and will be reviewed at our Service Delivery Group on a regular basis.

NHS Grampian's Opiate Replacement Therapy Accountable Officer has clinical sessions in Aberdeenshire. Meetings are held regularly with the NHS Grampian Controlled Drug Team to collect health intelligence regarding the use of Opiate Replacement Therapy in Grampian. One of our third sector organisations is starting up a Self Care / Support group. This will be reviewed this year and rolled out to other areas as required.

- **Ensuring a proactive and planned approach to responding to the needs of prisoners affected by problem drug and alcohol use and their associated through care arrangements**;

HMP Grampian has a strategic group which looks at a wide range of issues relating to prisoners affected by drugs and/or alcohol and the treatment/support on offer. Staff within the prison have been trained on ABI and other relevant information to enable meaningful interactions with prisoners to identify addiction issues and to ensure support is provided.
Harm Reduction/Naloxone can prove "political" in the prison environment. It has proved difficult of late to gain assistance of SPS to facilitate group training for Take Home Naloxone. This has been raised with SPS for action. This is likely to involve SPS staff who have expressed an interest, being trained as trainers along with more health care staff. In the meantime, training is being delivered to individuals as often as can be arranged and we will continue to monitor and support. Peer training will also be considered but so far, suitable candidates for this have not been identified. This should prove more positive with the prison reaching its full capacity.
Following discussions with SMS leads a wider range of services the following have been identified as being crucial to further development of the customer journey for prisoners with a drug or alcohol issue:

- Increase Primary Care nurse team to allow dedicated SM nurses.
- Work with SPS to make best use of time available to see patients.

- Introduce group sessions and conversation cafes/drop in clinics.
- Better communication with other agencies. Address recidivism – consistency in treatment within prison and community.
- Continue to improve on taking advantage of the “Captive Audience”.

- **Compliance with the Drug and Alcohol Treatment Waiting Times Local Delivery Plan (LDP) Standard, including, increasing the level of fully identifiable records submitted to the Drug and Alcohol Treatment Waiting Times Database (DATWTD);**

Aberdeenshire will continue to focus on this performance and are identifying additional resource to help increase performance and accurate recording. Whilst we have improved performance substantially in the last few months we are not complacent about this and realise that quite extensive monitoring and support is required, especially as we have a large number of services. During this year we will also review who is recording on DAWTD to ensure we have correct monitoring in line with our ROSC. Likewise we are making headway with reducing the numbers of anonymous recording and we are working with a couple of organisations to ensure we have an effective process that adheres to data protection regulations.

- **Preparing local systems to comply with the new Drug & Alcohol Information System (DAISy) which is expected to be operational by Autumn 2016;**

We are currently reviewing our recording systems and would like to have a case management system that ties in nicely with DAISY which is why we have delayed some actions around our choice of recovery outcome tool. Our Intention is to speak with Ayrshire and Arran to see if this is something that is possible. We would welcome Central Government support on this.

- **Compliance with the Alcohol Brief Interventions (ABIs) Local Delivery Plan (LDP) Standard**;

Aberdeenshire recognise that there is an issue in regards to a reduction in ABIs being recorded in GPs. We will look at identifying any recording issues and provide support and training to support improvements in activity. We will continue to promote delivery in wider settings and provide the support and training to do so.

- **On-going implementing of a Whole Population Approach for alcohol recognising harder to reach groups, supporting a focus on communities where deprivation is greatest**

As our Single points of Access develop we aim to have these within easy reach of our areas of highest deprivation. We will discuss with our wider partnerships about co locating some of these services e.g. there is a shop front service in Fraserburgh called Here to Help which offers a wide range of services and we would look to have a regular presence here. Marketing material and community engagement also will be an important area of focus to ensure that appropriate messages are disseminated as widely as possible. We will continue to support self help groups and recovery cafes and review good practice from these. The three licensing forums in this area will receive our information to help inform on alcohol issues within the areas.

- **ADP engagement in improvements to reduce alcohol related deaths**.

We are looking to use SPARRA data to help those identified most at risk reach the support available. Discussions will be taking place with GP practices to promote the contacting of these patients and making sure they are aware and can access the support available. Aberdeenshire ADP have identified we have little capacity for alcohol home/ community detox and plan to train a number of other staff to enable this to be readily available. A review will be undertaken to identify and address capacity issues ensuring support is available to service users to ensure all get best results.
NHS Grampian has provided resources to take an in depth look at Alcohol related deaths and what should be recorded or count as such. This will be looked at and there is the potential for this subject to be joined with the Drug Related Death group in Aberdeenshire.

- **Increasing compliance with the Scottish Drugs Misuse Database (SDMD), both SMR25a and b**;

Training will be delivered on this to all our services, as we did with Waiting Times. Compliance with this is part of our funding agreements with services. We recognise, as we continue to redesign our services, that there is a need to keep on top of this and this will again be covered in training.

- **Increasing the reach and coverage of the national naloxone programme and tackling drug related death(DRD)/risks in your local ADP;**

Please find below a summary of naloxone data to end Q1 2015-2016. Percentages quoted are of the national prevalence data 2009/10 which is still used nationally by ISD for naloxone figures. Having already met this year's national target the recommended local/stretch target for ADPs is 30% of people at risk have received a 1st supply.

Aberdeenshire ADP

1st supply person at risk = 70
1st supply service worker = 16
Resupply person at risk - used = 3
Resupply person at risk - not used = 6
Total in Q1 = 95

Total supplies to date = 469 (34%)
Total 1st supplies to date = 331 (24%)
Total kits used to date = 32

The ADP Drug Related Death Group will identify those in the area that have died of drug related causes (including from New Psychoactive Substances). These deaths will be investigated in a multi- disciplinary forum to identify learning aimed at preventing future deaths. This work will be built on information gathered since 2005 to identify and monitor trends. Information on non-fatal overdose will be included in the monitoring to identify risk taking that has not resulted in death. Information and insights from this group will be used by services to influence prevention and treatment interventions.

- **Improving identification of, and preventative activities focused on, new psychoactive substances (NPS).**

We intend to continue to conduct quarterly NPS 'RAG' assessments via survey monkey to keep up to date with emerging NPS use trends sufficient to inform community interventions and workforce development plans. We have been developing revised NPS marketing material for users, parents and services and plan to have published and distributed these by the end of the year. Our mobile school substance misuse classroom service ALEC will have updated their syllabus to include NPS within their p7-s2 offerings. We plan to repeat our public information meetings about NPS in other areas of Aberdeenshire in conjunction with local community safety groups. We will ensure the NEPTUNE clinical guidelines for acute care of NPS intoxicated patients are rolled out within our acute services. We will develop an agreed plan to minimise the availability of NPS in Aberdeenshire using the COSLAs recently launched NPS Guidance for Trading Standards Services in Scotland. Our Trading Standards service will implement an NPS operation under the General Product Safety Regulations.

APPENDIX 1: NOTES

1. Please **complete the RAG column** for each theme according to the following definitions:

ADPs should assess themselves against their three-year Delivery Plans.

RED	Not yet started or being considered for the future
AMBER	Work in progress but not yet completed or still some development needed
GREEN	Work either completed or a pattern of work fully established to the ADP

specification and now an on-going piece of work which includes further enhancements.

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). It is recognised that grey literature is issued in-between specific Commissioned Strategic assessments such as prevalence and ADPs will wish to factor this into their on-going planning.

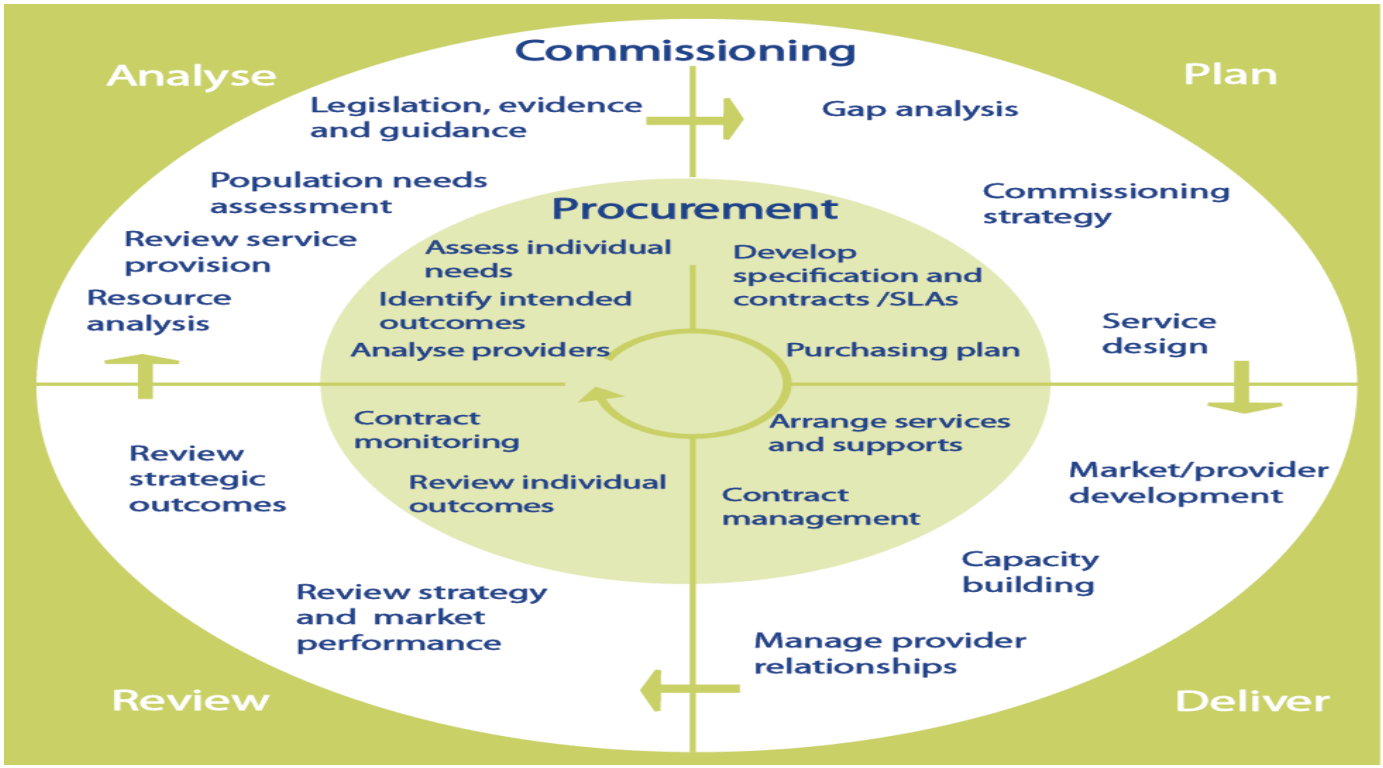
4. **Joint Performance Framework**: a national assessment process on how effectively local partnerships are achieving these improvements. (http://www.sehd.scot.nhs.uk/publications/cc2004_02.pdf)

5. **Integrated Resource Framework**: An Integrated Resource Framework is: Patient level data to explore service use and then evaluate pathways over time for people with problem alcohol or drug use, data for all hospital based services and GP prescribing have been linked by NHS ISD for everyone in Scotland for 4 years. Data has always been available at patient level from ISD but the activity data has also been costed using patient level costing, allocating fixed and variable costs by speciality and location across Scotland.

The Integrated Resource Framework was 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 for different population groups, enabling better local understanding of costs, activity and variation across service planning and provision for different population groups, 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/)

By providing Health Boards and their Local Authority partners with the information required to plan strategically and review services more effectively, and by developing financial relationships that integrate resources around populations instead of organizations', partners are able to realign their resources to support shifts in clinical/care activity within and across health and social care systems.

6**.** **Please indicate in your evidence if you have received feedback on this report from your Community Planning Partnership/Integrated Joint Board 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. **The [Alcohol and Drug Workforce Statement]** is addressed to anyone who has a role in improving outcomes for an individual, families or communities experiencing problematic drug and alcohol use.

8. A full range of **essential care Services** include identifiable community rehabilitation services – including using people with lived experience; access to detoxification and residential rehabilitation; access to a full range of psychological and psychiatric services; services addressing employability and accommodation issues. http://www.scotland.gov.uk/Resource/Doc/217018/0058174.pdf)

9. **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

10. **The Quality Principles**: Standard Expectations of Care and Support in Drug and Alcohol Services can be found at http://www.gov.scot/Publications/2014/08/1726 N.B. We plan to work with the Care Inspectorate over the next 18 months to validate ADPs and services' self-assessment against The Quality Principles. We expect fieldwork to begin in the later part of this calendar year and we will work with ADPs to assess their readiness to be involved at either the start, middle or end of the rolling programme. It is expected that a steering group (involving ADP reps and others) will oversee/ guide the work of the programme. The focus of the project is very much on improvement support as opposed to formal inspection and each ADP will receive an individualised briefing summary of the CI's findings (areas of strength in relation to the Quality Principles and opportunities for improvement). A national report will also be produced but this will be anonymous and not feature any ADP-identifiable data.

11. **The Independent Expert Review of Opioid Replacement Therapies in Scotland** 'Delivering Recovery' can be found at http://www.gov.scot/Publications/2013/08/9760/downloads

We are looking to improve this self-assessment for ADPs on a regular basis. Please describe briefly whether you found the questions asked to be useful in considering your current position.

Without sounding negative we found;

1. Some of the questions were quite repetitive and could be found in Delivery Plans etc. SG must distinguish the role of delivery plans and annual reports.
2. Numbers of questions could be reduced or some amalgamated
3. The form is already dated by the time we have it as you are asking us to report on information we may not have kept with easy access to e.g. ARBD Cases etc
4. The report format is only really of use to Scottish Government. It isn't in a format that we can readily use with CPPs and is not public friendly.

What we would like to see is

5. Simplified reporting e.g. 3 year Delivery Plan and strategy and annual reporting by exception and on last year's identified key priorities and on the ministerial Outcomes for funding.
6. We would welcome being challenged. Where specifically does SG think we are underperforming and what should we do differently.

7. Somewhere to record good news stories, good practice, something everyone is proud of, and perhaps an area where we would like help, other good practices, etc.