North Ayrshire
Alcohol & Drug Partnership

Strategy for 2015 to 2018

"Preventing harm, promoting recovery"

CONTENTS **PAGE**

Foreword

North Ayrshire is a great place to live and the majority of its residents take advantage of the many opportunities offered and enjoy the benefits of living in the area. There are, however, a significant number of residents that are less able to enjoy those benefits because of the negative impact of substance misuse.

North Ayrshire Alcohol and Drug Partnership (ADP) is committed to improving outcomes for people, families and communities blighted by substance misuse. The ADP operates within the Health and Social Care Partnership and overarching Community Planning Partnership and its vision is "Preventing harm, Promoting recovery". Those four words neatly summarise the partnership's key focus and it is working hard to reduce the risks posed by substance misuse and promote the recovery of those who have fallen prey to misuse and addiction issues.

Society's understanding of the harm caused by drugs and alcohol is improving and recent, encouraging evidence suggests that young people are becoming less likely to misuse drugs and alcohol. This is good news, but we cannot underestimate the scale of the challenge that remains in changing a long-established culture of indifference to or tolerance of the risks caused by substance misuse.

The ADP is a commissioning body, which means that it provides funding for a variety of organisations, to deliver a range of services and activities that will help to achieve its vision. It is important that these services are well designed and high quality, to ensure maximum impact, but the ADP is acutely aware that services can only do so much; prevention and recovery are much more effective when they are based on the support and engagement of families, friends and communities and the ADP is committed to helping that wider support network too.

I am delighted to introduce the ADP's strategy for 2015-2018. I look forward to working hard, with individuals, communities and service providers, to ensure that we do our very best to prevent harm and promote recovery in North Ayrshire.

Tim Ross
Chair of North Ayrshire ADP

SECTION 1: INTRODUCTION

1.1 This is the Strategy produced by the North Ayrshire Alcohol & Drug Partnership (ADP), to ensure future policies and services will best meet the continuing **ADP Vision**, of

"Preventing harm, Promoting recovery"

The strategy is purposefully brief, with additional information set out in appendices. The operational detail on delivering the strategy will be separately set out in action plans, for continuing and future services and other ADP activities.

1.2 The ADP was established in 2009, bringing together key agencies and stakeholders to oversee policies and services specific to tackling problems arising from alcohol and drug misuse. Since then there have been several significant changes to the structure and governance of public services across Scotland, as well as policy and practice developments. The ADP now reports to the newly formed North Ayrshire Health & Social Care Partnership (HSCP), which in turn reports to the North Ayrshire Community Planning Partnership (CPP). Appendix 1 sets out the current terms of reference for the ADP and the ADP sub-group structure.

1.3 Set within this fluid and complex organisational landscape, the ADP requires taking account of many priorities and requirements set by higher level bodies, including the Scottish Government, the CPP and HSCP. It is also charged with considering priorities set by neighbouring ADPs in East and South Ayrshire. Appendix 2 sets out fundamental policy themes and priorities amongst such bodies, and the extent and range of these illustrate the challenge of addressing them all. However, common themes and characteristics are reflected in the following guiding principles for our strategy for alcohol and drug services and issues.

ADP GUIDING PRINCIPLES

i. We will move ADP funded services towards **prevention** and will act on the principle of investing any new or released resources in preventative or **earlier intervention** services. At the same time, we will ensure treatment services remain effective, efficient and specifically focused on **recovery and avoidance of relapse**, to best meet the needs of people with longer term and complex needs.

ii. We will pro-actively address how service users and those important to them are involved and empowered in service development and delivery, and how **inequalities are reduced**.

iii. We will strive to fund path-finding and **innovative** services, where ADP funding will be time limited, and services that demonstrate

their value will be commended to other service programmes for their improved impact.

iv. Over the lifetime of the strategy, we will **review** ADP funding and **monitor** all funded services to ensure that service delivery remains relevant, appropriate and of high quality.

v. We will also **engage** and work with communities and a wider set of partners and stakeholders, to strengthen our capacity to advise and influence services not directed specifically at alcohol and drug issues, but where their operation does impact on those affected by such issues.

1.4 This approach will allow continuity from the previous ADP Strategy (2011-15), and its four Key Priority Areas for Action, i.e. Prevention; Protection; Recovery; and Communities.

1.5 This is a three year strategy and the ADP will review the strategy regularly and amend it as required to take account of changing circumstances. The present sub-group structure of the ADP will be assessed to ensure it continues to support our task as effectively as possible.

SECTION 2: CURRENT SERVICE ARRANGEMENTS

2.1 Before we set out the development of our commissioning strategy that will move us forward, it is important we understand our starting point.

2.2 From 1st April 2015, the two, pre-existing statutory service providers (NHS Addiction Services and North Ayrshire Council Social Services Addiction Team), merged as part of the new North Ayrshire Health & Social Care Partnership, and became a single, Integrated Addiction Service.

2.3 The NHS element of the Addiction Service delivers;

- a range of mental, physical and sexual health-related clinical interventions
- detoxification support at home and access to hospital-based admission
- access to Occupational Therapy support
- access to the prescribing of Opiate Replacement Therapy (ORT) medication with associated support
- the delivery of injecting equipment provision and needle exchanges
- blood borne virus related support
- Prevention and Service Support Team

2.4 NHS Addiction Services also manage a 12-bed residential facility in Ailsa Hospital for individuals across Ayrshire and Arran assessed as requiring such hospital based support. The NHS Prevention and Service Support Team delivers training, education and prevention activities, and supports service development and information collection and reporting.

2.5 The Council's Social Services part of the Addiction Team provides psychosocial interventions and a range of specialist group work programmes, such as creative art group, women's group, parenting group, activity programme, allotment project, and relapse and anxiety management.

2.6 Within the complementary nature of provision and function there are also unique and exclusive service components, designed to ensure that services both meet statutory duties in terms of child and adult protection functions and provide responsive assessments to risk and need.

2.7 Core interventions are informed by evidence, with a specific focus on recovery: support is person centred, with referral to partners for wider social support. These services work in conjunction with independent partners – mainly The Richmond Fellowship and Momentum, who provide complementary commissioned provision – to support people's ongoing recovery journey.

2.8 The range of drug and alcohol services provided can be described using a 'four-tiered model', which categorises services as described in Table 1

below.

Table 1: Four tiered model of service delivery

Tier	Description	Funding allocation (£)	% of total allocation
1	Interventions available within broader community settings such as education; training; welfare rights; housing; meaningful activities; and employability services **Examples:** ➢ 3TFM Community Radio, working with people in recovery in order to promote recovery activity and challenging perceptions ➢ NHS Prevention & Service Support Team providing a diverse range of training to the wider workforce ➢ 'Jump2It' basketball initiative within primary schools which promotes healthy living, increasing awareness of the impact of smoking and addictions ➢ UK SMART Recovery, delivering peer support groups within the community ➢ Multi Agency Problem Solving Group - community initiatives supporting and empowering community engagement, including the provision of diversionary activity for young people ➢ Café Solace – a community café managed and operated by people in recovery, which provides volunteering opportunities ➢ FITba4U- multi partnership initiative involving addiction, housing and credit union through delivering a weekly programme of football and educational initiatives	209065	13
2	Local services including harm reduction team and local counselling services **Examples:** ➢ Momentum and Richmond Fellowships service delivery that supports earlier engagement and through-care support from mainstream addiction services ➢ NHS Alcohol Liaison Service delivered within Crosshouse and Ayr Hospitals - supporting people and signposting to community services ➢ NHS Specialist Midwife (Alcohol) providing support to maternity staff and the vulnerable midwife team, and delivery of training incorporating foetal alcohol spectrum disorder	460409	27

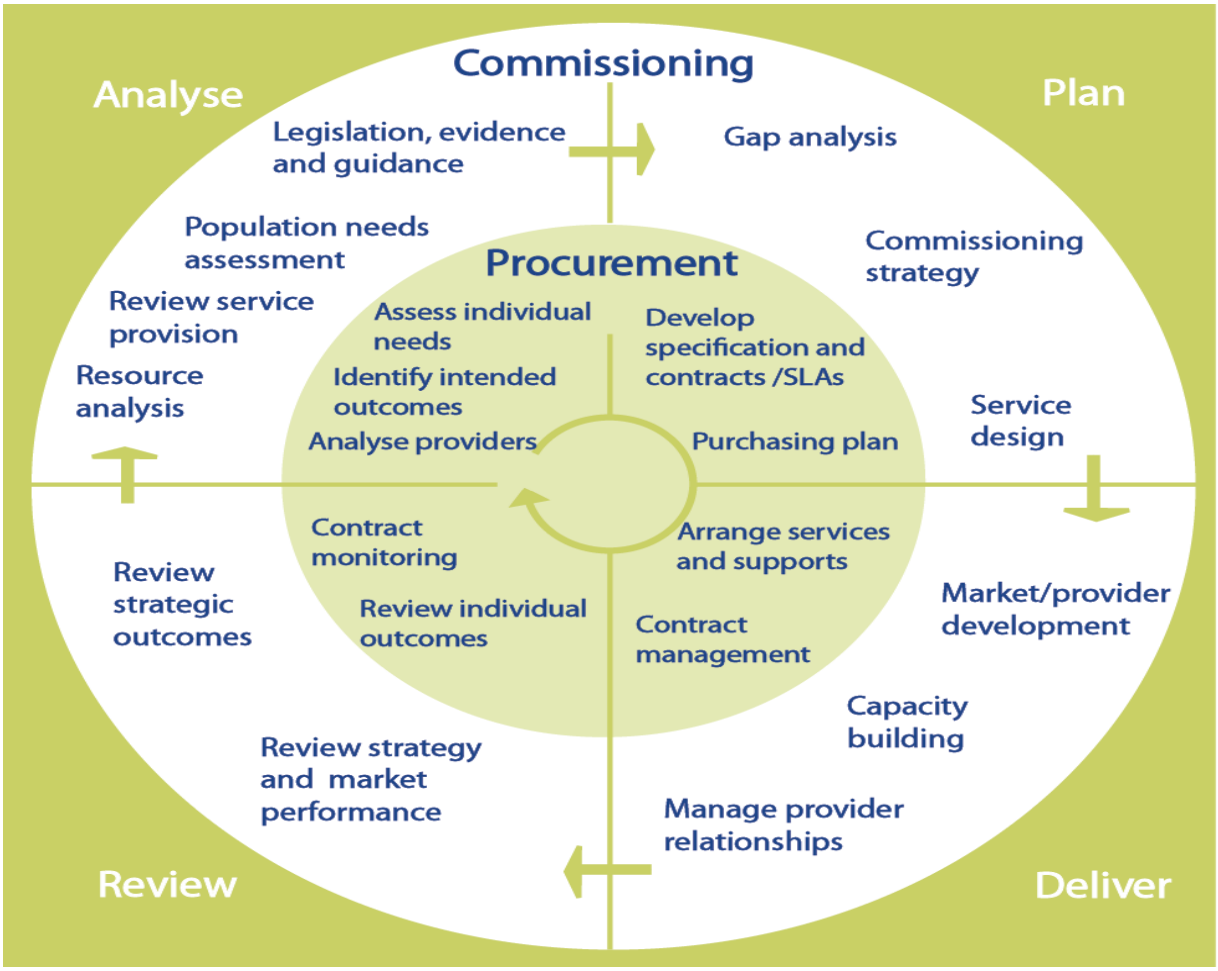
Tier	Description	Funding allocation (£)	% of total allocation
3	Specialist alcohol and drug support services **Examples:** ➢ NHS & NAC Addiction Services - integrated addiction service supporting the more complex client group with medication and psycho-social interventions. Part of the service delivery includes the Methadone Cessation programme, offering more intensive support in order to reduce medication; as well as Arts and Creative Writing Group	985175	58
4	In-patient/residential **Examples:** ➢ NHS Kyle Addiction Unit - providing intensive support within a residential setting, based within Ailsa Hospital	36290	2
Total		**1637384**	**100**

2.9 The full list of ADP funded services is set out at appendix 3. All services are (and will remain) charged with maximising their contribution to the delivery of this strategy, in terms of both what they do and how they do it.

SECTION 3: STRATEGIC COMMISSIONING

3.1 In developing our strategy and delivering it at an operational level, we will ensure a fit with other HSCP strategic and operational developments, as well as with the wider set of local and national priorities. With this in mind, we are setting out the ADP strategy using the Joint Strategic Commissioning Cycle as set out below.

Figure 1: Joint Strategic Commissioning Cycle



3.2 This model was first developed by the Institute for Public Care and subsequently adopted and developed by the Joint Improvement Team (JIT) in the Scottish Government.

3.3 Within this context, the JIT defines Joint Strategic Commissioning as; *"the term used for all the activities involved in assessing and forecasting needs, linking investment to agreed desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place"*

3.4 JIT guidance to HSCPs reiterated that strategic plans; "should focus upon delivering improved outcomes for users and carers through better

aligning investment with what the evidence tells us about the needs of people in local communities, currently available services and supports and what works in delivering better outcomes"

3.5 It is a cyclical process to ensure strategic planning is recognised and delivered as a dynamic activity. As such, it has no defined starting point but, for the purposes of this plan, we will start at the **Review** quadrant.

SECTION 4: REVIEW

4.1 In the **'Review'** quadrant of the commissioning cycle there are two commissioning activities (i.e. 'review of strategy and market performance', and 'review of strategic outcomes') and two supporting processes ('review of individual outcomes', and 'contract monitoring') identified in the inner procurement cycle.

4.2 Services will be delivered in line with our existing strategic priorities and target outcomes and the seven core outcomes for ADPs set by the Scottish Government (see appendix 2), with the added emphasis as set out in our **Guiding Principles**.

4.3 We will support the CPP emphasis on a 'Neighbourhood Approach' to service design and delivery, and will ensure this is reflected in our progress, and we commit to meeting our HEAT Alcohol Brief Interventions (ABI) and 'Access to Treatment' standards, and Ministerial Priorities

4.4 It is important to celebrate and acknowledge the progress made against the seven core outcomes since 2011, and the improved starting point this gives us for future action plans to take this new strategy forward.

a. As examples we might highlight the extensive achievements already on the theme of service user engagement and empowerment, including the creation and development of the Recovery at Work Committee, SMART groups, and Café Solace. The ADP sub-structure also now includes a Workforce Development group and a Practitioner's Forum.
b. On the recovery theme we have increased cross-disciplinary engagement amongst partners, and have introduced a new Recovery Capital Questionnaire (RCQ), which is an assets based approach that is being rolled out across all services. The RCQ is helping to ensure that recovery is placed at the heart of treatment and support services, and is a Recovery Oriented System of Care (ROSC)
    i. offers a comprehensive menu of person centred options;
    ii. is strengths based;
    iii. supports people to live as well as possible in the presence or absence of challenges;

iv. focuses on well-being and quality of life over morbidity and deficits;
v. includes peer recovery support;
vi. includes families and friends and other recovery allies;
vii. has an unwavering belief that positive change is possible for all; and
viii. achieves desired outcomes through collaborative, effective and high quality service provision and partnership.

c. We have funded a Methadone cessation pilot which has been assessed very positively for wider application.
d. In relation to our protection priority we have established closer working links between the ADP and the Child Protection Committee, to jointly develop Getting Our Priorities Right Practitioner Guidance, and systems to support the use of that guidance.
e. On a broader front, we have revised our website and other literature to raise and improve our profile across North Ayrshire communities and to reflect a whole population approach. There has of course been other worthwhile work done, but the above examples illustrate the breadth of progress already across our range of priorities, which we intend to expand and widen.

4.4 The relative dearth of tendering over the course of the last strategy period precludes any meaningful analysis of market performance in terms of the efficiency of the market in responding to new demand. However we will work to ensure improved capacity, within the lifetime of this strategy, to analyse market performance and intervene where potential market failure threatens progress.

4.5 Notwithstanding issues raised elsewhere in this strategy regarding the need for better data on impacts from existing services, we have not stood still on service development and improvement where evidenced need and opportunity presents. For example, following work with the Scottish Drugs Forum (SDF) where it undertook an independent review of ADP funded services involving contact with around 100 service users, we designed and tendered a new service to enhance local capacity on a recovery focus. Further work with the SDF involved female peer research to understand barriers to women engaging with services. We also commissioned STRADA to deliver a programme of workforce development to children & adult service practitioners, and we undertook work with Alcohol Focus Scotland to roll out the RORY resource in primary schools, and to pilot further work around this.

4.6 The ADP had previously identified issues in this review area of the commissioning cycle which were mostly linked to the further development and operation of a contract monitoring system. That system is now largely in place though, whilst we hold data on service performance against service specifications, which now reflect the seven core outcomes, this remains largely based on self-evaluation by services. There remains a need both to extend the monitoring of services against contract service specifications to include greater external

scrutiny, and to develop systems to review strategic impact as well as contractual performance.

4.7 Further work is also required to provide a clear picture on personal outcomes for service users, linked to clearly drawn and adequately scoped personal plans. The external scrutiny process will require sampling these as part of routine future monitoring.

4.8 As such, we will either enhance and support the contract monitoring system, or establish a system linked to the contract monitoring process to better assess the impact of services.

4.9 The model of grouping services into tiers for analytical and planning purposes (described in paragraph 2.7) is a useful device. These tiers can be illustrated using a pyramid structure, with tier one at the bottom comprising universal services available and/or delivered to the whole population, with tier four at the apex representing highly specialised services required and consumed by only a very small proportion of the population. Tiers two and three relate to services which are increasingly focussed, specialist and selective in targeting users. Within our alcohol & drug context: tier 1 would include interventions available within broader community settings, such as education, training, welfare rights, housing, meaningful activities and employability services; tier 2 would include local services such as the harm reduction team and local counselling services; tier 3 would be specialist alcohol and drug services; tier 4 would be in-patient or residential services.

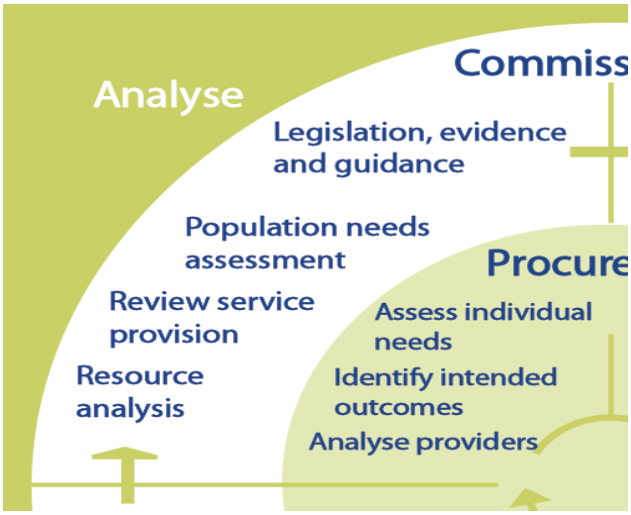
4.10 Our current pattern of services and expenditure is set out within point 2.7 and appendix 3, and this pattern is principally the result of historical service developments. This shows our pattern of spend across these four tiers in 2014-15 as:

- 13% at tier 1,
- 27% at tier 2,
- 58% at tier 3, and
- 2% at tier 4.

4.11 In principle, given our strategic emphasis established in our introduction, we should be aiming to continue to concentrate ADP funding at tiers 2 and 3, with an emphasis on prevention. We recognise the need to consider the pattern of ADP spend across the tiers within the lifetime of this strategy.

SECTION 5: ANALYSE

5.1 In the **'Analyse'** quadrant of the commissioning cycle there are four commissioning activities (resource analysis, review service provision, population needs assessment, and legislation evidence and guidance) and three supporting processes (analyse providers, identify intended outcomes, and assess individual needs) identified in the inner procurement cycle.



5.2 The financial resources of the ADP directed through this strategy amount to £1.6m. This money comes from the Scottish Government and funding for 2015/16 has been maintained at the previous years level. The services and activities currently funded from this ADP budget are listed at appendix 3.

5.3 Beyond this ADP controlled funding there is wider expenditure on services and activities by various partners that impact on alcohol and drug issues within peoples' lives and communities. Whilst this strategy limits commissioning considerations to the ADP budget, we are conscious of the importance to the integration agenda of better understanding the links between services we commission directly and the wider set of activities across public/voluntary/private sectors with an alcohol and drug focus or dimension. We will work with partners, and within the HSCP, to develop synergistic influence on this wider set of resources, to advance our objectives and vision. We will also seek opportunities to use ADP resources, either to draw in matched funding, or as a means to direct other resources to our objectives.

5.4 The process of reviewing service provision has been significantly better informed through the roll-out of the contract monitoring system, developed and delivered by North Ayrshire Council and funded by the ADP. This provides a baseline of performance by services against their contract service specification or service level agreement (SLA), which themselves are now couched with reference to our seven core outcomes. It is acknowledged that further work remains to be done on developing the monitoring of performance beyond self-assessment, and on developing a system for assessing and comparing continuing strategic relevance and impact, with cross referencing between our core objectives and individual outcomes achieved from personal planning for service users. We will ensure early progress on this further work on performance and impact, recognising that its absence inhibits fuller practical achievements on the tasks within the planning quadrant of the

commissioning cycle.

5.5 We are fortunate in having had a temporary additional resource to develop work on population needs assessment, which resulted in a report in December 2014, “A Needs Assessment for Alcohol and Drugs Services for Adults in North Ayrshire (2014)”. This report contains a wealth of data on deprivation levels in the area, as well as alcohol and drug specific data, and a link to the report is provided at appendix 4 for those interested in further detail.

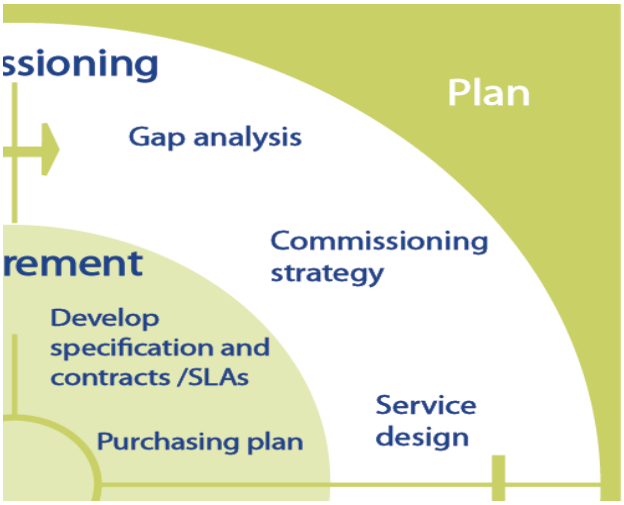
5.6 Generally, North Ayrshire records high levels of deprivation compared to Scottish averages across a range of indicators. Whilst this includes concerning figures around alcohol and drug measures, the picture is not widely inconsistent with other areas of Scotland with similar socio-economic profiles. However there are issues, for example around hospital admissions, levels of assault, young peoples' alcohol and drug use, and child protection, where North Ayrshire communities appear especially affected: we will use data on local needs to guide our work on gap analysis, in particular once our work on performance and impact is progressed.

5.7 Legislation, evidence, and guidance that requires or merits consideration in service development, delivery, and review, is a constantly evolving state of affairs. For further information and reference, key documents and sources are set out at appendix 4. We will ensure that the ADP and its sub-groups are fully informed of further changes in this area, so they might take proper account of these in their operational activities. At a strategic level we are confident that our current core objectives and programmes of implementation do not conflict with any of the current set of legislation or guidance, and that the developing programme of service impact review and gap analysis, and consequent commissioning of revised services, will be evidence based.

5.8 We will continue joint work with procurement and contract monitoring staff, to strengthen our information base on providers within this market and to identify any actions needed around development or diversification. We will work amongst partners to ensure care/treatment plans for service users properly set out personal outcomes that are matched to ADP core outcomes and wider social and health policy agenda.

SECTION 6: PLAN

6.1 In the **'Plan'** quadrant of the commissioning cycle there are three commissioning activities (gap analysis, commissioning strategy, and service design) and two supporting processes (develop service specifications and contracts/SLAs, and purchasing plan) identified in the inner procurement cycle.



6.2 As already set out, further work is needed to provide the standard and level of data on the impact of present services on strategic objectives that is needed to reliably inform our understanding of where gaps exist between current service provision, and a modified set of services and activities that might better serve our priorities. However we do know that the intention to focus more keenly than before on our guiding principles will require amended approaches to service design, management, and delivery; both for present services continuing into the future as well as for new services being developed.

6.3 It is also clear that emerging drug trends, including the increased availability and use of new psychoactive substances (NPS), present new challenges, and we will address these in planning our service developments.

6.4 We will feed data on the strategic impact of services and service proposals into a comparative appraisal system, that will inform decisions on what pattern and level of services will best deliver our priorities in future. This, in turn, will form our forward commissioning strategy/plan and determine specific service designs and specifications. This system is partly developed, based on a Programme Budgeting and Marginal Analysis (PBMA) approach, and will be completed and calibrated as the data becomes available.

6.5 We will assess existing and proposed services on their likely impact against our seven core outcomes, and on the degree to which they will operate in ways that support our guiding principles, all within the context of their resource requirement and likely ease of implementation. Future resources will be directed accordingly.

6.6 We will undertake parallel activity on the inner procurement cycle jointly with colleagues directly involved in service delivery across all sectors, with contract monitoring and procurement colleagues, and with provider and service user representatives, to ensure the most suitable service specifications are applied to support our service development, and that

purchasing systems and decisions are effective in matching service provision to those who will benefit most.

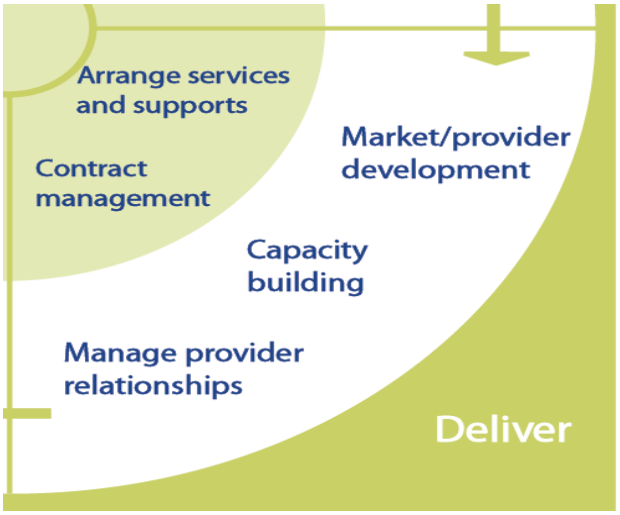
6.7 We will ensure that the National Quality Principles set out by the Scottish Government for ADPs in 2014, establishing basic standards of care and expectations of service delivery, are embedded in service design and reconfiguration.

6.8 We will similarly embed into service design and reconfiguration, evidence emerging that indicates how services might be improved, whether from local research, or from elsewhere if judged transferable to local circumstance. Examples of this kind of evidence include:

- The peer research referred to at paragraph 4.10 above, which will inform action to reduce barriers faced specifically by women, but also addressing equality issues for other service users, in relation to service access, delivery, and engagement, to ensure an improved service user experience alongside more recovery oriented outcomes.
- Work being undertaken to assess and improve the experience of children and young people in North Ayrshire. We will work closely with relevant stakeholders to ensure that future ADP commissioned services complement the strategy being developed to address the early initiation of substance misuse.
- Continued collaborative work with the Adult Protection Committee, to improve the identification and understanding of adults at risk of harm, and enhance the protective factors that can be put in place to mitigate that risk.

SECTION 7: DELIVER

7.1 In the **'Deliver'** quadrant of the commissioning cycle there are three commissioning activities (market/provider development, capacity building, and manage provider relationships) and two supporting processes (arrange services and supports, and contract management) identified in the inner procurement cycle.



7.2 At this stage of our commissioning development we cannot be clear what level or form of intervention may be required to develop the market for services that we will want in future. However, we will require those involved in service provision under this strategy to demonstrate how and to what extent their activities and methods deliver against not only their service specifications, but more widely against our guiding principles and seven core outcomes. They will also need to demonstrate their ability to develop a plan to extend their own capacity and improve performance, including on a joint working basis with other stakeholders.

7.3 Their performance in this regard will form an element of future appraisal, and feed into the next round of strategic review, alongside existing systems for contract management, contract/service monitoring, and individual outcome analysis.

SECTION 8: CONCLUSION

8.1 The ADP has set out in this strategy its determination to achieve significant progress towards the **Vision** that **"Preventing harm, promoting recovery"**.

8.2 This **Vision** has evolved from our earlier 'Strategy for the Future'. We acknowledge that progress achieved by services over the last four years, under changing circumstances, puts us in a position to continue to take forward our vision over the next three years, and through the further changes and challenges that will be presented.

8.3 We will achieve this further progress on our **Vision** by ensuring a mix of services, actions, and influence, which are individually focussed on one or more of the seven national Core Outcomes for ADPs, which we wholeheartedly support and adopt, and which collectively address all of them.

8.4 This approach will be augmented by our **Guiding Principles** for the duration of this strategy, which can be summarised as:

- We will move ADP funded services towards **prevention** and **earlier intervention**. We will ensure treatment services remain effective, efficient and specifically focused on **recovery and avoidance of relapse**.

- We will pro-actively address how service users and those important to them are involved and empowered in service development and delivery, and how **inequalities are reduced**.

- We will strive to fund path-finding and **innovative** services.

- Over the lifetime of the strategy, we will **review** ADP funding and **monitor** all funded services.

- We will **engage** with communities and a wider set of partners and stakeholders, to strengthen our capacity to advise and influence.

8.5 We will continue to work with partners to make sure that our activity fits with the wider aspirations for our community and society, as set out in other plans and strategies listed at appendix 2. We will have particular regard to how ADP services and activity matches and supports the five strategic priorities set by the HSCP.

8.6 We believe that the quality of service delivery achieved by services is dependent on a mix of what they do and how they do it. We will maximise the quality of services, and the positive difference they make to service users and the community, by forging clear links between inputs and outcomes, for service users and our community, at every stage of service commissioning, though concept; design; specification; operation;

management; self-monitoring and review; and external scrutiny and appraisal.

8.7 Throughout the life of this strategy we will ensure existing services, as well as any service proposals, are subject to a scrutiny and appraisal process that we will design and implement within 3 months of adopting this strategy, so that their contributions to our strategic progress can be measured and compared. This will form the baseline for future commissioning decisions and activity.

8.8 In light of the above, whilst we see our strategy as relatively fixed, our actions to move forward our objectives through services and influences is far from fixed: it will be adapted as understanding of service impacts improves, and circumstances and priorities evolve.

8.9 Appendix 5 considers the 27 commitments made throughout this Strategy (as set out in italics using a 'we will' format) and summarises these into 3 groupings. Within the ADP, we will remit each grouping of commitments to a sub-group charged with moving these from a strategic commitment, through the action planning system, to realisation. We recognise that the 27 commitments reflect situations at different stages of development and delivery, and the responsible sub-groups will produce an action plan for each one, which will be used as the basis for regular updates on our progress on them. This process will be consistent with the HSCP's Performance Management Framework, and will be reported by us on a regularly updated basis, to allow ourselves and everyone else to chart success, and identify and tackle impediments to progress.

8.10 We welcome feedback from any source at any time that may assist us to move forward in improving services in North Ayrshire, or in undertaking other activities, that tackle alcohol and drug misuse and its harmful effects within our community.

Appendix 1 – ADP Terms of Reference & Reporting/Liaison Structure

NORTH AYRSHIRE ALCOHOL AND DRUG PARTNERSHIP - TERMS OF REFERENCE

1. Background

1.1 Alcohol and Drug Partnerships have existed in a number of forms since 1989. In 2007 the Scottish Executive published the Report of the Stock take of Alcohol and Drug Action Teams (ADATs) which outlined a number of strengths and weaknesses in current arrangements.

1.2 In 2008 Ministers invited members of the Scottish Advisory Committee on Drugs Misuse and Scottish Ministerial Advisory Committee on Alcohol Problems to sit on a joint Delivery Reform Group to look at the future of alcohol and drugs delivery arrangements.

1.3 The report of the Delivery Reform Group informed A New Framework for Local Partnerships on Alcohol and Drugs which was jointly launched by the Scottish Government, NHS and CoSLA in April 2009.

1.4 The Framework is based on the following principles:

- Continuing need for multi-agency partnerships at the local level
- Partnerships should be firmly based within existing structures
- Governance and accountability arrangements consistent with current arrangements

1.5 In June 2009 a paper was submitted to the Community Planning Partnership (CPP) Board for consideration outlining the proposals for reviewing and reforming the strategic alcohol and drugs partnership planning arrangements in North Ayrshire.

2. Purpose

2.1 The North Ayrshire Alcohol and Drug Partnership (ADP) will work to reduce the harmful effects of alcohol and drug misuse on service users, families and communities and deliver the key outcomes of the CPP Single Outcome Agreement.

3. Remit

3.1 The principle responsibilities of the ADP will be:

- The development and implementation of a comprehensive evidence-based alcohol and drugs strategy
- The development of an Action Plan and Outcomes Framework to monitor progress and outcomes of the strategy

- To evidence quality and recovery outcomes in the provision of care, treatment and recovery services
- To ensure the National Quality Standards and Recovery Principles are embedded within all ADP services
- To report on performance of the ADP to the CPP Board and/or (Community Health & Social Care Partnership?)
- To ensure good financial management
- To influence the SOA in relation to alcohol and drugs, and how these will be measured
- A clear assessment of local needs and circumstances, including both met and unmet needs
- An outline of the services provided and/or commissioned reflecting the local assessment of need
- A description of resources that each partner is directing to the pursuit of alcohol and drugs outcomes
- Workforce development planning which ensures the workforce is equipped to deliver the current and future service need
- An evidence based approach to the commissioning and delivery of services in order to achieve ADP national outcomes, and the national and local priorities
- Develop service user, carer, families and communities involvement as required within the ADP
- To deliver services that will contribute in achieving the ADP Key Aim Statement
- To ensure the Opiate Replacement Therapy recommendations are reflected within the Action Plan
- To reflect the Alcohol and Drug Quality Improvement Framework, summarised as
    - a decisive shift towards prevention;
    - greater integration of public services at a local level driven by better partnership, collaboration and effective local delivery;
    - greater investment in the people who deliver services through enhanced workforce development and effective leadership; and
    - a sharp focus on improving performance, through greater transparency and innovation.

4. Membership

4.1 The membership reflects the continuing need for a multi-agency partnership at a local level focused on alcohol and drug issues and is representative of the wide range of partners engaged in community planning.

North Ayrshire Health & Social Care Partnership	Community Care Children and Families, Criminal Justice Mental Health

North Ayrshire Council	Housing Education Economy and Communities
NHS Ayrshire and Arran	Public Health Department Primary Care
Justice	Police Scotland Community Justice Authority HMP Kilmarnock
Employability	Job Centre Plus Ayrshire College
Licensing	Licensing Board representative
Voluntary Sector	Third Sector Interface representative
Other partnership representatives	Scottish Fire and Rescue Service User Committee
ADP Support	Lead Officer
Co-opted representatives	NAC and NHS Finance Department NAC Contracts & Commissioning Drug Death Review Group Drug Trend Monitoring Group (when required)

4.2 When joining the ADP each member will be required to formally nominate a named representative to attend ADP meetings if the member is not available to attend.

4.3 Members and nominated representatives will be responsible for taking issues between the ADP and their organisations/forums for information and action.

4.4 All members and nominated representatives will be expected to contribute fully and openly in the operation of ADP arrangements including the local and area wide coordination arrangements whilst ensuring the partnership arrangements enable their organisation to meet their respective responsibilities.

4.5 Additional representatives may be co-opted on to the ADP as required. The appointment shall be agreed by the ADP Chairperson. Co-opted members have no voting rights.

4.6 Other organisations may be invited to join the ADP, as and when a need is identified to extend the membership, and with agreement of partnership members.

4.7 All members and nominated representatives should have a detailed understanding of the alcohol and drugs agenda, how this fits within their service and is of significant seniority to act and make decisions on behalf of their service.

5. Appointment of Chairperson

5.1 The ADP members will nominate a Chairperson and Vice Chairperson from its membership for a period of two years.

5.2 The Chairperson and Vice Chairperson will be eligible for re-appointment for two further periods of one/two years.

5.3 The Chairperson shall preside at ADP meetings and in their absence the Vice Chairperson shall preside. In the absence of both, the ADP shall appoint a Chairperson for that meeting only from its members.

5.4 The responsibilities of the Chairperson are:

- To decide on the agenda of ADP meetings
- To decide on matters of order, competency, relevance and conduct and keep meetings focussed on the agenda
- To ensure that a fair opportunity is given to all members of the ADP to express their views on any matter of business
- To represent the ADP at appropriate meetings and communicate with external organisations

6. Executive members

6.1 The Chairperson, Vice Chairperson and ADP Lead Officer and a representative from the Health and Social Care Partnership, if this is not represented by the Chairperson or Vice Chairperson, will comprise the Executive Members.

6.2 The Executive will be empowered to consult and make recommendations on behalf of the ADP where decisions are required before the next meeting. The Executive must report all such decisions to the ADP for ratification.

7. Meetings

7.1 Frequency of meetings
The ADP will meet no less than quarterly.
The Chairperson may at any time convene additional meetings.

7.2 Notice of Meeting
The agenda and papers of the ADP meetings will be sent electronically to members not less than five clear working days before the date of the meeting. From time to time this deadline may be relaxed in which case members shall be informed electronically of the reasons and the expected date for circulation of papers

7.3 Agenda
The agenda of the ADP will normally be decided by the Chairperson.

Members of the ADP will be invited to propose agenda items not less than 10 workings day prior to the meeting date which are relevant to the priorities of the CPP and ADP. Partner organisations proposing agenda items will be responsible for the timeous production of all relevant reports and papers relating to that item.

7.4 Quorum

The quorum for the ADP is one third of the membership. For the meeting to be quorum representatives from NHS, Local Authority and Justice must be present. Non quorate meetings can still proceed with the agreement of those present with decisions ratified at the next full scheduled meeting.

7.5 Declaration of Interests

Any member of the ADP who has a personal financial interest, a business interest or any other direct or indirect private or personal interest in a matter under discussion should, as soon as it is practicable, declare that interest and take no part in the discussion of the matter. The member should absent himself/herself from the meeting while the discussion takes place.

In utilising the authority and carrying out the responsibilities delegated to them, officers must comply with the terms of the Code of Conduct for their partner organisation regarding conflicts of interest

7.6 Minutes

The draft minute of the ADP meeting will be prepared for the approval by the Chairperson, before being circulated electronically and submitted for final approval to the next meeting of the ADP. Following ratification at the following ADP meeting the Minutes will be posted on the ADP website and distributed to partner organisations as appropriate.

7.7 Absence

In an event of a member of the ADP being unable to attend, the nominated representative should attend in their absence and apologies for absence of the member should be sent to the ADP Lead Officer.

8. Decision-making procedures

8.1 The ADP will operate on the basis of consensus. Consensus, in respect of any particular item under consideration will be taken to constitute a majority rather than unanimity and the Chairperson will be the sole judge of consensus in respect of any item of business.

8.2 If there is dissent from agreement on a significant issue, the dissenting partner(s) may ask for that dissent to be recorded in the minute of the meeting.

8.3 The ADP may not take a final decision on any matter which is the

statutory responsibility of any member organisation, and may not take any final decision on the allocation of funds which are the responsibility of any member organisation, unless given the authority by that member organisation to do so. The ADP may however make recommendations on such matters.

9. Confidentiality

9.1 All members of the ADP will be responsible for maintaining the confidentiality of relevant documents. The Chairperson will rule where necessary to advise on the confidentiality of documents

10. Reporting arrangements

10.1 The ADP will report to the Health and Social Care Partnership on a quarterly basis.

Members of the ADP will be responsible for ensuring their organisation and all associated groups are informed of the work of the ADP

The ADP will produce an Annual Report which will be circulated widely to organisations, the community and placed on ADP website.

11. Specific reporting arrangements into Community Planning Partnership

The ADP will report to the CPP no less than on an annual basis

12. Review of the ADP Terms of Reference

Terms of Reference will be reviewed annually by members of the ADP during the Annual General Meeting

Amended Terms of Reference will be submitted to the Health & Social Care Partnership for endorsement.

13. ADP Support Arrangements

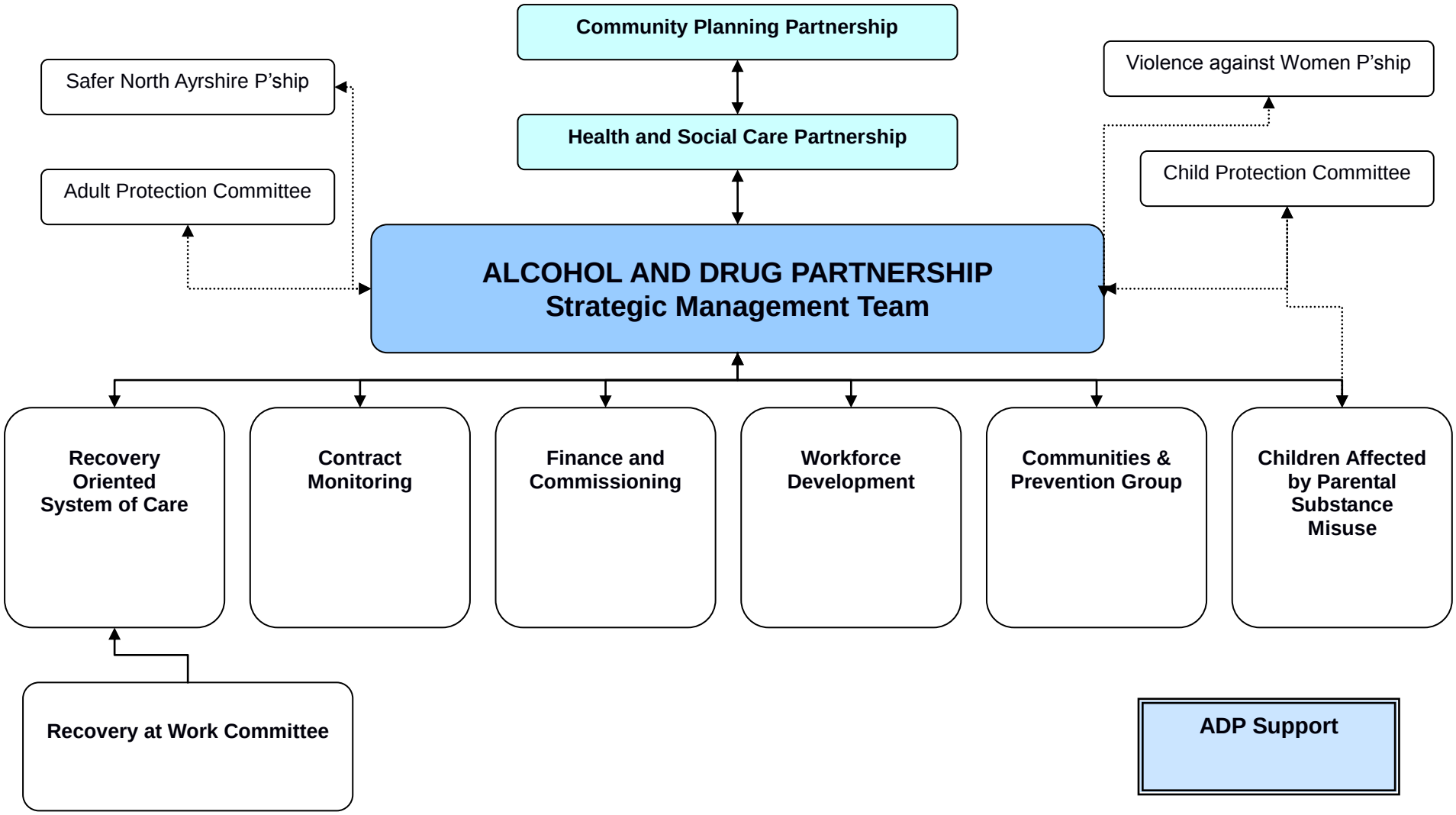
Comprehensive support will be provided to the ADP by a dedicated ADP Lead Officer:

- Support to the ADP Chairperson and all activities of the ADP
- Development and monitoring of the Alcohol and Drugs Strategy and Action Plan
- Co-ordination of all activity surrounding the partnership both internal and external
- Representation of the ADP at appropriate local and national meetings

- Coordinate communication activity
- Act as a source of alcohol and drug information and/or signposting on
- Any additional roles as deemed appropriate by the ADP Chairperson.

14 Annual General Meeting (AGM)

The ADP AGM will normally be held as part of the first hour of the scheduled ADP meeting in any new financial year


Community Planning Partnership
Health and Social Care Partnership
Safer North Ayrshire P'ship
Adult Protection Committee
Violence against Women P'ship
Child Protection Committee
ALCOHOL AND DRUG PARTNERSHIP
Strategic Management Team
Recovery Oriented System of Care
Contract Monitoring
Finance and Commissioning
Workforce Development
Communities & Prevention Group
Children Affected by Parental Substance Misuse
Recovery at Work Committee
ADP Support

Appendix 2 - Policy Themes & Priorities of ADP and Partner Agencies

North Ayrshire Alcohol & Drug Partnership

Vision - The harmful effects of alcohol and drug misuse in North Ayrshire are reduced

7 national core outcomes

- **Health**: People are healthier and experience fewer risks as a result of alcohol and drug use.
- **Prevalence**: Fewer adults and children are drinking or using drugs at levels or patterns that are damaging to themselves or others.
- **Recovery**: Individuals are improving their health, well-being and life chances by recovering from problematic drug and alcohol use.
- **Families**: Children and family members of people misusing alcohol and drugs are safe, well supported and have improved life chances.
- **Community Safety**: Communities and individuals are safe from alcohol and drug related offending and anti-social behaviour.
- **Local Environment**: People live in positive, health promoting local environments where alcohol and drugs are less readily available.
- **Services**: Alcohol and drugs prevention, treatment and support services are high quality, continually improving, efficient, evidence based and responsive, ensuring people move through treatment into sustained recovery.

Aim Statement (November 2013) - North Ayrshire ADP will increase the level of recovery capital by 15% by September 2016 for all discharged cases

4 Key Priority Areas for Action

- Prevention
- Protection
- Recovery
- Communities

4 Guiding Principles

- shifting the balance of service provision towards preventative services and a greater focus for treatment services on early intervention, recovery, and avoidance of relapse
- empowering service users and those important to them, identifying and reducing inequalities for those affected by alcohol and drugs
- promoting service innovation in our application of resources
- raising wider awareness of alcohol and drug issues and support for our vision

Health & Social Care Partnership

Vision - All people who live in North Ayrshire are able to have a safe, healthy and active life

5 Strategic Priorities

- Tackling inequalities
- Engaging communities
- Bringing services together
- Prevention & early interventions
- Improving mental health and well-being

7 Values

- person-centred
- respect
- efficiency
- care
- inclusiveness
- honesty
- innovation

12 Service Principles

- integrated from the point of view of service-users
- takes account of the particular needs of individual service-users
- takes account of the particular characteristics and circumstances of individual service-users
- respects the rights of service-users
- respects the dignity of service-users
- takes account of the participation by service-users in the community in which they live
- protects and improves the safety of service users
- improves the quality of the service
- is planned and led locally in a way which is engaged with the community
- best anticipates needs
- helps to prevent needs arising
- makes best use of the available facilities, people's abilities and other resources

NHS Ayrshire & Arran Local Delivery Plan

4 HEAT Priorities

- Health Improvement for the people of Scotland - improving life expectancy and healthy life expectancy.
- Efficiency and Governance Improvements - continually improve the efficiency and effectiveness of the NHS.
- Access to Services - recognising patients' need for quicker and easier use of NHS services.
- Treatment Appropriate to Individuals - ensure patients receive high quality services that meet their need.

Community Planning Partnership

Vision - 'North Ayrshire, A Better Life'

3 Overarching Themes

- reducing local inequalities of outcome
- building community capacity
- prevention and early intervention

3 Priorities

- worklessness
- health inequalities
- community safety

6 Neighbourhoods Approach

- Arran
- Irvine
- Kilwinning
- Three Towns
- Garnock Valley
- North Coast

North Ayrshire Council

2015/20 Mission - To improve the lives of North Ayrshire people and develop stronger communities

5 Priorities

- growing our economy, increasing employment and regenerating towns
- working together to develop stronger communities
- ensuring people have the right skills for learning, life and work
- helping all of our people to stay safe, healthy and actively
- protecting and enhancing the environment for future generations

Scottish Government

Vision for health and social care

by 2020 everyone is able to live longer healthier lives at home, or in a homely setting

5 Strategic Objectives

- Wealthier and Fairer
- Smarter
- Healthier
- Safer
- Stronger and Greener

9 National Health & Well-being Outcomes

- People are able to look after and improve their own health and wellbeing and live in good health for longer.
- People (including those with disabilities or long-term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
- People who use health and social care services have positive experiences of those services and have their dignity respected.
- Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
- Health and social care services contribute to reducing health inequalities.
- People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.
- People using health and social care services are safe from harm.
- People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
- Resources are used effectively and efficiently in the provision of health and social care services.

4 Pillars of public sector reform

- A decisive shift towards prevention
- Greater integration of public services at a local level driven by better partnerships, collaboration and effective local delivery
- Greater investment in the people who deliver services through enhanced workforce development and effective leadership
- A sharp focus on improving performance through greater transparency, innovation and use of digital technology

7 Core Outcome Themes for ADPs

- Health
- Prevalence
- Recovery
- Families
- Community Safety
- Local Environment
- Services

7 Ministerial Priorities

- Compliance with the Alcohol Brief Interventions (ABIs) HEAT Standard
- Increasing compliance with the Scottish Drugs Misuse Database (SDMD)
- HEAT Drug and Alcohol Treatment Waiting Times Standard, including, increasing the level of fully identifiable records submitted to the Drug and Alcohol Treatment Waiting Times Database
- Increasing the reach and coverage of the national naloxone programme and tackling drug related death(DRD)/risks in your local ADP
- 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
- 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
- Improving identification of, and preventative activities focused on, new psychoactive substances (NPS)

Appendix 3 – ADP Budget & Services/Activities Funded

Service/activity funded	Organisation	2015/16 Drug	2015/16 Alcohol	2015/16 Additional Funds
Budget Allocation (£)		**658,613**	**994,294**	**30,000**
ROSC Implementation Officer	NAC		39,284	
Methadone & Alcohol Cessation	NHS & NAC	37,980	54,226	
Substitute Prescribing	NHS	96,516		
Prevention Services & Support Team	NHS	48,977		
Community Addiction Teams	NHS	125,784		
Primary Care Addiction Teams	NHS	119,216		
NAC Addiction Services (DRUGS)	NAC	125,000		
Community Day Service	Momentum	40,736	47,438	30,000
Alcohol Support Service	TRFS		37,500	
ARBD	NAC		45,093	
Programmes Approach Team After Care Worker	NAC		84,515	
Pregnant Mothers Support/Forward Steps	Children 1st		72,000	
Alcohol Liaison Nurses	NHS		82,528	
Midwives	NHS		16,778	
Community Addiction Teams	NHS		157,325	
Primary Care Addiction Teams	NHS		154,144	
OT service	NHS		36,237	
Prevention Services & Support Team	NHS		14,199	
GP Brief Interventions	NHS		7,444	
Kyle Addictions Unit	NHS		35,746	
Presence at A&E	Police Scotland		7,468	
ADP Support	NAC		55,136	

ADP - Scoping & Project Monitoring	NAC	44,293		
SU Activity/Events	NAC	4,000		
SMART	UK SMART	4000		
FITBA4U	NAC	9000		
MAPSG	Police Scotland	6363		
Arts and Craft Writing Group	NAC		5,000	
JUMP2IT	SSF		9,500	
STRADA Course	NAC	1,700		
Website Hosting	Net Focus	1,500		
Total Allocated		**665,065**	**961,561**	**30,000**

Appendix 4 – Legislation evidence & guidance sources

- The Road to Recovery: A New Approach to Tackling Scotland's Drug Problem – May 2008
  http://www.gov.scot/Publications/2008/05/22161610/0
- Changing Scotland's Relationship with Alcohol: A Framework for Action – March 2009 **http://www.gov.scot/Publications/2009/03/04144703/1**
- Changing Scotland's Relationship with Alcohol: A Framework for Action - Progress Report - February 2012
  http://www.gov.scot/Resource/0038/00388540.pdf
- Framework for Local Partnerships on Alcohol and Drugs – April 2009
  http://www.gov.scot/Resource/Doc/270101/0080412.pdf
- Scottish Drug Strategy Delivery Commission – Independent Expert review of Opioid Replacement Therapies in Scotland – August 2013
  http://www.gov.scot/Resource/0043/00431023.pdf
- The Quality Principles: Standard Expectations of Care and Support in Drug and Alcohol Services – August 2014
  http://www.gov.scot/Resource/0045/00458241.pdf
- ADP Needs Assessment 2014
  http://www.naadp.com/resources/site1/General/ADPneeds.pdf

Appendix 5 - ADP Commitments

This appendix considers the commitments made throughout the document, which, where possible, are set out in italics and begin with *"we will"*. (For ease of reference these commitments are reproduced at the end of this appendix)

We have gathered these together into 3 broader groupings for ease of taking them forward and to allow a clearer tracking of their progress. It is understood that several of our commitments could fit just as appropriately into more than one grouping, and that their progress may involve elements of shared responsibility and accountability as well as oversight.

The first grouping encompasses the first 13 commitments. These are focussed around broader policy type issues where higher level strategic statements need to be given practical effect. Taking these commitments forward effectively will create the necessary policy and management environment to deliver on the more practical/operational commitments in the two other groupings.

The second group of 3 commitments gathers together those where finance issues are overtly to the fore. Our work around these will focus on ensuring we apply resources we control to activities that best drive forward our **Vision** via our **Guiding Principles**.

The third group comprising the final 11 commitments cluster around systems and processes that require to operate effectively, and in some cases differently, to ensure our intended outcomes can be realised. Principally they concern the design, supply, evaluation and review of services.

We intend to establish a new sub-group of the ADP, comprising the chairs of the ADP and its present sub-groups, along with the Lead Officer for the ADP, and anyone the sub-group thinks fit to co-opt, with the authority and responsibility to establish systems to ensure our commitments are carried forward. This sub-group will lead the ADP activity linked to the Performance Management Framework under development by the HSCP at our time of writing.

We also propose that each commitment will be linked to a single body or person made responsible to champion and report on progress. There will, however, be an absolute expectation that they will work with colleagues responsible for other commitments and with other agencies, to ensure that work to realise our commitments is as joined up as necessary.

List of our commitments within the document (with paragraph number in brackets):

First grouping (policy)

1. We will ensure services operate in accordance with the ADP guiding principles (1.3)
2. We will ensure a fit with other HSCP strategic and operational developments, as well as with the wider set of local and national priorities (3.1)
3. Services will be delivered in line with our existing strategic priorities and target outcomes and the seven core outcomes for ADPs set by the Scottish Government (see appendix 2), with the added emphasis as set out in our **Guiding Principles** (4.2)
4. We will support the CPP emphasis on a neighbourhood approach to service design and delivery, and will ensure this is reflected in our progress, and we commit to meeting our HEAT Alcohol Brief Interventions (ABI) and 'Access to Treatment' standards, and Ministerial Priorities (4.3)
5. We will ensure that recovery is placed at the heart of treatment and support services, and that this Recovery Oriented System of Care (ROSC): offers a comprehensive menu of person centred options; is strengths based; supports people to live as well as possible in the presence or absence of challenges; focuses on well-being and quality of life over morbidity and deficits; includes peer recovery support; includes families and friends and other recovery allies; has an unwavering belief that positive change is possible for all; and achieves desired outcomes through collaborative, effective and high quality service provision and partnership (4.4(b))
6. We will work with partners, and within the HSCP, to develop synergistic influence on this wider set of resources, to advance our objectives and vision (5.3)
7. We will ensure that the ADP and its sub-groups are fully informed of changes to legislation, evidence or guidance so they might take proper account of these in their operational activities. (5.7)

8. We will work amongst partners to ensure care/treatment plans for service users properly set out personal outcomes that are matched to ADP core outcomes and wider social and health policy agenda (5.8)
9. We will address emerging drug trends including the increased availability and use of new psychoactive substances (NPS) in planning our service developments. (6.3)
10. We will embed into service design and reconfiguration, evidence emerging, whether from local research, or from elsewhere if judged transferable to local circumstance, that indicates how services might be improved (6.8)
11. We will achieve further progress on our **Vision** by ensuring a mix of services, actions, and influence, which are individually focussed on one or more of the seven National **Core Outcomes** for ADPs, which we wholeheartedly support and adopt, and which collectively address all of them. (8.3)
12. We will continue to work with partners to make sure that our activity fits with the wider aspirations for our community and society, as set out in other plans and strategies listed at appendix 2. We will have particular regard to how ADP services and activity matches and supports the five strategic priorities set by the HSCP. (8.5)
13. We will remit each grouping of commitments to a sub-group charged with moving these from a strategic commitment, through the action planning system, to realisation. (8.9)

Second grouping (finance)

14. We will ensure resources are committed in accordance with the ADP guiding principles (1.3)
15. We will seek opportunities to use ADP resources, either to draw in matched funding, or as a means to direct other resources to our objectives. (5.3)
16. We will assess existing and proposed services on their likely impact against our seven core outcomes and on the degree to which they will operate in ways that support our guiding principles, all within the context of their resource requirement and likely ease of

implementation, and future resources will be directed accordingly. (6.5)

Third grouping (systems)

17. We will work to ensure improved capacity, within the lifetime of this strategy, to analyse market performance and intervene where potential market failure threatens progress. (4.4)
18. We will either enhance and support the contract monitoring system, or establish a system linked to the contract monitoring process to better assess the impact of services (4.8)
19. We will ensure early progress on further work on service performance and impact. (5.4)
20. We will use data on local needs to guide our work on gap analysis (5.6)
21. We will continue joint work with procurement and contract monitoring staff to strengthen our information base on providers within this market, and to identify any actions needed around development or diversification. (5.8)
22. We will feed data on the strategic impact of services and service proposals into a comparative appraisal system, that will inform decisions on what pattern and level of services will best deliver our priorities in future, which in turn will form our forward commissioning strategy/plan, and determine specific service designs and specifications (6.4)
23. We will undertake parallel activity on the inner procurement cycle jointly with colleagues directly involved in service delivery across all sectors, with contract monitoring and procurement colleagues, and with provider and service user representatives, to ensure the most suitable service specifications are applied to support our service development, and that purchasing systems and decisions are effective in matching service provision to those who will benefit most (6.6)
24. We will ensure that the National Quality Principles set out by the Scottish Government for ADPs in 2014, establishing basic standards of care and expectations of service delivery, are embedded in service design and reconfiguration (6.7)
25. We will require those involved in service provision under this strategy to

demonstrate how and to what extent their activities and methods deliver against not only their service specifications, but more widely against our guiding principles and seven core outcomes. They will also need to demonstrate their ability to develop a plan to extend their own capacity and improve performance, including on a joint working basis with other stakeholders (7.2)

26. We will maximise the quality of services, and the positive difference they make to service users and the community, by forging clear links between inputs and outcomes, for service users and our community, at every stage of service commissioning, though concept, design, specification, operation, management, self-monitoring and review, and external scrutiny and appraisal (8.6)
27. We will ensure existing services, as well as any service proposals, are subject to a scrutiny and appraisal process that we will design and implement within 3 months of adopting this strategy, so that their contributions to our strategic progress can be measured and compared This will form the baseline for future commissioning decisions and activity (8.7)