14 June 2018

Dear Mr Macdonald

PRE-BUDGET SCRUTINY (BUDGET 2019-20)

Following the evidence session on 5 June, my office was in contact with your Committee Clerk and I understand that you intend to write to me to request further information to assist your pre-budget scrutiny.

In the meantime, I enclose the items of information which I agreed to provide at the evidence session. Appendix A sets out the infographic on the burden of disease, which is included in the Chief Medical Officer’s Annual Report 2016-17. I have enclosed at Appendix B the summary of set aside budgets (budgets for unscheduled inpatient care in large hospitals), and I have enclosed at Appendix C the letter detailing the funding to support the delivery of agreed service levels for Alcohol and Drug Partnerships’ work within NHS Board areas for 2018-19.

Yours sincerely

Paul Gray
Burden of disease in Scotland, 2015

Note: Disability-adjusted life years rounded to the nearest 100. • Scottish burden of disease study • www.scotpho.org.uk/comparative-health/burden-of-disease/overview
Health & Sport Committee

Integrating unscheduled inpatient services with community services: set aside budgets

Background

Under the legislation for integration – the Public Bodies (Joint Working) (Scotland) Act 2014 and associated secondary legislation – Integration Authorities are responsible for the planning and delivery of, at least, social care, primary and community healthcare and unscheduled hospital care for adults. The objective of this approach, which for the first time brings together responsibility for the entire care journey of adults with multi-morbidities, is to create a coherent, single cross-sector system through which our longstanding ambition to shift the balance of care from institutions to communities can be achieved.

Previous arrangements with Community Health Partnerships, which were characterised by discrete organisational sectors of hospital, community health and social care, did not reflect the underlying pathways for unscheduled care and the mutual interdependence between these sectors along the pathway. The result was an asymmetry of risk and influence, with Health Boards carrying all of the risk for hospital capacity and Local Authorities carrying all of the risk of social care capacity, in a system in which decisions made by either partner affected the risks carried by the other. By creating a single point of responsibility for complex care pathways, our intention is to remove the old stumbling blocks of shunting costs and responsibility around the system and instead focus attention on improving outcomes and sustainability along the entire journey of care. This approach establishes a framework for accountability for overall use of the total resource associated with the unscheduled care pathway.

The legislation lists which functions and services must be integrated. It requires considerable direct engagement with local professionals and localities during the strategic commissioning process. We recognised from the outset that this approach is radically different to anything that has gone before – by including aspects of hospital care, integration goes well beyond merely bringing together services that have always been delivered in communities.

We recognise that such a departure from traditional ways of working, which requires the NHS to distinguish on a statutory, financial and planning basis between scheduled and unscheduled hospital care, is challenging. To support local systems, we have provided extensive statutory guidance for local leaders, planners and finance managers on the practicalities of managing this new approach to planning care. Two extracts, below, from the statutory guidance, capture what’s expected. The first of these emphasises the importance of collaboration and joined up leadership. The second addresses the responsibility on Integration Authorities and Health Boards to ensure local planning adds up to a manageable and sustainable ask of hospitals.

Extract 1

“It is recommended that [local plans] are developed . . . by a group comprising the hospital sector director (or similar postholder) and the Chief Officers of the Integration Authorities whose populations use the hospital services.”


Extract 2

“Where more than one partnership exists within a Health Board area, the change programme for hospital services will have to be coherent across individual strategic
plans (under S30 (3) of the Act). Consequently, there should be an overarching strategic plan for the hospital services delegated to Integration Authorities that is a consolidation of the individual partnership plans and this should be coordinated and held by the Health Board hospital sector. The strategic plans produced by the Integration Authority/ies must in turn be consistent with the strategic context set by the Health Board and Local Authority. The hospital capacity and hosted services included in the strategic plan should evolve from the existing capacity and plans for those services. Strategic plans will reflect locality planning in due course.”


Within this collaborative framework, Integration Authorities are responsible for planning their population’s use of unscheduled hospital care.

**Set Aside Budgets**

Budgets for social care and primary and community healthcare are paid across to Integration Authorities by the Local Authority and Health Board.

During the consultation on the legislation, Health Boards raised concerns that including the budget for delegated functions provided in large hospitals in the payment to the Integration Authority would be administratively difficult. In response to this concern, the legislation makes provision for an alternative arrangement, as follows: the budget for unscheduled inpatient care in these hospitals can be identified and “set aside” – ring-fenced – by the Health Board, for direction on its use by the Integration Authority.

Where the set aside approach is used, no physical payment is required and the powers of the Integration Authority are unaltered: hospital functions are delegated to the same extent as the other non-hospital functions, and the Integration Authority’s control of the sum set aside is the same as for the sums included in the payment. A practical manifestation of the Integration Authority’s responsibilities can be seen in the fact that both the amounts paid over and any sum set aside must be included in the Integration Authority’s audited annual accounts.

**Implementation**

We know from the experience of other health and social care systems that it is important to avoid risks that can result from a commissioner/provider split, such as the creation of perverse incentives that work against the wellbeing of people using services. To avoid this, the set aside arrangements are based on the premise of a *shared* risk for unscheduled care between the Integration Authority, the Health Board and the Local Authority, with full transparency over activity and associated budgets.

Making a success of this arrangements requires new kinds of working arrangements in local systems. The Scottish Government has published statutory guidance setting out six main recommendations:

1. A group should be established to bring together the NHS hospital sector director and the Chief Officer(s) and Chief Finance Officer(s) of the Integration Authorities whose populations use the hospital services. This group should then work together to ensure they have a shared understanding of how their populations are using unscheduled care hospital resources, as defined by the list of specialties referred to above. They can then develop strategic commissioning plans to deliver improvements in quality and sustainability and to shift the balance of care. Such groups will vary in size. In a small co-terminous area, such as Scottish Borders, the group will be small. In a larger, more complex partnership
arrangement, such as in NHS Greater Glasgow and Clyde, it will include the hospital director plus representatives from all of the Integration Authorities whose populations use the Health Board’s hospital services.

2. The baseline bed days used by the Integration Authority’s, or Integration Authorities’, residents in the specialties that comprise unscheduled inpatient care should be quantified. Relevant budgets should be mapped to the bed use of each Integration Authority’s population. This is the baseline “set aside” for each Integration Authority.

3. A method should then be agreed between the Health Board and Integration Authority for quantifying how the sum set aside will change with projected changes in bed use. The guidance recommends using a similar process to the one successfully used 20 years ago for implementation of Learning Disability Same As You (LDSAY) when mental health provision was largely shifted out of institutions and into communities. This is a tested and therefore repeatable method.

4. The Integration Authority and Health Board should then work together to agree a plan setting out intended changes to the bed capacity required for unscheduled inpatient care for the Integration Authority’s population. This plan should include agreement on how resources will be redirected as usage changes.

5. Regular information should be provided to the group to monitor performance against the plan.

6. The Integration Authority or Integration Authorities and the Health Board should agree how they will manage the shared risk involved in planning to reduce inappropriate use of unscheduled inpatient care. Our recommendation is that the risk is shared as follows:

   - The Integration Authority should bear the volume risk i.e., if unscheduled admissions for its population are higher than planned, responsibility should lie with the Integration Authority. This outcome implies that the Integration Authority’s plan to keep people out of hospital with alternative care in communities has not delivered to the extent anticipated.

   - The Health Board should bear the cost risk, i.e., if bed day costs are higher than previously agreed because of, for example, greater use of locum staff than anticipated. This outcome is associated with management of service delivery that is more costly than anticipated.

As noted at the evidence session on 5 June 2018, we are seeing good progress with these arrangements in some areas, such as Aberdeen City, although we note that further support is required. We have established an Integrated Finance Development Group, whose membership includes colleagues from Integration Authorities, Health Boards, Local Authorities, Audit Scotland, CIPFA, COSLA and Scottish Government, to ensure local systems are fully supported.

Integration Division
Health Finance Division
Scottish Government Health and Social Care Directorates

JUNE 2018
SUPPORTING THE DELIVERY OF DRUG AND ALCOHOL SERVICES: 2018-19
MINISTERIAL PRIORITIES AND FUNDING ALLOCATIONS

1. I write to provide detail about the funding to support the delivery of agreed service levels for Alcohol and Drug Partnerships (ADPs) work within your NHS Board area for 2018-19.

2. As you are aware, the responsibility for the delivery of both in-patient and community based addictions services has been transferred to Integration Authorities (IA’s). Accordingly, funding to support ADPs in 2018-19 has been transferred to NHS Board baselines for onward delegation to IA’s for drug and alcohol services. As in previous years, this baselined allocation is a combined amount covering alcohol and drug treatment and support services.

3. The Scottish Government is committed to tackling alcohol and drug related harm; ADPs have a wealth of expertise in providing and commissioning these services and we are keen to ensure that ADPs, IAs and other Community Planning Partners have effective joint-working relationships. We are currently giving consideration to how we best support local areas to continue to develop this relationship to aid strategic planning and the delivery of key activities to reduce drug/alcohol related harm align strategic delivery and investment plans. We will be in contact about the work that needs to be done here alongside expectations for the 2018/19 annual report.

4. Ministers are clear that the full funding allocation should be expended on the provision of ADP services and service supports. Further, these resources should be invested transparently, informed by a robust evidence base and appropriate needs assessment.

5. The allocations described in this letter represent the minimum amounts that should be expended on alcohol and drug treatment and prevention services in 2018-19. We fully expect that additional resources, including funding, will continue to be contributed by ADP partners with an emphasis on investment in innovation and prevention.
6. As you are aware the First Minister announced an increase of £20 million for drug/alcohol services within Programme for Government. We will be writing to you shortly about how this money will be invested.

Ministerial Priorities

7. ADPs and IAs should collectively demonstrate progress against both national and locally relevant alcohol and drug outcomes, and the Ministerial Priorities outlined below. At this time Ministerial Priorities will continue to be reviewed and set annually, as ADPs and IAs undertake to embed the structural and governance changes brought about by the Public Bodies (Joint Working) (Scotland) Act 2014. ADPs, IAs and other Community Planning Partners will need to develop effective joint-working relationships to ensure the effective discharge of these functions, in line with current strategic priorities.

Compliance Requirements

- Compliance with the Drug and Alcohol Treatment Waiting Times Local Delivery Plan (LDP) Standard, including, continuing action to increase the level of fully identifiable records submitted to the Drug and Alcohol Treatment Waiting Times Database;
- Implementation planning for the Drug and Alcohol Information System (DAISY) including adaptions to local delivery systems and IT infrastructure, to ensure full compliance with data entry and national reporting requirements.
- Continuing work to increase compliance with the Scottish Drugs Misuse Database data entry requirements for the SMR25 (a) and (b) datasets, in preparation for DAISY;
- Compliance with the Alcohol Brief Interventions Local Delivery Plan (LDP) Standard.

Quality Improvement

- Continued implementation of improvement activity at a local level, based on the individualised recommendations within the Care Inspectorate Report, which examined local implementation of the Quality Principles.

Harm Reduction and Reducing Deaths

- Improved planning and coordination of interventions to reduce and prevent drug and alcohol deaths;
- Work to support effective prisoner throughcare, particularly for locally identified vulnerable groups & whether this is referenced in local community justice improvement plans;
- Continuing support for the provision of naloxone in community, custodial and healthcare settings;
- Continued implementation of a Whole Population Approach for alcohol, targeting harder to reach groups, including those impacted most by the new minimum unit price for alcohol from 1 May 2018 and supporting a focus on communities where deprivation is greatest.

Further information on Ministerial Priorities is provided at Appendices 2 & 3.
Funding Allocations

8. The 2018-19 funding (transferred to NHS Board baselines for onward delegation to IAs) to support the delivery of drug and alcohol treatment and support services in your NHS Board Area is £. Where there is more than one Integration Joint Board within your health board area, the NHS Board should agree the distribution between IAs. ADPs and IAs should then agree local arrangements for the commissioning and delivery of services.

9. The 2018-19 funding allocated to ADPs includes costs for compliance with the Drug and Alcohol Information System (DAISy). This will vary from area to area and the DAISY project board and the Scottish Government National Support Team will continue to work with ADPs on local migration arrangements. ADPs should all now have implementation plans in place which will ensure readiness for DAISy by 1 October 2018.

10. If you have any queries, please contact Amanda Adams (Amanda.adams@gov.scot 0131 244 2278).

DANIEL KLEINBERG
Deputy Director, Health Improvement Division
Population Health Directorate
APPENDIX 1 – NATIONAL CONTEXT FOR ADP FUNDING

Measuring Success

The Road to Recovery drugs strategy\(^1\), Changing Scotland’s Relationship with Alcohol: A Framework for Action on Alcohol\(^2\), the National Delivery Framework for Alcohol and Drug Delivery\(^3\) and the Quality Alcohol Treatment and Support (QATS) report\(^4\) collectively provide the national framework for delivering alcohol and drug prevention, treatment and support in Scotland.

The Getting Our Priorities Right (GOPR) guidance\(^5\) provides a good practice framework for all child and adult service practitioners working with vulnerable children and families affected by problematic parental alcohol and/or drug use. It reflects the national Getting It Right for Every Child approach and the Recovery Agendas, both of which have a focus on ‘whole family’ recovery. GIRFEC continues to be threaded through all existing policy, practice, strategy and legislation affecting children, young people and their families. This approach underpins the Children and Young People (Scotland) Act 2014, the Early Years Framework, Curriculum for Excellence and a range of programmes to support improvements in services.

We are committed to keeping outcomes and indicators under review as frameworks develop. In this regard we will seek to prioritise effective outcomes measurement, in order to improve the quality of services and their responsiveness to service-user need. The RO tool and data set (for which further information remains available via the Social Services Knowledge Website) is an important component of the Drug and Alcohol Information System (DAISy), which is scheduled to come online in October 2018 with the Ro tool following in April 2019. All relevant drug and alcohol services in Scotland are expected to comply with the data collection and management requirements of DAISy.

National Support

The National Support Team take forward key projects to deliver national strategic priorities; it also is available to support capacity building, sharing of learning and good practice amongst ADPs in order to promote the delivery of our national strategic priorities. Examples of the support available include:

- improving skills to use data for evidencing progress against core outcomes;
- delivering recovery-oriented systems of care through system redesign (including the transition from prison back to the community and the importance of ensuring effective pathways are in place to support through-care arrangements);
- a whole population approach to addressing problem alcohol use; and
- strengthening SG engagement with sector in relation to drug and alcohol policy objectives and drug and alcohol workforce development.
- Developing plans to reduce drug and alcohol deaths and harm.

We strongly encourage ADPs to use the national support available to them as well as utilising local expertise. Please contact Nick Smith (nicholas.smith@gov.scot) in the first instance to discuss opportunities for support.

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\(^1\) http://www.scotland.gov.uk/Publications/2008/05/22161610/0
\(^2\) http://www.scotland.gov.uk/Publications/2009/03/04144703/0
\(^3\) http://www.scotland.gov.uk/Publications/2009/04/23084201/0
\(^4\) http://www.scotland.gov.uk/Publications/2011/03/21111515/0
\(^5\) http://www.scotland.gov.uk/Publications/2013/04/2305
Planning and Reporting Arrangements

Quality improvement remains a Ministerial Priority for 2018-19. We expect all ADPs to have an improvement plan in place following on from the supported self-assessment that was undertaken by the Care Inspectorate, which examined implementation of the Quality Principles in ADP areas across the country. Additionally, we now expect that ADPs will implement DAISy on 1 October 2018. All ADPs should have implementation plans in place covering the migration of local systems and data inputting infrastructure. Emerging or ongoing issues should continue to be raised with the DAISy Implementation Group and brought to the attention of the National Support Team. All ADPs should continue to report on local data compliance via the standard reporting template.

We will write to you in the coming weeks about ADP reporting arrangements for 2017-18.

National Services Scotland, Information Services Division, continues to update the ScotPHO profiles which are invaluable in assessing performance against the National Core Indicators. The profiles can be accessed here: http://www.scotpho.org.uk/comparative-health/profiles/online-profiles-tool.

Health and Social Care Integration

The Public Bodies (Joint Working) (Scotland) Act 2014 provides a statutory framework for the integration of health and social care delivery in Scotland. The legislation provides that both in-patient and community based addictions functions are delegated to IAs. It is imperative that ADPs continue to make effective connections into local decision-making and raise awareness of alcohol and drug issues to inform local priorities, ensuring Strategic and Delivery plans for alcohol and drug outcomes are embedded within local Health and Social Care arrangements. ADPs continue to play an important role in ensuring that local service delivery responds to the national priorities of our drug and alcohol strategies. Whilst the Scottish Government has not been prescriptive about the shape and governance of local joint-working relationships, it is expected that all ADP Chairs and IA Chief officers will encourage and facilitate effective partnership working. Scottish Government funding to support the delivery of ADPs work is included within board baseline budgets, for onward delegation to IAs.
APPENDIX 2 – MINISTERIAL PRIORITIES AND IMPROVEMENT GOALS FOR 2017-18

The Minister for Public Health and Sport has identified a number of on-going priority areas for continuing improvement in the delivery of our national alcohol and drugs strategies. These are arranged according to the themes set in 2015-16: Compliance; Quality Improvement; Harm Reduction and Reducing Deaths. Additionally, ADPs are being asked to provide detail on the local governance and accountability arrangements that have been put in place to ensure effective joint working between ADPs and IAs, thinking in particular about how those arrangements facilitate the delivery of current strategic priorities.

Compliance

DAISy; Data Compliance; LDP Waiting Times Standard; ABI Delivery

Data compliance continues to be a fundamental component of managing the transition to and implementation of DAISy. This goes hand in hand with a continuing focus on the delivery of the LDP standard for drug and alcohol treatment waiting times (further information on which is provided at Appendix 3).

As you are aware DAISy will be implemented from 1 October 2018. It will replace the Drug and Alcohol Treatment Waiting Times Database (DATWTD) and the Scottish Drug Misuse Database (SDMD). It is important to note that DATWTD provides for the anonymous submission of patient record data; this anonymity function will not be a part of DAISy. ADPs and services are required to continue to take action to minimise the numbers of anonymous records and to continue to ensure that accurate data is available. All services should operate according to the requirements of UK data protection law and associated human rights legislation, maintaining client confidentiality should continue to be at the forefront of effective service delivery.

The implementation of DAISy will provide local areas with data which will enable a better understanding of the needs of those using their treatment services. In turn this should enable local areas to improve their ability to plan these services to best meet the needs of those at risk. At a both a national and local level, the picture generated provides vital evidence of the continuing case for investment in service provision.

Additionally, the Ministerial Priority requiring delivery and embedding of ABIs remains. ABIs are formally linked to the NHS Board Local Delivery Plan (LDP) as an LDP standard. The split between delivery in priority and wider setting delivery remains the same in 2018-19 as 2017-18: 80% delivery in priority settings; 20% in wider settings. NHS Boards and their partners within the ADP are asked to continue to consider ways to increase coverage of harder to reach groups, supporting the focus in communities where deprivation is greatest. All delivery should be planned, implemented and evaluated in line with the ABI LDP standard national guidance6. Data should continue to be reported through ISD and through the National Core Indicators in ADP Annual Reports.

Quality Improvement

ADPs have been asked to implement improvement methodology locally, demonstrating how they will implement the alcohol and drug quality principles at a local level. The Quality Principles: Standard Expectations of Care and Support in Drug and Alcohol Services were

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6 http://www.show.scot.nhs.uk/alcohol-brief-interventions/
published in August 2014. All ADPs are expected to implement the Quality Principles and assess local services' compliance with the Principles; this has been supported by a validated self-assessment exercise undertaken in all ADP areas and supported by the Care Inspectorate during the course of 2016.

The Care Inspectorate’s national findings have been published and local areas should have used the feedback from individualised reports to inform improvement planning going forward.

The Scottish Government continues to fund the Scottish Drugs Forum to undertake both Strategic Workforce Development and National Quality Development Activity to support the embedding the Quality Principles and provide a sustained training offer to ADPs nationally.

Harm Reduction and Reducing Deaths

Drug and Alcohol Related Deaths; Prisoner Healthcare and Throughcare; NPS; Whole Population Approach to Alcohol

Both drug and alcohol deaths have continued to rise over the longer term in Scotland. This is a concerning trend and it is clear from the data available that there are groups of people who are at greater risk of these deaths. ADP’s should have a plan in place at a local or health board level to address both drug and alcohol related deaths.

The Partnership for Action on Drugs in Scotland (PADS) group continues to have a strategic focus on drug related harm reduction, in particular to promote effective action to effectively tackle rising drugs related deaths. It is acknowledged that further action needs to be taken across the sector to respond to the acute challenges presented by an ageing cohort of drug users with complex needs, including action to promote engagement with and retention in services. The Scottish Government has been working with the Scottish Drugs Forum to examine current practice across the country and to develop and implement strategies to combat deaths within this cohort in particular. Of particular note are the following publications: Staying Alive in Scotland – Strategies to Combat Drug Related Deaths; Older People with a Drug Problem in Scotland: Addressing the Needs of an Ageing Population. Whilst there is a lot of positive action being taken, further work needs to be undertaken to look specifically at how services respond to the needs of this population, in order to enhance the protective factors associated with being in treatment. The Scottish Drugs Forum will publish additional new research which builds upon the findings of the Staying Alive in Scotland report during the course of 2018-19.

ADPs should also make use of the forthcoming SHAAP publication on reducing alcohol related deaths which will be published in summer 2018.

Further, a proactive and planned approach is required to respond to the needs of individuals in the justice system affected by problem drug and alcohol use, whether in the community, participating in community justice processes, or in custody, and their associated throughcare arrangements. It is expected that IAs, ADPs and the Scottish Prison Service will work more closely to ensure consistent processes before, during and after an individual is in custody. It is expected that ADPs and IAs will need to work closely with the prison(s) within their local area to take this work forward. Work should be on-going to develop effective throughcare pathways to support offender reintegration, thinking specifically about the skills needed to build recovery and support employability.
Since 1 April 2016, naloxone provision has been mainstreamed into individual NHS Boards, who also monitor local kit distribution. The provision of first supplies of naloxone to the most at risk individuals, including those not in contact with treatment services, should remain a priority for ADPs and NHS Boards. The National Naloxone Advisory Group (NNAG) highlighted the importance of ensuring that take-home naloxone kits are supplied to all new clients receiving prescribed opiate substitute treatment, as well as those released from prison and discharged from hospital, all of whom are vulnerable to an increased risk of opiate overdose and drug related death.

The Scottish Government continues to support the distribution of Naloxone and to raise awareness, supporting the role of the National Naloxone Coordinator at the Scottish Drugs Forum.

ADPs should ensure they are aware of, and respond accordingly to intelligence regarding emerging trends of drug/alcohol use and related harm. This would include the use of new psychoactive substances (NPS), problematic use of prescription drugs, risky injecting practices and other drug/alcohol related harm.

SDF are establishing National Drug Trend Monitoring Group which will provide useful information for local areas on national and regional trends. Alongside this the Forensic Centre for Excellence in New Psychoactive Substances Research based at the University of Dundee works to develop new research which promotes understanding of the nature of NPS, identify the threats that these drugs pose, and work across services to tackle those threats and associated challenges.

ADPs should continue to develop and implement a Whole Population Approach for alcohol, which targets, in particular, harder to reach groups, and focuses on communities where deprivation is greatest. This needs to consider responses for those impacted most by the new minimum unit price for alcohol from 1 May 2018. The Scottish Government is committed to pursuing action that reduces consumption at a population level, whilst supporting tailored interventions and supports for those engaged in harmful and hazardous drinking. Alcohol Focus Scotland have produced a briefing outlining possible action ADPs can take to support whole population approaches across the range of ADP outcomes. This briefing can be accessed at http://www.alcohol-focus-scotland.org.uk/media/86446/whole-population-approach-briefing.pdf.

The following links may be helpful:


Scottish Neighbourhood Statistics (SNS) website – enter the range of ADP Postcodes (top left of the home page), or use an Area Profile for ADP area (lower right of the home page) http://www.sns.gov.uk/


Scotpho alcohol and health and wellbeing profiles:  https://scotpho.nhsnss.scot.nhs.uk/scotpho/homeAction.do

To deliver these Ministerial priorities, ADPs are asked to set their own improvement goals, measures and tests of change to drive quality improvement at a local level in line with continuous improvement methodology.

Local improvement measures for delivering these Ministerial priorities should be described in the ADP Reports due for completion in the autumn. Further information will be forthcoming on these reports.
APPENDIX 3 – LDP STANDARD FOR DRUG AND ALCOHOL TREATMENT WAITING TIMES (2016-17)

1. Continuing to achieve the LDP Standard on access to drug and alcohol treatment services, by ensuring early access to appropriate recovery-oriented treatment, remains a joint Ministerial priority and is a key indicator of better outcomes for service users. The first stage in helping people to recover from problem drug and alcohol use is to support action across the country to provide a wide range of services and interventions for individuals and their families that are recovery-focused, person-centred, high quality and that can be accessed where and when they are needed.

The LDP standard supports sustained performance in fast access to services and requires that 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery. The two HEAT A11 targets (“below the waterline” Key Performance Indicators) remain as part of the LDP standard:

- Nobody will wait longer than 6 weeks to receive appropriate treatment
- 100% compliance is expected from services delivering tier 3 and 4 drug and alcohol treatment in Scotland

2. To provide a full picture of waiting times for people accessing specialist drug and alcohol treatment services, drug and alcohol treatment waiting times data for people accessing services in prison has been gathered since 1st April 2013 and forms part of the LDP Standard. It is expected that all prisons fully comply with this Standard.

3. Performance against the Standard will continue to be measured via the Drug and Alcohol Treatment Waiting Times Database (DATWTD) with national reports being published on a quarterly basis via the ISD website: http://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/

This will continue until the new national integrated Drug and Alcohol Information System (DAISy) is operational, when waiting times will be reported through DAISy.

4. It is expected that access to treatment is equitable across all areas and settings in Scotland and across drug and alcohol treatment interventions. We expect that ADPs and services undertake routine reviews of subsequent treatments to ensure that people are not waiting lengthy periods of time between interventions. We also expect that nobody will wait longer than 6 weeks to receive treatment and as such expect that any on-going waits are dealt with swiftly. ADPs should review data on secondary waits for treatment, particularly where there is local intelligence that people are waiting longer than 3 weeks for interventions such as opiate replacement therapy.

5. We would welcome a continued dialogue with local colleagues around any risks or issues which could impact on the delivery and sustainability of the LDP Standard. Please contact Nick Smith (nicholas.smith@gov.scot) or Mark Holroyd (mark.holroyd@gov.scot) to discuss any issues further.