Partnership Delivery Framework: Alcohol and Drugs (2026)

COSLA

Scottish Government
Riaghaltas na h-Alba

Contents

Ministerial / Spokesperson Foreword

Alcohol and drug related harm continues to have a profound impact on individuals, families and communities across Scotland. These issues are complex and closely linked to inequality, trauma, poverty and poor health. Addressing these harms requires long-term commitment, compassion and coordinated action across the whole system.

The Scottish Government (SG) and COSLA share a strong commitment to reducing harm and improving outcomes for all those who are affected by substance use. This Partnership Delivery Framework (PDF) has been developed collaboratively, in line with our Verity House Agreement, and through extensive consultation with partners. Making progress to reduce harms and improve outcomes depends on effective partnership working across national and local government, health and social care, justice, housing, the third sector, and communities. The PDF reflects a joint approach based on collaboration, mutual respect, and clear lines of accountability across partners.

This PDF supports the delivery of our new Strategic Plan: Preventing Harm, Promoting Recovery and sits alongside the National Service Specification. It aligns with Scotland's public health and human-rights-based approach, including the Charter of Rights for People Affected by Substance Use.

The PDF sets out shared expectations for how the alcohol and drugs system operates. It provides clarity on roles, responsibilities and ways of working across national and local partners.

The PDF makes clear that Alcohol and Drug Partnerships (ADPs) are central to the planning and coordination of services that best meet the needs of our communities, through visible and collaborative leadership and partnership working at a local level. The PDF supports ADPs to translate national priorities into locally responsive action and recognises the importance of strong governance, clear accountability, and effective use of resources.

This PDF represents a renewed shared commitment to working together to reduce alcohol and drug related harm and improving the lives of all who are affected. Through partnership, leadership, and compassion, we can strengthen delivery and support better outcomes for people across Scotland.

Maree Todd MSP
Minister for Drugs and Alcohol Policy and Sport

Councillor Paul Kelly
Health and Social Care Spokesperson

1. Context

1.1 This Partnership Delivery Framework (PDF)

This document details the partnership arrangements needed to reduce the use of and harms from alcohol and drugs. The purpose of this framework is to ensure that all partners have a clear understanding of accountability arrangements, their responsibilities and duties within the framework, and some of the higher-level practices necessary, to achieve agreed and shared outcomes.

This new PDF is designed to be consistent with, and to build directly upon:

- The Verity House Agreement between Scottish Ministers and COSLA to work together in partnership;
- The Scottish Government's (SGs) strategic aims and National Performance Framework;
- The existing statutory reporting and performance arrangements, including NHS Annual Delivery Planning and Integration Authority (IA) performance reporting under the Public Bodies (Joint Working) (Scotland) Act 2014; Scottish Police Authority monitoring and reporting; etc.;
- Statutory duties for community planning, built around a purpose that local public services work together and with community bodies to improve outcomes and tackle inequalities;
- The Charter of Rights for People Affected by Substance Use which was launched in 2024 by the National Collaborative and supported by the SG and COSLA Leaders;
- The Population Health Framework, which sets out SG's and COSLA's long-term collective approach to improving Scotland's health and reducing health inequalities for the next decade through an emphasis on prevention;
- The Health and Social Care Service Renewal Framework, which highlights the shared ambition between the SG and COSLA to ensure people of all ages are able to live well, with the right support in the right setting, and to lead healthier and more fulfilling lives;
- Preventing Harm, Promoting Recovery: Scotland's Alcohol & Drugs Strategic Plan; and
- The National Service Specification for the alcohol and drugs treatment and recovery system.

This PDF supersedes the following documents in full:

- A new Framework for Local Partnerships for Alcohol and Drugs (2009);
- Supporting the Development of Scotland's Alcohol and Drug Workforce (2010);
- Updated Guidance for Alcohol and Drug Partnerships on Planning and Reporting Arrangements 2015-18 (2014); and
- Partnership Delivery Framework (2019).

The provisions contained herein represent the current agreed expectations and commitments of signatory and endorsing partners.

This framework has been formally approved by Scottish Ministers and COSLA Leaders, demonstrating a clear commitment from both national and local government to work collaboratively, with the joint aim of reducing the levels of drug and alcohol related harm in Scotland. To achieve this aim, ongoing collaboration will be required alongside Community Planning Partnerships (CPP), Alcohol and Drugs Partnerships (ADPs), Integration Authorities (IAs), NHS Boards, Local Authorities (LAs), Police Scotland, Third Sector and other Community Partners. All partners are encouraged to have regard to this PDF within their existing statutory governance arrangements.

1.2 Background and Evolution of the System

This section provides brief contextual background to the development of ADPs and the current strategic landscape. It is not intended as a comprehensive policy history.

1.2.1 Origin and Purpose of ADPs

ADPs were established to provide a coordinated, multi-agency approach to addressing alcohol- and drug-related harm at a local level. Their creation recognised that no single organisation can prevent harm, deliver treatment and recovery services, nor address the wider social determinants of substance use in isolation.

ADPs bring together key statutory partners – including Local Authorities (LAs), Territorial Health Boards, Integration Authorities (IAs), Police Scotland, the Scottish Prison Service (SPS) and Third Sector organisations – alongside people with lived and living experience (LLE). Their core purpose is to consider, plan, monitor, and improve local alcohol and drug services in line with evidence, national policy, statutory duties, and local need.

From their inception, ADPs have been rooted in partnership working, and collective and collaborative leadership. They operate within broader community planning and public protection structures and are expected to align their work with wider local outcomes relating to health, wellbeing and inequalities.

1.2.2 Integration and Governance Context

The integration of health and social care through the Public Bodies (Joint Working) (Scotland) Act 2014 strengthened the requirement for coordinated planning and delivery of services across organisational boundaries. In most areas, ADPs operate within, or report to, IAs as part of integrated governance arrangements. In all cases, they sit within the wider local public service landscape and are accountable through established lines of democratic and statutory oversight.

Governance arrangements vary across Scotland to reflect local structures. However, regardless of configuration, ADPs are expected to demonstrate clear lines of accountability, transparent decision-making, and effective performance oversight. This includes clarity about how strategic priorities are translated into commissioned services, how resources are deployed, and how outcomes are monitored and improved.

1.2.3 Current Strategic Landscape

ADPs operate within a national framework comprising:

- The National Charter of Rights for People Affected by Substance Use, which sets out the rights of people affected by alcohol and drugs and the expectations placed on services and partners in upholding those rights, building on;
- The National Alcohol and Drugs Strategic Plan, which sets the overarching vision, aims and outcomes;
- The National Specification for Drug and Alcohol Services, which defines what services and pathways should be available; and
- The Medication Assisted Treatment (MAT) Standards, which establish nationally mandated standards to ensure timely, evidence-informed and consistent access to medication-assisted treatment and related support.

Within this architecture, this PDF sets out who is responsible for designing, delivering, supporting and scrutinising local systems. It clarifies roles, relationships and accountability across partners, and describes how ADPs function within the wider system of national and local governance.

The remainder of this PDF therefore focuses on the governance and partnership arrangements through which national strategic commitments are considered and delivered locally, and how partners assure improvement in outcomes for individuals, families and communities.

1.3 Preventing Harm, Promoting Recovery: Scotland's Alcohol & Drugs Strategic Plan

This PDF sits alongside the publication of Preventing Harm, Promoting Recovery: Scotland's Alcohol & Drugs Strategic Plan, which follows the end of the National Mission on Drugs and sets out our long-term ambition to address the complex challenges associated with alcohol and drugs.

Alcohol and drugs related harm remains very high within our communities with people living in the most deprived areas continuing to be significantly disproportionately affected. Many people with alcohol and drug issues face overlapping challenges including homelessness, experience of domestic abuse, adverse childhood experiences, and involvement with the justice system. Hundreds of children lose a parent to a drug death every year. There continues to be changing trends to the ways that substances are consumed. Polysubstance use, increasing prevalence of cocaine use, contaminated drug markets, and the emergence and unpredictable nature of toxic synthetic substances has increased the risk of overdose and death for users. Additionally, Scotland continues to have the highest rate of alcohol-specific deaths within the UK constituent countries.

The SG's National Mission, launched in 2021, marked a step change in investment and commitment to address Scotland's drug-related public health crisis, driving major progress in treatment standards, rehab capacity, and harm reduction facilities.

The new Strategic Plan, supported by this PDF, reiterates this commitment and outlines our outcomes and priorities alongside immediate commitments that will lay the foundation for lasting change and help achieve our long-term outcomes. At its heart is a renewed pledge to ensure that individuals and families affected by alcohol or drugs receive person-centred care, delivered with dignity, respect, and compassion. It is grounded in a human rights-based approach that recognises everyone's right to health, equality, and participation in decisions affecting their lives.

The Strategic Plan will also be supported by a new National Specification that defines the minimum expected components of drug and alcohol treatment and recovery services across Scotland to ensure equity, consistency, and quality in service provision, while allowing for local flexibility based on need.

The Strategic Plan, like its predecessors, recognises the need for a whole systems, cross-policy, approach to tackling the harms of alcohol and drugs and recognises the need for co-ordination with a wide range of stakeholders.

The Plan aligns with the broader approach and ambitions set out in the Public Service Reform Strategy, Population Health Framework, and Service Renewal Framework, which are central to driving whole-system change across public services, including health and social care, housing, education, and justice.

Self-Assessment Checklist: Context and Induction

Individuals and organisations noted as partners have a clear understanding of the historical development and policy context of current alcohol and drugs policy and this PDF, including recognition of many underlying and evolving social, health, and systemic challenges impacting people's recovery journeys.

There are means in place locally and within the Alcohol and Drugs Partnership (ADP), to ensure that partners are appropriately inducted and informed of the context within which we are collectively attempting to deliver improved holistic support to people affected by problematic use of alcohol and drugs.

To Note: These Self-Assessment Checklist boxes are highlighted throughout the sections of this Partnership Delivery Framework (PDF), and collated in **Annex A**. The reflective questions contained in these checklists are intended to support self-evaluation and improvement. They do not create new statutory duties or override existing governance responsibilities.

2. Structures and Resources

2.1 Broad Structures

The policy, planning and delivery landscape supporting people affected by problem use of alcohol and drugs is complex. This narrative describes the overall structure, with later sections setting out practical implications.

At a UK level, the UK Government retains reserved responsibility for the legislative framework governing the supply and misuse of drugs, primarily through the Home Office, underpinning enforcement and judicial responses. Alcohol policy is not reserved. The UK Department for Work and Pensions (DWP) provide financial support for people experiencing wider hardship or deprivation.

At a national level, the Scottish Government (SG) adopts a public health approach and provides strategic direction through consultation and evidence gathering; national policy frameworks; funding mechanisms; and national performance monitoring and reporting. Social Security Scotland provides financial support, while National Records of Scotland maintains data supporting policy development.

Between national and local levels sit statutory and third sector partners operating on a Scotland-wide basis but delivering regionally or locally.

At a local level, NHS Boards and Local Authorities (LAs) each hold statutory responsibility for their respective functions. Certain adult health and social care functions are delegated to Integration Authorities (IAs) in accordance with approved integration schemes. IAs operate under the Public Bodies (Joint Working) (Scotland) Act 2014. In most areas this takes the form of an Integration Joint Board (IJB) (a distinct legal entity). In lead agency areas, integration functions are exercised by the relevant Health Board (HB) or Local Authority (LA) in accordance with the integration scheme. For the purposes of this Partnership Delivery Framework (PDF), references to IAs include areas operating lawful integration arrangements.

IAs facilitate local strategic planning through Alcohol and Drugs Partnerships (ADPs). ADPs operate within a wider landscape of local partnerships, often subordinate to Community Planning Partnerships (CPP) and/or Chief Officers Groups (COGs), and are expected to work in a complementary and aligned way. Throughout this PDF, references to ADP leadership relate to coordination, assurance, influence and escalation, rather than direct service delivery or statutory accountability.

At service delivery level, partners are accountable for commissioned activity under the local ADP strategic plan. Delivery, effectiveness, and outcomes should be monitored and reviewed through contractual and ADP arrangements to support learning, improvement, and decisions on future commissioning.

2.2 Partners

Outlined below are the key organisations and groups that hold significant interest in, responsibility for, or influence over the planning, governance, and delivery of services to support people affected by problematic use of alcohol and drugs. This list is not exhaustive but seeks to ensure that key partners are clearly identified and that their respective roles and contributions are understood within the wider system.

In line with this PDF, ADPs are expected to engage a broad and inclusive range of stakeholders beyond their core membership. This includes people with lived and living experience and other individuals and groups who can contribute meaningfully to strategic planning, service design, and delivery. ADPs should consider involving these wider stakeholders through formal meetings, sub-groups, and other mechanisms that support genuine, participatory engagement.

A table detailing the principal lines of accountability for the partners listed below is included at **Annex B**.

2.2.1 People with Lived and Living Experience (LLE)

People with LLE of substance use play a vital role in shaping effective, fair, and evidence-informed alcohol and drugs policy and services at all levels of the policy and service landscape. Meaningful participation is central to a human rights-based approach which underpins the SG's Alcohol and Drugs Strategic Plan, Preventing Harm Promoting Recovery.

Direction for the participation of people with LLE is set through national policy, guidance, and commissioning expectations, with decisions about how involvement is realised taken within the governance arrangements of national programmes, ADPs, and individual organisations. This includes decisions on ethical application of participation models, support, and how input is used in decision-making.

LLE adds value to service design and improvement by shaping strategies and services that are grounded in real-world experience and recovery. Meaningful participation supports safer, more accessible, services and improves accountability to the people most affected.

Accountability for meaningful and well-supported LLE involvement sits with Ministers, senior officials, ADP Chairs, Chief Officers, and service leaders, who should ensure the structures, resources, and cultures are in place to enable real influence in decision making.

Staff as a Voice of Lived and Living Experience (LLE):

Staff with LLE are recognised as vital, offering unique insights that enhance service delivery, provide hope, and shape policy, particularly in substance use and mental health sectors. The Scottish Government's Guiding Principles on Supporting Employees with Lived and Living Experience emphasise treating staff with experience as equal partners, ensuring parity with paid staff, removing employment barriers, and providing appropriate support.

2.2.2 National Partners

2.2.2.1 UK Government (and Departments)

The UK Government holds reserved responsibility for key aspects of the legislative, regulatory, and fiscal framework within which alcohol and drugs policy operates across the UK. In particular, the Home Office has statutory responsibility for drugs policy and control under the Misuse of Drugs Act 1971, including classification and scheduling of controlled substances, alongside responsibilities for the associated criminal justice framework. The DWP holds UK-wide responsibilities for social security and employability.

Direction is set by UK Ministers, with policy developed within Departments and delivery overseen through their executive agencies. Within the Home Office, Ministers and senior officials set policy

and operational priorities for reserved drugs legislation and enforcement approaches that influence justice partners operating in Scotland; within DWP, Ministers and senior officials set welfare and labour market policy and delivery expectations through established departmental governance.

In relation to alcohol and drugs, UK reserved legislation and justice policy directly shape the context in which devolved prevention, treatment, and recovery services operate, including where interventions intersect with controlled drug law or justice pathways. DWPs policies influence income security, housing stability, and employability, which are key determinants affecting vulnerability, engagement with services, and recovery outcomes.

Key accountable officeholders include the Home Secretary and Secretary of State for Work and Pensions, supported by their Permanent Secretaries, and relevant Directors General / senior policy leads, who should ensure UK policy and operational practice is developed with due regard to impacts on Scotland's alcohol and drugs priorities.

2.2.2.2 Scottish Government (SG) (and Agencies)

The SG provides national leadership and strategic direction for Scotland's response to alcohol and drug harm within devolved competence, setting national strategy, policy and priorities and allocating funding to support local delivery through ADPs and partners. This role is grounded in ministerial accountability to the Scottish Parliament and exercised primarily through policy, guidance, oversight and engagement rather than direct service provision.

Direction is set by Scottish Ministers, with decisions taken through the SG's established governance and budget processes, supported by Directors General, Directors, and senior officials. Executive agencies operate within this framework, delivering statutory or operational functions on behalf of Ministers.

In relation to alcohol and drugs, the SG sets the national outcomes, expectations, and improvement approach that ADPs and partners are expected to deliver against, and funds national and local activity. Social Security Scotland delivers devolved benefits under powers transferred through the Scotland Act 2016, which can materially influence stability and recovery for people affected by substance use. National Records of Scotland produces authoritative population statistics under the Registration of Births, Deaths and Marriages (Scotland) Act 1965 and related legislation, including drug-related and alcohol-related death statistics that inform planning, scrutiny, and evaluation.

Key accountable officeholders include relevant Cabinet Secretaries and Ministers, the Permanent Secretary, Directors General, and the Chief Executives of the agencies above.

2.2.3 National Partners with a Local Role

2.2.3.1 The Convention of Scottish Local Authorities (COSLA)

COSLA is a politically-led, cross-party organisation that represents the collective interests of Scotland's Local Authorities (LAs). COSLA is the representative voice of Local Government (LG) on national issues relating to policy, funding, and legislation and negotiates on behalf of LAs in order to secure the resources and powers they need.

Direction is set democratically through COSLA's political leadership, with policy positions developed through engagement with elected members and local partners, including officers in LAs and professional associations. Decisions are taken through COSLA's internal governance, which

includes policy boards, meetings of council Leaders and COSLA Convention which sets the strategic direction and is representative of the political make up of councils. Elected members from all member councils are represented across COSLA's governance.

In relation to alcohol and drugs, COSLA is a key national partner in shaping approaches that are deliverable locally, supporting sector-led improvement, peer learning and shared practice, and helping align alcohol and drugs priorities with wider local government responsibilities such as housing, social work, community planning and community justice. COSLA jointly owns the PDF and Strategic Plan for Alcohol and Drugs with Scottish Government.

Key accountable office-holders include COSLA's political leadership, Chief Executive and Directors.

2.2.3.2 Special NHS Boards

Special or Special NHS Boards are statutory NHS bodies operating within the NHS governance framework, including the National Health Service (Scotland) Act 1978, the Public Services Reform (Scotland) Act 2010, and associated direction and accountability arrangements. They provide national capability that supports local planning and delivery. All Special Boards have a SG Sponsor team who work to ensure partnership working and delivery of shared goals, and each has a Board Operating Framework which sets out how the organisations will interact.

Public Health Scotland (PHS) provides public health intelligence, analytical capability, and improvement support, and is accountable to Scottish Ministers and COSLA Leaders through its Board and Chief Executive. To reflect the key importance of driving whole system working locally and nationally in order to improve population health, PHS is jointly sponsored by the SG and COSLA Leaders, who work collaboratively to inform and guide the work of the body. Decisions sit with the Board and Executive Team. In relation to alcohol and drugs, it supports evidence-based planning and improvement through data, benchmarking and support to ADPs and partners. Key accountable officers are the Chief Executive, and relevant Directors.

Healthcare Improvement Scotland (HIS) is NHS Scotland's improvement body, supporting and assessing the quality of health and social care services, operating independently within its legislative remit and accountable to Scottish Ministers through its Board and Chief Executive. Decisions are taken by its Board and Executive Team. In relation to alcohol and drugs, it develops standards, undertakes scrutiny and supports improvement to ensure services are safe, effective, and person-centred. Key accountable officers are the Chief Executive, and relevant Executive Directors.

The Scottish Ambulance Service is a Special Health Board delivering national emergency and urgent care, accountable through its Board, Chief Executive, and clinical governance arrangements within the strategic and policy framework set by Ministers. Decisions are taken by the Board and Executive Team. In relation to alcohol and drugs, it provides frontline response (including naloxone) and supports pathways into care through conveyance/signposting. Key accountable officers are the Chief Executive, and Medical Director / clinical governance leads.

2.2.3.3 Crown Office and Procurator Fiscal Service (COPFS)

COPFS is Scotland's public prosecution service and death-investigation authority, led independently by the Lord Advocate (a Law Officer of the Scottish Government) under constitutional arrangements including the Scotland Act 1998. It is responsible for investigating and prosecuting crime and investigating sudden, suspicious and unexplained deaths.

Direction is set by the Lord Advocate, supported by the Solicitor General, Crown Agent and senior prosecutors, with operational prosecution decisions taken by Procurators Fiscal locally in line with prosecution policy.

In relation to alcohol and drugs, COPFS supports proportionate, public-health-informed justice responses through appropriate use of diversion, and by supporting community-based sentencing pathways (e.g., Drug Testing and Treatment Orders (DTTOs) and Community Payback Order (CPOs) that can reduce reoffending while enabling treatment and recovery. It also supports victims and witnesses affected by associated crime.

Key accountable officeholders are the Lord Advocate, Solicitor General, Crown Agent, Area Procurators Fiscal, and senior legal managers.

2.2.3.4 Scottish Courts and Tribunals Service (SCTS)

SCTS is the statutory body responsible for the administration of Scotland's courts and tribunals under the Judiciary and Courts (Scotland) Act 2008, providing buildings, staff and systems while preserving judicial independence.

Direction is set by the SCTS Board (chaired by the Lord President) with operational management led by the Chief Executive. Decisions on resources and operations sit within Board governance and executive management.

In relation to alcohol and drugs, SCTS enables the operation of specialist and problem-solving courts (where established) by providing the infrastructure and administrative support that allows judicially-led therapeutic and problem-solving approaches to function and to link justice processes with treatment and recovery pathways.

Key accountable officeholders are the Lord President (as Board Chair), SCTS Board members, Chief Executive, and senior operational leaders.

2.2.3.5 Police Scotland

Police Scotland is Scotland's national police service established under the Police and Fire Reform (Scotland) Act 2012, responsible for public safety, crime prevention/detection, and protecting people at risk of harm.

Strategic oversight is provided by the Scottish Police Authority, with operational independence exercised by the Chief Constable through national and divisional policing structures where local decisions are taken.

In relation to alcohol and drugs, Police Scotland contributes through enforcement (including disruption of illegal supply), safeguarding and partnership working, sharing intelligence to support prevention and harm reduction, and directing people towards services. This supports a balanced approach between public protection and public health.

Key accountable officeholders are the SPA Chair and Board (oversight), Chief Constable, Deputy Chief Constables, Divisional Commanders, and relevant local senior officers.

2.2.3.6 Scottish Prison Service (SPS)

SPS is Scotland's national prison authority, established under the Prisons (Scotland) Act 1989, responsible for safe custody, security and rehabilitation within the prison estate.

Direction is set within the strategic framework established by Scottish Ministers, with governance through the SPS Board and operational decisions taken by the Chief Executive, senior leadership and Governors within establishments.

In relation to alcohol and drugs, SPS reduces substance-related harm in custody through security measures and recovery-focused approaches, working with NHS and partners to deliver harm reduction, treatment, continuity of care and reintegration planning, including strong links to community services on liberation.

Key accountable officeholders are the Cabinet Secretary/Ministerial portfolio lead, SPS Board Chair, Chief Executive, Governors, and relevant health/rehabilitation leads.

2.2.3.7 Scottish Fire and Rescue Service (SFRS)

SFRS is Scotland's national fire and rescue service established under the Police and Fire Reform (Scotland) Act 2012. The main purpose of the SFRS is to work in partnership with communities and with others in the public, private and third sectors, on prevention, protection, and response, to improve the safety and well-being of people throughout Scotland.

Scottish Ministers' priorities are set out in a Fire and Rescue Framework, with governance provided by the SFRS Board and operational decisions taken by the Chief Officer and local senior officers based on national and local risk assessment.

In relation to alcohol and drugs, SFRS contributes by targeting prevention and early intervention where substance use increases vulnerability and household risk, including through home fire safety visits, risk assessment, and partnership working with ADPs and community planning structures.

Key accountable officeholders are the SFRS Board Chair, Chief Officer, relevant Directors, and senior local officers.

2.2.3.8 National Third Sector Organisations

National third sector or independent organisations are funded by the SG or its agencies to deliver specialist functions. Their role derives from commissioning/grant arrangements and organisational purposes rather than statute.

Direction is set through grant conditions or contracts, with internal decisions taken by each organisation's Board/Trustees and senior leadership, and accountability for public funds shared through reporting and governance arrangements with commissioners.

In relation to alcohol and drugs, these organisations bring specialist expertise, innovation, and links to LLE, supporting ADPs and partners through advocacy, workforce development, quality improvement, and direct support, often addressing gaps or groups less well served by mainstream provision.

Key accountable officeholders are commissioning senior responsible officer(s) within government, and the Chairs, Boards/Trustees, Chief Executives, and relevant service leads within the organisations themselves.

2.2.3.9 Elected Members of Respective Parliaments

Elected Members of the UK Parliament and Scottish Parliament provide democratic accountability for public policy through legislation, budget scrutiny, and holding governments to account. Their role derives from electoral mandate rather than executive responsibility for delivery.

Direction is exercised through parliamentary processes (Chamber business, committees, scrutiny and questions), with individual Members shaping debate and accountability through representation, committees, and engagement with Ministers and public bodies.

In relation to alcohol and drugs, Members raise constituent experience, highlight emerging issues, and scrutinise outcomes, transparency, and use of public funds, supporting alignment between national strategy and lived community experience.

Individual Members are accountable to their electorates. All partners should ensure Members can fulfil scrutiny and representative roles through the provision of appropriate information and engagement.

2.2.4 Local Partners

2.2.4.1 Territorial Health Boards

Scotland's 14 Territorial Health Boards (HBs) are statutory NHS bodies under the National Health Service (Scotland) Act 1978, responsible for planning, commissioning and delivering healthcare services for their populations.

Direction is set through national policy, funding, and performance frameworks established by Scottish Ministers, with decisions taken by each HB and Executive Team under clinical and corporate governance arrangements (including Medical Director, Director of Public Health, and Nursing Director roles).

In relation to alcohol and drugs, HBs deliver and/or commission a broad range of relevant services across primary care and contracted services, specialist nursing, mental health (including CAMHS), emergency/acute care, and relevant specialisms such as hepatology and BBV services, making integration essential for continuity, co-morbidity, and harm reduction.

Key accountable officeholders are Board Chairs, Chief Executives, Medical Directors, Directors of Public Health, Nursing Directors, and relevant service directors.

2.2.4.2 Local Authorities (LAs)

Scotland's 32 LAs are statutory bodies established primarily under the Local Government (Scotland) Act 1973, responsible for a wide range of local public services and democratic governance.

Direction is set by elected members through council decision-making (committees, cabinets and full council), with operational decisions taken by senior officers within corporate governance arrangements and, where relevant, through integrated or partnership structures.

In relation to alcohol and drugs, LAs provide leadership and coordination within ADPs and contribute directly through social work and social care (children and adults), housing and homelessness, education, and community planning. These responsibilities are critical to prevention, safeguarding, recovery, and the wider determinants of harm.

Key accountable officeholders are Council Leaders/Conveners, Chief Executives, Chief Social Work Officers, Directors of Social Work/Social Care, and relevant Directors (e.g., Housing, Education).

2.2.4.3 Integration Authorities (IAs)

IAs are statutory bodies established under the Public Bodies (Joint Working) (Scotland) Act 2014. The primary duty is to strategically plan, commission and oversee the delivery of integrated adult health and social care services in a LA area (including through Integration Joint Boards (IJBs) or locally agreed alternative arrangements).

IAs have responsibility for governance, planning, and resourcing of integrated health and social care services in their local area (through IJBs where applicable). Accountability is shared to partner organisations and within national performance frameworks. Decisions on commissioning and resource allocation are taken by the IJB/lead governance body and Chief Officer/finance leadership.

In relation to alcohol and drugs, IAs embed substance use services within wider care pathways (community health, adult social care, mental health and related supports such as housing and family services), enabling coordinated, person-centred, support and continuity across prevention, treatment, recovery, and ongoing care.

Key accountable officeholders are IJB Chairs, Chief Officers, Chief Finance Officers, relevant clinical and social care leaders, and partner organisation Chief Executives as appropriate.

Chief Officers (COs)

As set out in the Chief Officers' Public Protection Induction Resource (November 2023), COs are determined as:

Chief Executives of Health Boards
Chief Officers of Local Authorities
Senior Police Officers with delegated authority of the Police Chief Constable

Chief Officer Public Protection Groups (COGs) are the mechanism through which COs ensure their agencies fulfil their statutory duties across all public protection domains. In other words:

Statutes and guidance impose duties on agencies, not on COGs directly.
COs, as the senior accountable leaders of those agencies, must ensure these duties are delivered.
Chief Officer Groups exist as the collective structure through which this statutory accountability and oversight is exercised.

Where Alcohol and Drug Partnerships (ADPs) sit as part of the Chief Officers Public Protection Group the Chief Officers' Public Protection Induction Resource (November 2023), states that COs responsibilities include ensuring that the ADP has strong governance, clear accountability, and

effective leadership, including appointing an impartial Chair, providing resources, overseeing delivery plans, monitoring performance and finance, and enabling collaboration with wider partnerships. Chief Officers should either sit on or be represented within the ADP and ensure that its work aligns with national frameworks and reporting requirements.

2.2.4.4 Chief Officers' (Public Protection) Groups (COGs)

COGs are senior multi-agency leadership forums within local public protection and community planning arrangements. They are not statutory bodies. Their authority derives from the statutory responsibilities of member organisations and officeholders.

Direction is set collectively by senior leaders through local governance arrangements, providing oversight, coordination, and assurance across strands such as Child Protection, Adult Support and Protection, Multi-Agency Public Protection Arrangements (MAPPA), Violence Against Women and Girls (VAWG), Suicide Prevention, and Alcohol and Drug-related harm.

In relation to alcohol and drugs, COGs can help to provide greater accountability and align ADP activity with wider public protection and community safety systems, supporting shared risk awareness, integrated planning, coherent escalation/assurance, and accountability where harms overlap.

2.2.4.5 Local Strategic Planning and Delivery Groups and Partnerships

Community Planning Partnerships (CPPs) are statutory partnerships under the Community Empowerment (Scotland) Act 2015 that align local priorities, resources and action across public services to improve outcomes and reduce inequality.

Direction is set collectively through agreed CPP governance. Accountability remains with each partner organisation for its statutory functions. CPPs produce Local Outcomes Improvement Plans (LOIPs) and Locality Plans, with priorities and delivery agreed collaboratively.

In relation to alcohol and drugs, where substance use is identified as a local priority, CPPs sometimes act as a higher-level coordinating body, aligning the objectives and investment in broader community wellbeing and public protection priorities, and ensuring alcohol and drugs responses are embedded within.

Key accountable officeholders are senior leaders from statutory partners participating in the CPP, particularly local authority Chief Executives and elected members, NHS Chief Executives, and relevant senior officers.

2.2.4.6 Third Sector Organisations

Third sector organisations are independent bodies (often charities or not-for-profit organisations) delivering community-based support. Their role is derived from organisational purposes and, frequently, commissioning or grant arrangements with public bodies, including LAs or IAs.

Direction is set by Boards/Trustees, with operational decisions taken by senior managers in line with regulatory obligations and funding agreements. Accountability for public funds sits with both providers and commissioners through agreed governance and reporting.

In relation to alcohol and drugs, third sector organisations deliver trauma-informed, person-centred, support including harm reduction, peer recovery, advocacy, family support, and outreach, often improving access and complementing statutory provision through integrated or hub models.

Key accountable officeholders are Trustees/Boards, Chief Executives, senior managers/service leads, and commissioning leads within partner public bodies.

2.2.4.7 Locally Elected Members

Locally elected members (councillors) provide democratic leadership, scrutiny and accountability within and of LAs. Their mandate derives from election rather than executive responsibility for delivery.

Direction is exercised through council governance (committees, cabinets and full council) where budgets and priorities are set, and through scrutiny arrangements holding senior officers and partnerships to account.

In relation to alcohol and drugs, councillors can strengthen transparency and alignment between ADP priorities and wider council objectives (housing, education, social care, community planning), and may engage with ADP governance in line with local arrangements.

Elected members are accountable to their electorates, supported by Council Leaders/Committee Chairs, and senior officers, ensuring members can fulfil scrutiny and governance roles.

3. What is an Alcohol and Drugs Partnership (ADP)

ADPs are not statutory bodies and do not hold corporate legal responsibility. Statutory accountability for functions and services remains with the relevant NHS Boards, Local Authorities (LAs), Integration Authorities (IAs) and other public bodies and partners. ADPs provide a structured mechanism to support coordination, planning, assurance, and improvement within existing statutory governance arrangements. The adoption of ADPs is therefore provided for under the terms of this Partnership Delivery Framework (PDF) and accepted, widely endorsed, and encouraged as the best-practice means of lending relevant intelligence and authority to the collaborative planning of alcohol and drugs, and wider wrap-around, support services at a local level.

An ADP is convened with the intention of:

- Collaboratively creating a local strategic plan for the holistic and coordinated delivery of services, interventions, and initiatives, at the local level;
- Improving understanding, promoting harm reduction, combatting stigma, and ensuring the consideration and integration of alcohol and drugs related issues and mitigation in wider strategic planning, at the local level;
- Providing a primary conduit for the exchange of information and shared learning between partners to ensure informed and effective service planning and provision;
- Providing strategic input to, and coordination of, the commissioning and disbursement of national strategic (and other) funding to, local service partners, per local strategic plans;
- Facilitating peer and public scrutiny of local and partner activity, against local strategic planning, through the monitoring, ingathering, collation, evaluation, and communication of reporting and performance data and information, and robust financial monitoring information.

Children and Young People

Children and young people are a core consideration within local alcohol and drug planning, recognising both the direct and indirect impacts of alcohol and drug use on children's wellbeing, safety and life chances. This includes the importance of prevention, early intervention, and reducing intergenerational harm.

Alcohol and Drug Partnerships (ADPs) are expected to maintain clear links with Children's Services Planning Partnerships and other relevant children's planning and safeguarding structures, to ensure alignment between alcohol and drug priorities and wider children and families planning arrangements, including education, youth justice, and early years partners, as appropriate.

An ADP may be thought of as consisting in two parts: the forum, and the support team:

3.1 The ADP Forum

The first is as a forum for discussion, collaboration, problem-solving, planning, monitoring, peer-scrutiny, evaluation, learning, and improvement of local services and initiatives aimed at supporting people affected by problematic use of alcohol and drugs.

There should be no senior or superior member, either individual or institutional, within the ADP, with all partners bringing relevant value, experience, and expertise, as well as several accountabilities, to ensure balanced, holistic, and considered discussion and outcomes.

The forum may convene in a plenary, or subordinate subject-specific format, dependent on agreed local requirements, and should convene in plenary format at least quarterly.

The recommendations, planning, and any other products of the ADP are to be compiled collaboratively and by broad agreement of the ADP as a whole, before being subject to final endorsement, or agreement, and ratification by local statutory commissioning partners. This gives authority to, and a clear line of accountability for, those products.

3.1.1 Minimum Expected Cohort of an ADP

The specific organisations and individuals involved in any ADP will vary depending on local context. Any combination of the Partners described in Section 3, or others not listed, may be represented on a local ADP. Those participating in the ADP or its sub-groups should have the authority and responsibility to influence provision and contribute to decision-making across the ADP's strategic priorities. Their involvement should support the ADP's overarching aim of improving outcomes for individuals, families, and communities affected by alcohol and drug use. Below is a list of the minimum or core expected cohort of any ADP.

- Lived & Living Experience (LLE)
- Integration Authority (IA) (incl. Chief Officer, Chief Financial Officer)
- Local Authorities (LA) (incl. Social Work, Children and Young People, and Housing.)
- Health Board (HB) (incl. Primary Care)
- Police Scotland (and other justice services such as Scottish Prisons Service (SPS), where appropriate)
- Third Sector

Self-Assessment Checklist: The Alcohol and Drugs Partnership (ADP)

All key statutory and strategic partners been invited to participate in the ADP in some form.

The ADP comprises all representatives noted within the minimum expected cohort.

The ADP has taken steps to incorporate meaningful engagement with people with lived and living experience of substance use, in line with the Charter of Rights and the principles of participation, dignity, and co-production.

There are processes in place to regularly review, strengthen, and potentially broaden partner involvement.

3.2 The ADP Support Team

The second form an ADP takes is in its coordinating Support Team, providing secretariat function to the ADP Forum and supporting the coordination, communication, commissioning, monitoring, and accounting for the ADP's collective priorities.

The relevant employing body, as determined through local integration arrangements, will resource the ADP Support Team, whilst allowing the ADP the autonomy to engage in independent discourse and activity.

As a minimum the ADP should be supported by a Chair, and a dedicated Coordinator. Whilst there may be variations in local populations, needs assessment, resourcing, and practices, these two roles are the keystone to ensuring cohesive and effective collaboration between other partners. Their respective roles are described in the following sections.

Where an IA or other employing body determines that the functions of the ADP Support Team can be delivered through a reduced or differing staffing complement, that decision should be informed by a documented assessment of capacity, risk, and mitigation. This assessment should provide assurance that the expectations set out in this PDF remain deliverable and that appropriate governance, resilience, and workforce wellbeing arrangements are in place.

3.2.1 The ADP Chair

The Chair of the ADP provides strategic leadership and oversight to aid effective multi-agency collaboration in tackling substance-related harm. The ADP Chair plays a pivotal role in challenging partners in being coordinated, inclusive, and responsive to community needs. The Chair is responsible for:

- Setting strategic direction in alignment with national frameworks.
- Facilitating partnership working across statutory services, third sector organisations, and lived experience groups.
- Providing strategic oversight of governance and accountability arrangements, including monitoring progress against local delivery plans, and ensuring transparent financial arrangements.
- Championing LLE, embedding rights-based and trauma-informed approaches – as provided for in the *Charter of Rights for People Affected by Substance Use* – in service design and decision-making.
- Driving continuous improvement, through performance monitoring, data-informed planning, and quality assurance.

In partnership with Healthcare Improvement Scotland (HIS), ADP Chairs have undertaken the development of a formal role profile to support and clarify the responsibilities of the Chair position. This can be found in **Annex C**.

Local Autonomy, Propriety, and Objectivity in the Appointment of Alcohol and Drug Partnership (ADP) Chairs:

In some areas, the ADP Chair is appointed as an independent role, separate from statutory agencies, to enhance impartiality, strengthen accountability, and support cross-sector collaboration.

In other ADPs, the Chair may be drawn from senior leadership within local authorities, health boards, or integration authorities, to draw on existing relationships, networks, and influence.

The decision on Chair appointment rests with each individual Integration Authority (IA), based on local governance arrangements and partnership needs.

3.2.2 The ADP Coordinator / Lead

The ADP Coordinator / Lead plays a pivotal role in coordinating and driving local efforts to reduce harm from substance use. Their fundamental responsibilities span strategic leadership, partnership coordination, service improvement, community engagement, and reporting. Here's a breakdown of their core functions:

- Strategic Leadership
  - Contribution to National Policy Making, Engagement, and Improvement
  - Set the direction for local alcohol and drug strategies, in alignment with national frameworks.
  - Lead the development of a recovery-oriented approach across the whole continuum of support, from preventing and reducing initial harm to promoting long-term recovery and wellbeing. This includes ensuring commissioned services are person-centred, trauma-informed, and support people to have agency in improving their health and wellbeing.
  - Encourage alignment with broader public health, justice, and social care strategies.

- Partnership Coordination
  - Act as the central coordinator for multi-agency collaboration, bringing together partners both within and associated with the ADP.
  - Facilitate local forums to enable informed decision-making and improved accountability.

- Service Planning and Commissioning
  - Influence, coordinate, seek assurance, and escalate with partners to ensure that the contributions of people with LLE are considered and integrated within planning and service delivery.
  - Influence, coordinate, seek assurance, and escalate with partners to ensure services are responsive to local needs, and evidence-based, including support for families and children affected by substance use.
  - Support and coordinate the planning, commissioning, and evaluation of services for prevention, treatment, and recovery.

- Data, Monitoring, and Reporting
  - Co-ordinate on data collection and analysis to monitor progress against strategic goals and national standards.
  - Proactively report outcomes and impact to national and local bodies, ensuring transparency and accountability

3.2.2.1 Qualifications and Training

While formal qualifications may vary depending on local arrangements, ADP Coordinators are typically expected to have:

- Relevant professional experience in public health, social care, community planning, or substance use services.
- Strong skills in partnership working, project management, and strategic planning.
- Knowledge of national policy frameworks.

To support effective delivery, ADP Coordinators should have access to:

- **Induction and orientation** covering ADP governance, local priorities, stakeholder roles, and provisions otherwise contained in the Drugs and Alcohol Workforce: Knowledge and Skills Framework.
- **Ongoing professional development**, including training in trauma-informed practice, data analysis, commissioning, and lived experience engagement.
- **Peer learning opportunities**, such as national coordinator networks, workshops, and cross-ADP collaboration.

Local Autonomy and National Resourcing in Relation to Alcohol and Drug Partnership (ADP) Support Staff:

Responsibility for ADP Support Staff training and development typically lies with Integration Authorities (IAs) as their employer.

These organisations are expected to work in collaboration with national bodies such as Public Health Scotland (PHS) and Healthcare Improvement Scotland (HIS), and relevant professional networks to ensure Coordinators are supported in accessing appropriate learning and development opportunities.

Training should reflect the evolving nature of substance use policy and promote consistency, leadership, and innovation across ADPs.

Future Commitment: Alcohol and Drug Partnership (ADP) Support Resourcing

The Scottish Government (SG) will support enhanced capacity and consistency across ADP chairs and officers, whilst protecting the autonomy and flexibility of local planning and decision-making.

Self-Assessment Checklist: The Alcohol and Drug Partnership (ADP) Support Team

The ADP Coordinator / Support Team have the capacity and skills to support the ADP in setting a clear direction for local alcohol and drug strategies that align with the national Strategic Plan, relevant national frameworks and broader public health, justice, and social care priorities.

The ADP Coordinator / Support Team have the capacity and skills to support and encourage multi-agency collaboration across statutory, third sector, and community partners, including people with lived experience.

The ADP Coordinator / Support Team have the capacity and skills to support organised planning and project management and monitoring on behalf of the ADP.

The ADP Coordinator / Support Team have the capacity and skills to encourage and support appropriate information and data management and exchange between partners.

The ADP Coordinator / Support Team has on-going relevant training in areas such as:

Collaborative leadership and partnership working
Trauma-informed practice
Equality, diversity, and inclusion

Community engagement and co-production
Data analysis and performance reporting
Commissioning and financial oversight
Safeguarding and risk management
Human rights-based approaches

The ADP Coordinator / Support Team have identified any gaps in knowledge or skills that require further training and pursued options to fill those gaps.

The Integration Authority (IA) has provided support in sourcing corporate or other training to the ADP Coordinator / Support Team.

4. Practices

4.1 Flow of Finance

This framework highlights the vital role of Alcohol and Drug Partnerships (ADPs) in coordinating local use of earmarked and additional resources. Scottish Government (SG) funding to support national alcohol and drugs strategic objectives is delegated in its entirety for disbursement per local ADP Strategic Plans. As ADPs are not incorporated legal entities, SG funding is provided, via NHS Boards, to Integration Authorities (IAs), to allow accountable local commissioning and distribution.

SG funding allocated via this route, which is additional, should not be subject to any efficiency or wider savings targets, or redirection, at the NHS or IA levels.

Responsibility for funding treatment medications, including medicines used in the treatment of alcohol and drug dependence, and for the supply and distribution of naloxone, sits with NHS Boards and Health and Social Care Partnership (HSCP) treatment budgets. ADP funding is intended to support strategic planning, prevention, improvement, and coordination, and should not be used as a substitute for core treatment responsibilities.

Further local resourcing specific to alcohol and drugs support services may be made available, or put at the disposal of the IA, via or from local authority (LA) budgets. Where possible, ADPs should account for the integration of this funding within their planning and reporting.

It is the expectation that the Chief Finance Officer (CFO) of the IA, or their representative, should be present on the ADP.

ADPs are responsible for coordinating how dedicated and supplementary alcohol and drugs resource is used. The funding supports a range of priorities under agreed ADP strategic plans.

ADP partners are expected to link spending to priorities outlined in strategic plans and IA CFOs (supported by ADP Support Teams), as accountable budget-holders for locally allocated national funding, are expected to maintain auditable records of financial decision making and disbursement, to improve monitoring and evaluation.

Self-Assessment Checklist: Flow of Finance

The Integration Authority (IA) has provided specialist corporate finance support or training to allow prudent commissioning and disbursement of funding per the Alcohol and Drug Partnership (ADP) Strategic Plan.

The ADP has received its full allocation of Scottish Government (SG) national strategic funding, as detailed in the associated allocation letter, without the application of any top-slicing or efficiency savings.

The ADP has not been asked or encouraged by any partner to divert SG national strategic funding towards services or initiatives that should otherwise be resourced through other baselined/mainstreamed allocations.

The ADP has received, or been provided control over, any additional funding from other sources beyond SG national strategic funding and this has been transparently accounted for in planning and reporting.

The ADP, in its planned commissioning and disbursement, has accounted for any decision to deviate from, or otherwise reallocate funds allocated to fulfil, specific national objectives, and there is robust needs assessment and evidence to justify this.

All partners on the ADP contribute transparently to the strategic direction of the ADP, disclosing accurate and timely financial and resource reporting, ensuring that decisions on resource allocation are informed by local needs assessments and evidence-based approaches.

4.2 Evidence in Policy Formulation

Evidence is a fundamental element in policy making and provides policymakers with reliable data and insights helping them make decisions based on facts. Policies grounded in evidence are more likely to achieve intended outcomes and makes the policy making process more transparent. This allows stakeholders to understand the rationale behind decisions, holding policymakers accountable. Evidence-based policy making should be supported by ongoing and timely data collection, monitoring, and evaluation which leads to better outcomes and more resilient policies.

4.2.1 Sources of Evidence

Alcohol and drugs insights and data reporting, that contribute to evidence, are obtained from various sources which include PHS and SG. Other contributors include National Records of Scotland (NRS), Office for National Statistics (ONS), and the Scottish Prison Service (SPS), as well as the voices of people with lived and living experience (LLE). Much of the data that these institutions collect and use is published and available online, for example via the Scottish Public Health Observatory (ScotPHO).

DAISy

A key data collection tool within PHS is the Drug and Alcohol Information System (DAISy). DAISy was introduced and rolled out across all health boards during 2021 to assist Alcohol and Drug policy makers with data to support an evidence-based approach when making decisions on resource allocation. DAISy is a data collection tool which gathers key demographic treatment and outcome data on people who engage in tier 3 and 4 specialist alcohol and drug treatment services across Scotland.

In response to changing requirements, a review of DAISy was undertaken during 2024/25 followed by implementation in 2025. The key purpose of the review was to ensure DAISy continues to meet current requirements and can be adapted to support any future changes in service design.

RADAR

Also within PHS, recognising the need to understand changes in the substances people are taking, alongside being able to identify potential threats, the Rapid Action Drug Alerts and Response (RADAR) is Scotland's drugs early warning system. RADAR validates, assesses, and shares information to reduce the risk of drug-related harm by identifying new and emerging harms, recommending rapid and targeted interventions, and publishing accessible, up-to-date information on services, harms, and emerging drug trends.

SG Annual ADP Survey

SG undertake an Annual ADP Survey with the main aim to provide information on the activity undertaken by ADPs and the barriers experienced at a local level. It is crucial for local accountable entities to report to the SG on their monitoring and prudent application of public funds and progress made towards national outcomes.

To facilitate data collection and reporting, the survey is structured around the current priorities of national alcohol and drugs policy, and in collaboration with ADPs, with the survey reviewed annually to reflect evolving priorities while enabling year-on-year comparison. Findings from the survey have contributed to metrics in the current National Mission Annual Monitoring Report and are used to inform ongoing policy decision making. Findings also contribute to informing cross-government priorities in intersecting areas such as mental health, children and families, and justice.

Medication Assisted Treatment (MAT)

The Medication Assisted Treatment (MAT) programme is multi-agency, co-ordinated and led jointly by PHS and the Drugs Policy Division. The PHS based MAT Implementation Support Team (MIST) supports the roll out of the MAT standards by ensuring local areas have systems, protocols, and procedures in place, and publishes an annual National Benchmarking Report each summer. This provides an update on ADP progress towards implementation of the MAT Standards. The report scores each ADP area on a RAGB (Red, Amber, Green, Blue) basis for all 10 standards, with Blue representing sustained implementation. This scoring is based on having continuous improvement processes in place for the support and treatment options services offer, based on evidence, including experiential evidence from people who use the services, in community and justice settings.

The Strategic Plan details plans for expanding on the principles and approach of the MAT standards, the new standards for young people, and the Health and Social Care Standards, by establishing standards of support for all drugs and alcohol treatment. These will ensure the same level of focus on access, choice and support for everyone, regardless of the substance impacting them.

There is a significant body of qualitative research available which covers areas such as lived experience of using alcohol and drug services, outputs from evaluations and collated evidence around the effectiveness of different interventions and deep dives in specific topic areas. This evidence includes interviews, focus groups, ethnographic studies and peer research with people who use substances, their families and service providers, as well as secondary analysis of national and international research.

4.2.2 Data Sharing

The General Data Protection Regulation (GDPR) applies to ‘Controllers’ and ‘Processors’. A Controller determines the purposes and means of processing personal data and a Processor is responsible for processing personal data on behalf of a controller. PHS is the Scottish Government’s primary source of regular information and evidence regarding drug and alcohol use, service use, and harms. PHS processes personal data under the lawful basis of GDPR and the Data Protection Act 2018, which is not based on consent. Service users do not need to be asked to consent to this data collection and should be told how, and for what purposes, their data will be used.

It is imperative and expected that local areas input data into national systems and databases (e.g. DAISy) in accordance with deadlines and validation rules set by data partners, as these are an invaluable source of data for monitoring and evaluating drug and alcohol services across Scotland, informing policy development and funding at a local level. Data helps all partners understand the scope, scale, and nature of alcohol and drug use and their effects. It reveals trends, affected populations, and geographic hotspots.

We expect that ADPs (and associated local commissioning bodies) to work with service providers to ensure that input to national systems and databases is a condition of grant that is evaluated alongside delivery outcomes. Without robust data to inform our resource allocations, future funding decisions may not adequately reflect local needs, and it is therefore incumbent upon service providers to ensure they are accounting for their activity.

Self-Assessment Checklist: Data Sharing

The importance of data exchange is communicated to, and understood by, partners at all levels; and conditions of data compliance have been incorporated into commissioning agreements and contracts.

Contributing partners support the expectation that all commissioned services contribute to national systems for information exchange and statistical analysis (e.g. Rapid Action Drug Alerts and Response (RADAR) and Drug and Alcohol Information System (DAISy).

4.3 Lived and Living Experience (LLE)

The SG and COSLA are committed to meaningful participation as a fundamental component of a human rights-based approach. Participation is one of the PANEL principles that underpin how rights-respecting public services should be designed, delivered and reviewed. This means that people whose rights may be most directly affected should have genuine opportunities to shape the decisions, policies, and systems that impact their lives.

In the context of substance use, participation is particularly critical. As set out in the Charter of Rights, people with lived and living experience (LLE), along with their families and communities, are rights-holders whose insights are essential to understanding need, tackling harms, and improving outcomes. Meaningful participation is central to shifting power imbalances and ensuring that local and national decision making reflects the realities of people affected by substance use.

The FAIR model, outlined in the Charter of Rights Toolkit, is a key tool to ensure that the voices and rights of people affected by substance use help to support the design and delivery of human rights-based support services. In addition, national participation guidance, including the Participation Handbook and Planning with People, is available to ADPs and partners to support meaningful engagement and co-production. This guidance covers early involvement in needs assessment and design as well as supported participation in delivery and review. Practical enablers such as fair reimbursement for time and expenses should also be considered.

Partners' accountable officers should monitor, assess, and report on whether engagement has occurred and how effectively LLE has influenced decisions and improvement. Evidence should demonstrate transparent routes for involvement, proportionate support to participate, use of structured approaches such as FAIR, feedback loops showing impact, and learning from experience informing change.

Self-Assessment Checklist: Lived and Living Experience (LLE)

We recognise people with LLE as rights-holders and value their insights and perspectives.

LLE voices are involved early and throughout strategy, commissioning, service design, delivery and review.

We are clear about what can be influenced, what is fixed and how decisions are made.

We use structured, transparent approaches to engagement e.g. FAIR method.

Engagement methods are accessible, trauma-informed and responsive to people's circumstances (time, location, digital access, and safety).

We support people with LLE to participate meaningfully (e.g. advocacy, peer support, preparation, and debriefing).

LLE engagement reflects diverse experiences.

We have clear routes for feedback, complaints and anonymous input.

We report back to people with LLE on what we heard, what can change and what could not change and why.

LLE involvement is embedded in governance, reporting and assurance and we regularly review our approach to ensure it remains rights-based and effective.

5. Planning, Reporting, and Scrutiny

5.1 Principles for Transparency in Planning and Pro-Active Reporting

To provide truly person-centred care, services must respond promptly and effectively when individuals raise concerns or feel their needs are not being met. It is imperative that those with influence and decision-making power across public service, not only act consistently to compassionately deliver services and rectify such situations, but also proactively and conspicuously demonstrate their leadership in doing so. A human rights-based approach, as articulated in the Charter of Rights for People Affected by Substance Use, requires that services uphold the principles of dignity, participation, and accountability. Those using services must have confidence and trust that, at all levels, decisions are taken in absence of stigma and with their rights, interests, and concerns in mind.

Further, being in receipt of public monies, all partners commissioned to provide such services must be able to demonstrate their reasoned and prudent decisions, delivery, and outcomes, in undertaking their respective statutory or commissioned duties. Accountability for, and the opportunity for scrutiny of, their activity should, as far as possible, be open to the public, as well as those individuals and bodies otherwise enabled or tasked to monitor their activity by statutory means.

With this in mind, the signatories to this Partnership Delivery Framework (PDF) affirm their commitment to improving openness and transparency at all levels of decision making in relation to the delivery of alcohol and drugs treatment, recovery, and wrap-around services. We encourage all partners, at all levels, to engage in the proactive disclosure of:

- Who is responsible for decision-making and planning;
- How they have reached decisions, including evidence considered and deliberated;
- How those decisions will be implemented;
- Who will implement those decisions, and why they have been selected to do so;
- The projected and actual costs of that implementation;
- Who will evaluate that implementation, and why they have been selected to do so; and
- The evaluated evidence, outcomes, and efficacy of that implementation.

The service delivery landscape is complex and multi-layered and this chapter will outline the expectations for reporting, scrutiny, and constructive challenge at each level.

Future Commitment: Establishing a Single Point for Sign-Posting Key Information:

The Scottish Government (SG) will investigate the feasibility of maintaining a single online directory of planning documents and reports, from national and local partners, to better facilitate improved public scrutiny of partners at all levels.

5.2 National Transparency and Scrutiny

The Scottish Government (SG) is responsible for setting the national direction of policy and service delivery in relation to alcohol and drugs and commits to the continued provision of published high-level strategy.

The formulation of that strategy will take place in consultation with service users, service providers, and other relevant partners in the spirit of meaningful, collaborative, co-production and

partnership working. The evidence and rationale for that strategy will be made clear and accessible as an integral part of its publication.

The SG will provide specific funding to selected delivery partners to allow national and local implementation of the strategy. These partners may be statutory public services, or third-sector providers, dependent on specific strategic aims and providers' capacity to deliver against those. The rationale for selecting specific partners will be made clear by the SG and be in accordance with procurement practices and procedures as detailed in the Scottish Public Finance Manual.

Budget decisions of the SG are communicated to the Scottish Parliament and general public at least twice annually, through the standard budget process. Details of allocations and grants to service providers will continue to be formally communicated to recipients and proactively published on the SG website.

The outcomes and priorities of the strategy will inform the primary performance indicators adopted for progress and performance monitoring.

The SG and COSLA will establish and maintain a robust structure for continuous monitoring and reporting on activity and delivery of the strategy through joint governance structures aligned with the wider health and social care reform agenda. Independent scrutiny will continue to be provided by external bodies such as the Scottish Parliament and Audit Scotland.

Self-Assessment Checklist: National Transparency and Scrutiny

The Scottish Government (SG) has consulted upon and published a current high-level national strategy for the delivery of alcohol and drugs services.

The SG has observed proper regulations and procedures in commissioning and funding delivery partners in the implementation of that strategy.

The SG has proactively reported on national progress against the strategy.

The SG has submitted, and responded to, the scrutiny and evaluation of relevant individuals and bodies in respect of any national strategy on alcohol and drugs.

The SG has embedded a human rights-based approach, as articulated in the Charter of Rights for People Affected by Substance Use, including the PANEL Principles of Participation, Accountability, Non-Discrimination and Equality, Empowerment into any national strategy.

5.3 Local Transparency and Scrutiny

The ADP is the vehicle for the formulation of an overarching and holistic local ADP Strategic Plan for the collaborative and connected delivery of alcohol and drugs services. The ADP allows a range of key partners to come together, share their collective intelligence, experience, expertise, and resource, and consequently produce considered and realistic local planning that takes account of national direction, local circumstance and needs assessment, and institutional capacity.

The minimum suggested content of an ADP Strategic Plan is detailed in Annex D of this PDF and the rationale for that content is annotated and explained there.

The ADP is not a legal entity. The **ADP Strategic Plan** must therefore be finalised and collectively agreed in the first instance by the ADP, and then formally approved severally by those contributing partners with statutory responsibility for delivery and/or commissioning of services – as a minimum, but not limited to:

- The local IA (in its delegated capacity to coordinate and commission alcohol and drugs services on behalf of the NHS Board and LA);
- The local Police Scotland Division; and
- The local Scottish Prison Service Representative (usually a Governor) (where appropriate).

This ensures that accountable partners fully acknowledge, understand, and agree, the commitments that their representatives to the ADP have made as part of the ADP Strategic Plan.

The frequency at which such planning is conducted and published should ideally reflect the duration of any National Strategy. However, to account for local resource planning, potential changes in national or local circumstances, or unforeseen events, the ADP may collectively elect to review or revise their ADP Strategic Plan more frequently, as they see fit.

The IA (usually via the ADP Support Team) will monitor, collate, and contextualise local data in relation to:

- Performance against any national indicators, as defined by the SG;
- Performance against local objectives and proposed outcomes, as detailed in their ADP Strategic Plan.
- Disclosure of associated spend and financial forecasting against both of the above.

ADPs are expected to report formally to their local Chief Officers' Group (COG) (or equivalent senior governance forum) and to engage with Community Planning Partnerships (CPP) as part of wider public protection and community planning arrangements. This includes providing assurance on delivery risks; escalating unresolved concerns; and supporting collective leadership, strategic planning, workforce development, and data sharing for improvement where alcohol and drug harms intersect with other local priorities. Links with Child Protection Committees and Adult Support and Protection Committees should be established to foster collaborative, multi-agency and multidisciplinary working, and strategic planning on shared concerns, priorities, and improvements.

To reiterate, the ADP is not a legal entity. ADP **reporting** clearance should therefore mirror that described in the paragraph(s) above detailing accountability for planning.

This ensures that accountable partners fully acknowledge and understand the quality, efficacy, and costs of delivery of commitments that their institutions (and other services that they may have commissioned) have fulfilled under the ADP Strategic Plan.

The frequency at which such reporting is conducted and published should be no less than annual (and in the case of financial reporting, should ideally be compiled quarterly).

Having been approved, the **ADP Strategic Plan** and any associated **reporting** should be published and communicated to ADP Members, to any other relevant scrutiny body to which partners are generally accountable, and – as far as possible – to the public for broader scrutiny.

The SG allocates alcohol and drugs services funding, with the expectation that IAs (via ADPs and their Support Teams) integrate these conditions of transparency and reporting, to ensure a degree of compliance and consistency in the capacity to scrutinise delivery at the local/ADP level.

Self-Assessment Checklist: Local Transparency and Scrutiny

The Alcohol and Drug Partnership (ADP) has a Strategic Plan for delivery of identified outcomes which ensures adequate alignment with other aligned strategic plans.

Where local Strategic Plans consciously deviate from national strategy, such decisions, the rationale for them, and the projected outcomes thereof must be explicitly accounted for within the local Strategic Plan(s).

The ADP has embedded a human rights-based approach, as articulated in the Charter of Rights for People Affected by Substance Use, including the PANEL Principles of Participation, Accountability, Non-Discrimination and Equality, and Empowerment into local strategic planning.

The ADP can demonstrate appropriate Governance and Oversight in delivery of the Strategic Plan.

The work of the Integration Authority (IA) and the ADP is aligned, and the Integration Authority (IA) is able to provide formal direction or assurance through its statutory governance routes.

The ADP can demonstrate public money is used to maximum benefit to deliver measurable outcomes for the local population in delivery of the Strategic Plans.

The ADP regularly (at least annually) reports, and publishes reports, in relation to implementation of the strategic plan and associated finances, and shares these with accountable officers.

5.4 Service Level Transparency and Scrutiny

The expectations set out in this section apply equally to statutory services and to commissioned or grant-funded providers. This PDF does not intend to create differential accountability between sectors. Transparency and scrutiny arrangements should be proportionate to public funding, risk, and impact, regardless of organisational form.

Where individual delivery partners have been commissioned to provide certain services, in accordance with their local ADP Strategic Plan, there is an expectation that those partners will consciously adopt a position of proactive transparent accountability for those services.

If the partner institution publishes its own comprehensive strategy (short, medium, or long term), then that strategy should reference the specific commission or contribution that the organisation provides, under any ADP Strategic Plan(s), including:

- The objectives and proposed outcomes from that commissioned work.
- The strategic connections with other aspects of delivery within their remit.
- The disclosure of any associated funding and its origins.

The frequency at which such planning is conducted and published should match either the commissioning period of the overarching ADP Strategic Plan, or the planning cycle of the partner institution, whichever is more frequent.

This ensures that the profile and priority of drug and alcohol services within the commissioned organisation is clear and apparent.

If the partner institution publishes its own reports monitoring or evaluating performance against their comprehensive strategy, then those reports should detail:

- Progress against delivery of any specific commission that the organisation fulfils, under any ADP Strategic Plan(s);
- Any measured outcomes that have been monitored as a result of the commissioned work; and
- Disclosure of associated spend and financial forecasting.

The frequency at which such reporting is conducted and published should be no less than annual (and in the case of financial reporting, should ideally be compiled quarterly).

These plans and reports should proactively be made available to the commissioning IA (ADP Support Team), to any other relevant scrutiny body to which the partner is generally accountable, and, as far as possible, to the public for broader scrutiny.

IAs, ADP Support Teams, and/or relevant commissioning personnel should integrate these conditions of transparency and reporting for commissioned service delivery partners into contract/grant agreements to ensure a degree of compliance and consistency in the capacity to scrutinise delivery at service level.

Self-Assessment Checklist: Service Level Transparency and Scrutiny

The service has a delivery plan for identified commissioned outcomes which ensures adequate alignment with other aligned strategic plans.

Where service delivery plans consciously deviate from national strategy or local Strategic Plan(s), such decisions, the rationale for them, and the projected outcomes thereof must be explicitly accounted for within the local Strategic Plan(s).

The service can demonstrate appropriate governance and oversight in delivery of commissioned outcomes.

The work of the Alcohol and Drug Partnership (ADP) and the service is aligned, and the ADP is able to provide coordinated strategic leadership, challenge and escalation to partners in support of the ADP Strategic Plan.

The service can demonstrate public money is used to maximum benefit to deliver measurable outcomes for the local population in delivery of the commissioned outcomes.

The service proactively publishes or otherwise makes accessible clear information on commissioned activity, outcomes achieved, and associated public spend, proportionate to risk and scale.

5.5 Feedback, Complaints, and Accountable Means of Learning and Improvement

5.5.1 Flagging, Learning, and Improving from Experience

Scottish Learning and Improvement Framework:

Performance and improvement are important components of a well-functioning system; the draft Scottish Learning and Improvement Framework for Adult Social Care Support and Community Health (SLIF) has been developed to provide a robust approach to using data for learning and improvement that moves away from targets and measurement alone.

The SLIF sets out a vision and priorities for improvement that have been agreed across the system based on the outcomes that matter to people. It aims to embed learning and improvement and quality management across the adult social care support, social work and community health system.

Recent work has concentrated on the operationalisation of the SLIF, to move it from a strategic document to a digital tool that can be used in an operational setting. This digital tool will support all professionals and organisations working in adult social care support, social work, and community health to capture intelligence around their improvement activities, and to inform decisions in a way that drives improvements for people.

Initial testing of the operationalised SLIF is due to commence. Once tested and implemented the SLIF will be a way that Alcohol and Drug Partnerships (ADPs) and services can track their improvement journeys.

At a national level, learning should be supported through collaboration between partners and ADPs, drawing on aggregated intelligence, thematic analysis, and shared challenges across areas. This collective learning can inform policy refinement, guidance, and improvement support, and help ensure that systemic issues are identified and addressed consistently rather than repeatedly at local level.

At a local level, ADPs should support partners to use learning from performance information, service user feedback, adverse events, and improvement activity to understand what is working well and where change is needed. This includes facilitating shared reflection across statutory, third sector and community partners, recognising different governance arrangements and organisational remits, while promoting a common improvement ethos.

At the service delivery level, learning should be embedded in day-to-day practice, with providers encouraged and supported to identify issues early, test improvements, and share learning through the ADP. ADPs should help connect this frontline insight to wider local and national learning, ensuring that experience at service level informs improvement activity across the system.

5.5.2 Queries and complaints from service users or the public

A human rights-based approach, as articulated in the Charter of Rights for People Affected by Substance Use, places accountability at its core. This means that individuals should be able to challenge decisions, seek redress, and expect transparency from services and systems. Ensuring clear, accessible complaints procedures is essential to upholding the rights of people affected by substance use and fostering trust in public services.

Clarity in where to direct queries and complaints is key to ensuring that service users' voices are heard and that appropriate action is taken to prevent or mitigate further harm or detriment. The following outlines the high-level responsibilities, approach, and escalation that may be applied in instances where a query or complaint is submitted.

Queries or complaints directed to a specific service:

- Any commissioned service should have in place a feedback and/or complaints and associated improvements procedure as part of their working practices.
- Any commissioned service should report, at least annually, to IAs, ADP Support Teams, and/or relevant commissioning personnel, on the numbers and general nature of complaints received and processed by their service. This allows the identification of trends and/or need for specific improvement or intervention.
- In instances where the service is unable to satisfy the complainant, the service must signpost the complainant to the relevant commissioning organisations or personnel, to provide a reasonable avenue for escalation and further consideration.
- Complainants should be informed of any alternative complaint routes that may be available to them, such as complaining to inspection bodies where applicable.
- Services delivered by statutory bodies should be processed through the statutory bodies' existing complaint procedure. Complainants should be informed of the Model Complaint Handling Procedure relevant to their complaint and any escalation routes available to them, including the option to escalate their complaint to the Scottish Public Services Ombudsman if they are dissatisfied with the statutory bodies final response.
- IAs, ADP Support Teams, and/or relevant commissioning personnel should integrate these terms as a condition of contract/grant agreements, to ensure a degree of compliance, consistency, and assurance, at the service level.
- Where correspondents or complainants approach individuals or institutions outside of the hierarchy described here to advocate or influence on their behalf (including elected representatives), consideration should be given to whether the relevant correspondence or complaints process is ongoing, and premature intervention and escalation should be avoided where possible.

Queries or complaints directed to the ADP:

- ADPs do not investigate or determine complaints. Responsibility for receiving, handling and responding to complaints rests with the relevant service provider through its established organisational procedures. ADPs may support coordination and signposting to appropriate complaints or advocacy routes, including the Scottish Public Services Ombudsman, the Independent National Whistleblowing Officer, the Care Inspectorate, or relevant professional regulators, as appropriate, including where queries or complaints are initially raised with an ADP.
- This section refers to handling correspondence and learning at a system level, not the investigation or determination of service-level complaints.
- ADPs should have in place a feedback and/or complaints and associated improvements procedure as part of their working practices that reflects this.
- ADPs should ensure that information about their feedback and/or complaints procedure is clearly explained, well publicised, and accessible to all service users.
- Where a query or complaint is received in relation to a specific commissioned service, ADPs should investigate whether service level correspondence and complaints procedures have been exhausted before referring to any other body.

- ADPs should incorporate information on the numbers and general nature of complaints escalated to, or directly received, and processed by them, within their published reporting. This allows the identification of trends and/or need for specific improvement or intervention.
- Where correspondents or complainants approach individuals or institutions outside of the hierarchy described here to advocate or influence on their behalf (including elected representatives), consideration should be given to whether the relevant correspondence or complaints process is ongoing and premature intervention and escalation should be avoided where possible.

Queries or complaints directed to the SG:

- The SG will handle correspondence or complaints in accordance with published procedures.
- It should be noted that the SG will not normally intervene in individual complaint cases against a local service, unless their complaint describes or demonstrates a significant or systemic failure.
- The SG will respond to feedback or complaints in relation to national strategy or policy.
- Where a query or complaint is received in relation to a specific commissioned service or ADP, SG officials should investigate whether service and ADP-level correspondence and complaints procedures have been exhausted before proceeding with their own processes or intervention.
- The SG incorporate information on the numbers and general nature of complaints escalated to, or directly received, and processed by them, within their published reporting. This allows the identification of trends and/or need for specific improvement or intervention.

The Scottish Public Services Ombudsman:

- The Scottish Public Services Ombudsman (SPSO) is the final stage for unsatisfied complaints about local authorities, the National Health Service, housing associations, colleges and universities, prisons, most water providers, the SG and its agencies and departments.

Self-Assessment Checklist: Queries and Complaints

There is clarity from all partners in where to direct queries and complaints and the criteria and means for escalation, should remedy prove unsatisfactory.

Trends, themes and learning from complaints and queries are periodically analysed and reported through appropriate governance routes.

Evidence of learning from complaints and queries is used to inform service or system improvement.

5.5.3 Intervention and Escalation Within a Support and Improvement Culture

5.5.3.1 Deviation from The Partnership Delivery Framework (PDF)

This PDF has been written with the intention of providing clarity on the **fundamental** governance requirements that any organisation engaged in the delivery of services for people affected by problematic use of alcohol and drugs should have in place. With that in mind, care has been taken to ensure that it does not detract from, or restrict, the autonomy and flexibility afforded to partners to put into effect services in ways that best reflect and respond to the evidenced circumstances and needs of those partners and the individuals they serve.

Where local circumstances and subsequent practices in any instance necessarily significantly deviate or differ from the provisions set out in this PDF, it will be for the partner who made the decision to differ or deviate to evidence and justify their reasoning for doing so, and to report on the efficacy and outcomes of their alternative provision for the sake of robust scrutiny and accountability.

5.5.3.2 Deviation from Agreed Strategies

The hierarchy of strategic planning, commissioning, monitoring, and reporting, from the national level, through the local level, to the service level, may allow for a degree of flexibility and autonomy in the application of higher level strategies.

For example, should a local ADP conclude, through needs and resource assessment, and/or other deliberation, that a specific policy initiative or intervention proposed at the national level is not applicable or effective at the local level, then:

- It is for that ADP to make a reasoned and evidenced case to deviate from the national strategy in their proposed ADP Strategic Plan.
- It is for the local IA and other statutory partners to consider that reasoned evidence and either approve or reject the proposed ADP Strategic Plan accordingly.
- It is for that ADP to establish how best to monitor, evaluate, and present for scrutiny the effects and outcomes of the decision to deviate from national strategy.

Further, should a commissioned local Service Delivery Partner, or their commissioning ADP, conclude, through continuing monitoring, and assessment of uptake and outcomes, that the provision of said commissioned initiative or intervention is not having the intended effect, then:

- It is for that Service Delivery Partner, and/or the ADP to make a reasoned and evidenced case to review that commission and alter the ADP Strategic Plan accordingly.
- It is for the local IA and other statutory partners to consider that reasoned evidence and either approve or reject any necessary revisions to the ADP Strategic Plan accordingly.
- It is for that Service Delivery Partner to account for their performance against the original commission and to ensure transparency covering their tenure.
- It is for the ADP to record any decision to recommission and to establish how best to monitor, evaluate, and present for scrutiny the effects and outcomes of the decision to do so.

5.5.3.3 Highlighting/Sharing Good Practice

The SG and COSLA commit to facilitating improved communication and engagement between ADPs as the local coordinating bodies for practical implementation of strategy and delivery. This framework will not prescribe the methods for this in a way that may limit the flexibility or range of solutions that may be applied, but, as a minimum, we will:

- Maintain a contact and liaison function with the ADP Chairs and Coordinators cohorts;
- Maintain a schedule of appropriate engagement events for those cohorts, either facilitated by us, or other partners;
- Continue to examine ways to allow local ADP representatives to better communicate with their counterparts in other localities.

Through facilitating this communication and engagement, the intention is to provide a space that allows for:

- Reciprocal feedback between national and local partners on efficacy and improvement of strategic and operational approaches;
- Open dialogue and facilitated learning on emerging knowledge and understanding of the field; and
- General networking and mutual support amongst the cohorts.

5.5.3.4 Emergency Measures / Enhanced/Collaborative Support

Alcohol-Related Death Reviews should be initiated periodically and overseen by ADPs, working closely with NHS Public Health teams and other statutory and third-sector partners. Reviews should be commissioned using an agreed local approach and resourced appropriately.

Alcohol-related death reviews are expected to follow a public-health, systems-based approach, drawing on both quantitative data and qualitative insight. In the absence of statutory national guidance, local areas should align with expectations set by the SG and refer to practical guidance developed by national partners, including Alcohol Focus Scotland, supported by Public Health Scotland (PHS).

Outputs from reviews should be reported through ADP governance and shared with relevant strategic and planning forums. Findings should inform local alcohol strategies, prevention activity, service design and partnership priorities, supporting continuous improvement and population-level harm reduction.

Drug-Related Death Reviews should be undertaken by ADPs, with arrangements in place to support systematic and timely consideration of each death for learning and improvement. ADPs should have clear local arrangements to invoke reviews in a timely or regular fashion, working with statutory partners including NHS Boards, IAs, Police Scotland and relevant third-sector providers.

There is not currently a single statutory national framework governing the conduct of drug-related death reviews. Local areas are expected to align with relevant expectations set by the SG, alongside analytical and improvement support from PHS and locally agreed multi-agency protocols. Reviews should be conducted on a learning-focused, non-blaming basis, considering system factors, service access, pathways, transitions and missed opportunities for intervention.

Findings and recommendations from alcohol-related and drug-related death reviews should be documented and reported through ADP governance and to Chief Officers Groups or equivalent. Learning must be translated into clear, time-bound improvement actions, informing local planning, commissioning and service improvement, with thematic learning shared where appropriate to support wider system improvement.

Future Commitment: Enhanced National Guidance on Alcohol-Related and Drug Related Death Reviews:

The Scottish Government (SG) commits to provide enhanced national guidance on the consistent and effective conduct of alcohol-related and drug-related deaths reviews. This work is currently being led by Public Health Scotland (PHS) and is being undertaken in parallel with efforts to

enhance consistency in learning review practice across those disciplines falling under the remit and consideration of the National Public Protection Leadership Group (NPPLG).

Incident Management Teams (IMTs) are a means of investigating, responding to, and learning from significant adverse events. Responsibility for managing adverse alcohol and/or drug-related events sits primarily with NHS Public Health teams and health protection functions, working in partnership with ADPs, LAs, Police Scotland and relevant third-sector services. NHS Boards are responsible for leading initial assessment and response, with escalation to national partners where incidents are significant, cross-boundary, or present wider population-level risk. The SG and PHS provide strategic oversight, coordination and analytical support where required.

Potential incidents may be identified through routine surveillance, early-warning systems, or intelligence from services and communities. Where there is evidence of a cluster, spike or other unusual pattern of harm, local public health leads may convene a Problem Assessment Group (PAG) or IMT in line with established public-health incident management arrangements. IMTs coordinate information-sharing, risk assessment, communications, harm-reduction responses, and operational actions to mitigate further harm, drawing on national or local partners as required.

For drug-related harms, national arrangements exist to support coordination where incidents exceed local capacity or have national implications. There is no dedicated alcohol-specific national IMT; alcohol-related adverse events are managed through the same mainstream public-health incident management processes.

Incident decisions, actions and outcomes should be recorded and reported through NHS and ADP governance routes, including Chief Officers Groups (COGs) or equivalent. Learning from incidents should inform local improvement activity, service planning and prevention measures, and be shared where appropriate to support regional or national learning.

5.6 Agreement on Public Comms

Complementing the expectations on transparency already described, signatories and partners should, as a priority, collaborate to ensure the free flow of pertinent information on the status and efficacy of service delivery at all times, to ensure accurate and consistent communications to service users and the general public.

At times where there may be burgeoning situations that may affect proper service delivery, partners should work together to ensure timely and effective joint-resolution, and provide clear and consistent messaging via the most effective agreed channels.

Future Commitment: Alcohol and Drug Partnership (ADP) Support Communications and Engagement:

The Scottish Government (SG) and COSLA commit to facilitating improved communication and engagement between ADPs as the local coordinating bodies for practical implementation of strategy and delivery, whilst protecting the autonomy and flexibility of local planning and decision-making.

Self-Assessment Checklist: Flagging, Learning, and Improving From Experience

Mechanisms are in place to identify, flag and share learning from adverse events, near misses, reviews, or emerging risks related to alcohol and drugs harm.

Learning from experience is considered through appropriate Alcohol and Drug Partnership (ADP) or partner governance forums and informs improvement actions.

Where learning has system-wide relevance, it is shared with relevant partners and, where appropriate, nationally.

The ADP can demonstrate Quality Improvement in delivery of outcomes.

Deviation from the terms of this Partnership Delivery Framework (PDF) at a local level is rationalised, agreed, accounted for, and its efficacy reported on.

Deviation from national strategy at a local level is rationalised, agreed, accounted for, and its efficacy reported on.

There is a well-communicated mechanism and timetable for regular and effective engagement between national and local partners.

There is proactive communication between partners to avoid the unnecessary escalation of issues, queries, and complaints and to ensure most effective remedy is achieved either individually or in collaboration.

6. Maintenance and Revision

6.1 Joint Responsibility

As a joint publication, this Partnership Delivery Framework (PDF) should, in every aspect, be subject to the mutual development and agreement of the Scottish Government (SG) and COSLA, with suitable consultation and contributions from wider partners. That has been the case in the drafting of this version and should be for any revision and republication thereafter.

6.2 Joint Publication and Comms / Promotion of the PDF

The SG and COSLA will work together to agree and execute the most effective methods for dissemination and promotion of the PDF, as well as considering how best to engage with partners on the implementation and compliance with the principles and guidance detailed herein.

6.3 Agreed Standard Duration / Timetable for Regular Review

The SG and COSLA agree to responsive and reasoned adaptation and review, to ensure the provisions herein remain relevant and effective. Review will take place at two key points:

- Spring 2028: An interim (2yr) review of the efficacy of implementation in the improvement of governance and accountability of planning and delivery of services, with any identified key points of failure identified, and further recommendations tabled for inclusion at full-term evaluation and review.
- Spring 2030: A full-term (4yr) review, wider consultation, and revision to ensure continued relevance and efficacy.

6.4 Structure and Leadership of the Review Group

A Joint Review Group comprising officials from both the SG and COSLA should be maintained, or established as required, to support any evaluation, consultation, advice to decision-makers, and redrafting efforts. In jointly leading such a Review Group, those officials should ensure that as wide a cohort as possible and practicable, of representatives from institutions referenced within the PDF, are actively consulted and given opportunity to contribute to any revision.

As a minimum, Scottish Ministers and the COSLA Health and Social Care Spokesperson should be the signatories to any review or republication. Wherever possible or practicable consideration should be given to appropriately widening the cohort of signatory or endorsing bodies.

6.5 Circumstances / Triggers for Extraordinary Review beyond the Timetable

Should the authorities or structures that underpin the planning and delivery of services change so significantly, for example:

- Due to legislative change conveying or transferring statutory authority over service delivery.
- Due to the dissolution, amalgamation, or reconstitution of any key partner institution
- Due to discovery that any provision herein, has become unlawful, unworkable, or materially misaligned with either SG, COSLA, or partners' aims and policy.

The SG and COSLA may, by agreement, seek to review or revise the PDF on timescales outwith those described in Section 7.3 above.

Annex A: Self-Assessment Checklist (Complete / Consolidated)

This Annex consolidates all Self-Assessment Checklists embedded throughout the Partnership Delivery Framework (PDF). These reflective prompts are intended to support self-evaluation, governance assurance and continuous improvement. They do not create new statutory duties or override existing governance responsibilities.

1. Context and Induction

- Individuals and organisations noted as partners have a clear understanding of the historical development and policy context of current alcohol and drugs policy and this PDF, including recognition of underlying and evolving social, health, and systemic challenges impacting people's recovery journeys.
- There are means in place locally and within the Alcohol and Drug Partnership (ADP) to ensure that partners are appropriately inducted and informed of the context within which collective efforts are undertaken to deliver improved holistic support to people affected by problematic use of alcohol and drugs.

2. The ADP

- All key statutory and strategic partners have been invited to participate in the ADP in some form.
- The ADP comprises all representatives noted within the minimum expected cohort.
- The ADP has taken steps to incorporate meaningful engagement with people with lived and living experience of substance use, in line with the Charter of Rights and the principles of participation, dignity and co-production.
- There are processes in place to regularly review, strengthen, and potentially broaden partner involvement.

3. The ADP Support Team

- The ADP Coordinator / Support Team have the capacity and skills to support the ADP in setting a clear direction for local alcohol and drug strategies that align with the national Strategic Plan, relevant national frameworks and broader public health, justice, and social care priorities.
- The ADP Coordinator / Support Team have the capacity and skills to support and encourage multi-agency collaboration across statutory, third sector, and community partners, including people with lived experience.
- The ADP Coordinator / Support Team have the capacity and skills to support organised planning, project management and monitoring on behalf of the ADP.
- The ADP Coordinator / Support Team have the capacity and skills to encourage and support appropriate information and data management and exchange between partners.
- The ADP Coordinator / Support Team has on-going relevant training in collaborative leadership, trauma-informed practice, equality, diversity and inclusion, community engagement and co-production, data analysis and performance reporting, commissioning and financial oversight, safeguarding and risk management, and human rights-based approaches.
- The ADP Coordinator / Support Team have identified any gaps in knowledge or skills that require further training and pursued options to fill those gaps.

- The Integration Authority (IA) has provided support in sourcing corporate or other training to the ADP Coordinator / Support Team.

4. Flow of Finance

- The IA has provided specialist corporate finance support or training to allow prudent commissioning and disbursement of funding per the ADP Strategic Plan.
- The ADP has received its full allocation of Scottish Government (SG) national strategic funding, as detailed in the associated allocation letter, without the application of any top-slicing or efficiency savings.
- The ADP has not been asked or encouraged by any partner to divert SG national strategic funding towards services or initiatives that should otherwise be resourced through baselined or mainstream allocations.
- The ADP has received, or been provided control over, any additional funding from other sources beyond SG national strategic funding and this has been transparently accounted for in planning and reporting.
- The ADP has accounted for any decision to deviate from, or reallocate funds allocated to fulfil specific national objectives, supported by robust needs assessment and evidence.
- All partners on the ADP contribute transparently to strategic direction, disclosing accurate and timely financial and resource reporting.

5. Data Sharing

- The importance of data exchange is communicated to, and understood by, partners at all levels; and conditions of data compliance have been incorporated into commissioning agreements and contracts.
- Contributing partners support the expectation that all commissioned services contribute to national systems for information exchange and statistical analysis (e.g. Rapid Action Drug Alerts and Response (RADAR) and Drug and Alcohol Information System (DAISy.)

6. Lived and Living Experience (LLE)

- People with lived and living experience (LLE) are recognised as rights-holders and their insights and perspectives are valued.
- LLE voices are involved early and throughout strategy, commissioning, service design, delivery and review.
- There is clarity about what can be influenced, what is fixed, and how decisions are made.
- Structured and transparent approaches to engagement are used.
- Engagement methods are accessible, trauma-informed and responsive to people's circumstances.
- People with LLE are supported to participate meaningfully.
- LLE engagement reflects diverse experiences.
- There are clear routes for feedback, complaints and anonymous input.
- There is reporting back to people with LLE on what was heard, what changed, and what could not change and why.
- LLE involvement is embedded in governance, reporting and assurance and regularly reviewed.

7. National Transparency and Scrutiny

- A current high-level national strategy for alcohol and drugs services has been consulted upon and published.
- Proper regulations and procedures have been observed in commissioning and funding delivery partners.
- National progress against the strategy has been proactively reported.
- Relevant scrutiny and evaluation processes have been engaged with and responded to.
- A human rights-based approach including the PANEL Principles has been embedded within national strategy.

8. Local Transparency and Scrutiny

- The ADP has a Strategic Plan aligned with other strategic plans.
- Any deviation from national strategy is explicitly accounted for.
- A human rights-based approach is embedded in local strategic planning.
- The ADP can demonstrate appropriate governance and oversight.
- The IA and ADP work are aligned.
- Public money is demonstrably used to maximum benefit to deliver measurable outcomes.
- The ADP reports and publishes implementation and financial reports at least annually.

9. Service Level Transparency and Scrutiny

- The service has a delivery plan aligned with other strategic plans.
- Any deviation from national or local strategy is explicitly accounted for.
- The service can demonstrate appropriate governance and oversight.
- The ADP and service work are aligned with coordinated leadership and escalation.
- Public money is demonstrably used to maximum benefit.
- The service proactively publishes accessible information on commissioned activity and spend.

10. Self-Assessment Checklist: Queries and Complaints

- There is clarity from all partners in where to direct queries and complaints and the criteria and means for escalation, should remedy prove unsatisfactory.
- Trends, themes and learning from complaints and queries are periodically analysed and reported through appropriate governance routes.
- Evidence of learning from complaints and queries is used to inform service or system improvement.

11. Flagging, Learning and Improving from Experience

- Mechanisms are in place to identify, flag and share learning from adverse events or emerging risks.
- Learning informs improvement actions through governance forums.
- System-wide learning is shared locally and nationally where appropriate.
- The ADP can demonstrate quality improvement in delivery of outcomes.
- Deviation from this PDF or national strategy is rationalised and reported.
- There is a well-communicated mechanism for engagement between national and local partners.
- There is proactive communication to avoid unnecessary escalation of issues and complaints.

Annex B: Partners: Lines of Accountability

Purpose and use of this Annex

This Annex provides a concise, high-level summary of the main accountability, scrutiny and transparency arrangements for partners referenced in Section 3 of this Framework. It is intended to support shared understanding and public transparency, rather than to provide a comprehensive account of all governance or reporting duties.

Where terms such as “usually”, “sometimes” or “indirect” are used, this reflects legitimate variation in organisational form, statutory remit, or local governance arrangements, rather than inconsistency or deficiency. In particular, some partners operate independently of ministerial direction (e.g. judicial and prosecutorial functions); some arrangements are collective or partnership-based rather than vested in a single body; and some planning or reporting arrangements are multi-year, thematic or embedded within wider corporate publications rather than standalone alcohol and drugs documents.

Entries should therefore be read alongside Section 3, which provides fuller narrative context on roles, responsibilities, and relationships across the system.

Organisation / partner (body or group)	**Accountability and scrutiny (incl. route to democratic accountability where applicable)**	**Publishes a plan (annual or multi-year) setting priorities and delivery commitments?**	**Publishes an annual report / annual report & accounts (or equivalent public reporting)?**	**Mentions alcohol and/or drugs in published plans or reporting? (Y/N + where)**
UK Government (and Departments – incl. Home Office; DWP)	UK Ministers accountable to UK Parliament; Permanent Secretaries as Accounting Officers accountable to Parliament for propriety, regularity and value for money; scrutiny via Parliamentary committees and NAO.	Yes – departmental Outcome Delivery Plans or equivalent.	Yes – Annual Report & Accounts.	Yes – Home Office drugs policy; DWP determinants of recovery (plans/accounts).

Organisation / partner (body or group)	Accountability and scrutiny (incl. route to democratic accountability where applicable)	Publishes a plan (annual or multi-year) setting priorities and delivery commitments?	Publishes an annual report / annual report & accounts (or equivalent public reporting)?	Mentions alcohol and/or drugs in published plans or reporting? (Y/N + where)
Scottish Government (and Agencies)	Scottish Ministers accountable to the Scottish Parliament; scrutiny via Parliament and Audit Scotland; agency Chief Executives accountable through Boards and sponsor arrangements.	Yes – national strategies and policy frameworks (not always annualised).	Yes – consolidated accounts and agency annual reports.	Yes – alcohol and drugs strategies and publications.
Social Security Scotland	Executive agency accountable to Scottish Ministers; public reporting and audit under Scottish public body arrangements.	Yes – Corporate / Business Plan.	Yes – Annual Report & Accounts.	Indirect – where referenced in outcomes and equality reporting.
National Records of Scotland (NRS)	Accountable to Scottish Ministers and Parliament under statutory and public finance arrangements; Audit Scotland scrutiny.	Yes – corporate strategy and plans.	Yes – Annual Report & Accounts.	Yes – drug-related death statistics publications.

Organisation / partner (body or group)	Accountability and scrutiny (incl. route to democratic accountability where applicable)	Publishes a plan (annual or multi-year) setting priorities and delivery commitments?	Publishes an annual report / annual report & accounts (or equivalent public reporting)?	Mentions alcohol and/or drugs in published plans or reporting? (Y/N + where)
People with lived and living experience (LLE)	Not a statutory body; accountability sits with commissioning or host organisations and senior officeholders for ethical, supported participation.	N/A	N/A	Yes – via Charter, National Collaborative and hosted programme outputs.
COSLA	Accountable to member councils through constitutional and governance arrangements; political leadership on behalf of local government.	Yes – strategic priorities and policy positions.	Yes – audited annual accounts.	Yes – policy statements and briefings.
Public Health Scotland (PHS)	Special NHS Board accountable to Scottish Ministers; scrutiny via Board governance and Audit Scotland.	Yes – strategic and operating plans.	Yes – Annual Report & Accounts.	Yes – alcohol and drugs intelligence and reporting.
Healthcare Improvement Scotland (HIS)	Statutory body accountable to Scottish Ministers through Board/Chief Executive; independent scrutiny role.	Yes – corporate plans.	Yes – Annual Report & Accounts.	Yes – where quality, standards and scrutiny relate to alcohol and drugs services.

Organisation / partner (body or group)	Accountability and scrutiny (incl. route to democratic accountability where applicable)	Publishes a plan (annual or multi-year) setting priorities and delivery commitments?	Publishes an annual report / annual report & accounts (or equivalent public reporting)?	Mentions alcohol and/or drugs in published plans or reporting? (Y/N + where)
Scottish Ambulance Service (SAS)	National NHS Board accountable through Board and Chief Executive within NHS governance framework.	Yes – strategic and annual plans.	Yes – Annual Report & Accounts.	Yes – overdose response and urgent care pathways.
Crown Office and Procurator Fiscal Service (COPFS)	Independent prosecution and death investigation authority led by the Lord Advocate; constitutional accountability and public reporting.	Yes – multi-year strategic plan.	Yes – Annual Report & Financial Statements.	Yes – death investigation and justice interface.
Scottish Courts and Tribunals Service (SCTS)	Statutory body administering courts; governance via SCTS Board chaired by the Lord President, preserving judicial independence.	Yes – corporate and business plans.	Yes – Annual Report & Accounts.	Yes – problem-solving courts and relevant justice reporting.
Scottish Police Authority (SPA)	Statutory oversight body for policing; accountable through public reporting and parliamentary scrutiny.	Yes – corporate plan and policing plans.	Yes – Annual Report & Accounts.	Yes – oversight of policing response to drug harm.

Organisation / partner (body or group)	Accountability and scrutiny (incl. route to democratic accountability where applicable)	Publishes a plan (annual or multi-year) setting priorities and delivery commitments?	Publishes an annual report / annual report & accounts (or equivalent public reporting)?	Mentions alcohol and/or drugs in published plans or reporting? (Y/N + where)
Police Scotland	Operationally independent Chief Constable; oversight by SPA; democratic scrutiny via Parliament and local scrutiny arrangements.	Yes – Annual Policing Plan.	Yes – reporting via Police Scotland and SPA publications.	Yes – drug harm reduction and enforcement strategy.
Scottish Prison Service (SPS)	National prison authority accountable through ministerial framework, Board governance and public audit.	Yes – corporate plan.	Yes – Annual Report & Accounts.	Yes – harm reduction, treatment and throughcare reporting.
Scottish Fire and Rescue Service (SFRS)	National service accountable through Board and ministerial framework; Audit Scotland scrutiny.	Yes – strategic and annual operating plans.	Yes – Annual Report & Accounts.	Indirect – prevention and community safety links.
National Third Sector Organisations (Scotland-wide)	Accountable to Boards/Trustees and regulators (e.g. OSCR) and to funders via grant/contract terms.	Usually yes – organisational strategies or business plans.	Usually yes – annual report and accounts.	Yes – often core mission content.
Territorial NHS Boards	Statutory NHS bodies accountable through Boards/Chief Executives within NHS governance and ministerial framework.	Yes – corporate and annual delivery plans.	Yes – Annual Report & Accounts.	Yes – ADP, public health and service planning documentation.

Organisation / partner (body or group)	Accountability and scrutiny (incl. route to democratic accountability where applicable)	Publishes a plan (annual or multi-year) setting priorities and delivery commitments?	Publishes an annual report / annual report & accounts (or equivalent public reporting)?	Mentions alcohol and/or drugs in published plans or reporting? (Y/N + where)
Local Authorities (Councils)	Democratically accountable to local electorates; scrutiny via elected members, Audit Scotland and public reporting.	Yes – corporate and service plans.	Yes – annual accounts and reporting.	Yes – community planning, social work, housing and health improvement reporting.
Integration Authorities (incl. IJBs and lawful alternatives)	Statutory integration arrangements under the Public Bodies (Joint Working) (Scotland) Act 2014; accountability shared with NHS Boards and Local Authorities and exercised through Chief Officers and established governance routes.	Yes – strategic commissioning and integration plans (model-dependent).	Yes – annual performance and financial reporting (model-dependent).	Yes – substance use embedded within integrated service planning and ADP commissioning.
Community Planning Partnerships (CPPs)	Statutory partnerships; accountability remains with individual partner organisations for their statutory functions, with democratic scrutiny primarily through local authorities.	Yes – Local Outcomes Improvement Plans and locality plans.	Usually yes – public reporting on LOIP progress (format varies).	Sometimes – where alcohol and/or drugs is identified as a local priority.

Organisation / partner (body or group)	Accountability and scrutiny (incl. route to democratic accountability where applicable)	Publishes a plan (annual or multi-year) setting priorities and delivery commitments?	Publishes an annual report / annual report & accounts (or equivalent public reporting)?	Mentions alcohol and/or drugs in published plans or reporting? (Y/N + where)
Chief Officers' Groups (COGs)	Non-statutory senior leadership forums; authority derives from the statutory responsibilities and accountabilities of member organisations.	Variable – commonly operate via terms of reference and linked plans rather than a standalone strategy.	Variable – may not publish annual reports as discrete entities.	Sometimes – where alcohol and/or drugs intersect with public protection or community safety priorities.
Third sector organisations (local / service delivery)	Accountable to Boards/Trustees (and regulators such as OSCR where applicable) and to commissioning bodies for delivery and use of public funds.	Usually yes – service or business plans aligned to commissioning periods.	Usually yes – annual report and accounts.	Often yes – service descriptions, evaluation reports and outcome reporting.
Locally elected members (councillors)	Democratically accountable to local electorates; exercise scrutiny and governance through council decision-making and committee structures.	N/A	N/A	Indirect – through council and CPP scrutiny where alcohol and/or drugs is a local priority.

Annex C: Alcohol and Drug Partnership (ADP) Chair Role Profile (Co-Authored by ADP Chairs and Healthcare Improvement Scotland (HIS))

Diversity

- Commitment to eradicating any stigma and prejudice people face who use alcohol and drugs
- Focus on inequalities and alignment of public protection
- Strong values and ethics
- Experience of reducing stigma and inequalities
- Awareness of impact of approach, language and positive messages in the reduction of stigma
- Focus on inclusion and work on stigma to be led by the ADP

Skills

- Developing and delivering strategies and policies
- Implementation of national strategies at a local level
- Managing and governing public funding
- Identifying and maintaining priorities for the ADP
- Foster open, honest and challenging conversations. This includes:
  - facilitating relationships and connections at meetings
  - good links into committee processes
  - good links into public protection, community safety, justice, community planning etc. and
  - strengthening channels of communication with Scottish Government
- Ability to build and maintain strong and effective working relationships with key stakeholders e.g. NHS boards, Health and Social Care Partnership (HSCP), Integrated Joint Board (IJB), Chief Officers Groups (COGs), Community Planning Partnerships (CPPs), other ADPs
- Ability to challenge and hold senior executives to account on improvement, governance and accountability
- Ability to make connections within existing governance structures
- Ability to network and make connections across multiple areas to deliver better integrated working in areas such as health, housing and justice
- Build and maintain good relationships between ADPs and public protection functions
- Ability to challenge and adapt working practices to improve performance
- Ability to report into national policy conversations based on local contexts
- Share appropriate challenges via committees

Experience

In terms of experience - there was debate about whether all the elements listed would be needed in advance of appointment to be effective in this role, or whether some of these could be listed as desirable with a need to then support individual's development once in post if there are gaps in experience.

The group noted having an ADP Chair with limited experience of working in health and social care could bring added value due to the benefits of the fresh perspective. However, there are also benefits to having a good understanding of health and social care including enabling strengthened relationships.

- Experience of working effectively with third sector and those with lived and living experience
- Experience of improving performance at national, regional and local levels
- Experience of developing and working in an integrated public protection landscape
- Experience in good governance of community leadership and resilience
- Implementation of national strategies and directives at a whole system level
- Importance of trauma-informed practice and using a human rights-based approach

- Experience in how data is governed
- Experience in self-assessment or evaluation methods

Additional Information
The groups also identified the following considerations for the 'enablers' of good governance for the ADP Chair role.

Resource, Support and Infrastructure
- Importance of resource and infrastructure. Specifically sufficient time/capacity dedicated to the role to effectively achieve the expectations of the role including participation in national forums and learning events
- To continue to support or even strengthen the key enabling role of ADP coordinators and wider team to support delivery
- A consistent reporting structure / model to support good governance practices
- Clarity of the ADP purpose, including clarity of the resource (budgets) the ADP is responsible for and accountability of partners in strategic decision making
- Whole-system approach with key role around making valid connections across multiple areas and reducing silo working, including importance of connections with:
  - other ADPs and ADP Chairs for support, peer review opportunities and mutual problem solving and learning - for example, the ADP Chair Leadership Forum facilitates peer support and sharing of good practice to develop standards
  - between ADP governance structures and standing committees
- A governance structure that reflects collective leadership rather than a single governance structure. It is a difficult ask to describe good governance practices within the role description when governance structures are typically written for single organisations and not necessarily fit for purpose as a chair within a partnership structure
- Strengthening the relationship with Scottish Government (SG) (e.g. the National Drugs Mission Delivery Group is a good opportunity to strengthen channels of communications between SG and ADPs).
- Consistency in input and expectations from Chief Executives and Executive Leads
- Need for strategic direction at a national level (demonstrated by the Audit Scotland report)

Management, Personal and Professional Development
- Clear line management, accountability and reporting structures, including an appraisal process
- Involvement of key stakeholders in recruitment and induction processes
- Learning and development including:
  - role specific to support effective achievement of role duties and responsibilities
  - national training and development to enable greater consistency between ADP Chairs
  - local training and CPD requirements
- Being open to doing things differently

Annex D: Alcohol and Drug Partnership Strategic Plan Template

How to use this template:

This template sets out the expected substance of ADP strategic plans.

It is designed to provide a consistent and proportionate way for ADPs to demonstrate effective governance, accountability, and delivery in line with the Partnership Delivery Framework (PDF).

ADPs are not expected to generate new analysis. Existing local strategies, needs assessments, delivery plans, and performance reports should be summarised or referenced where appropriate.

Where an ADP chooses to use an alternative format, it should be able to clearly demonstrate how all elements of this template are addressed.

This template provides a consistent and proportionate way for ADPs to demonstrate compliance with the PDF.

It does not introduce new requirements. It makes explicit the governance, accountability, and delivery arrangements that ADPs are already expected to have in place.

A. Purpose, Status and Scope

This section should clearly set out:
- the purpose of the strategic plan
- the period it covers
- its formal status within local governance arrangements

ADPs should state:
- the period covered by the plan
- the body (or bodies) that have approved it
- how it aligns with national alcohol and drugs strategy
- how it demonstrates compliance with the PDF

B. Local Context and Need

This section should summarise:
- key alcohol- and drug-related harms and trends locally
- inequalities and population groups most affected
- any relevant local system factors (e.g. rurality, islands, service configuration)

ADPs are strongly encouraged to:
- draw on existing needs assessments, Joint Strategic Needs Assessments (JSNAs), or profiles
- link to rather than reproduce detailed analysis

C. Strategic Priorities and Intended Outcomes

This section should:
- set out a small number of strategic priorities for the period of the plan
- show how each priority:
  - reflects national priorities
  - responds to local need

- contributes to agreed outcomes
- A clear format is encouraged – for example:

Strategic Priority	Rationale / Need	Intended Outcomes

ADPs should also explain:
- how priorities were agreed
- who was involved in prioritisation (including lived and living experience)

D. Governance, Roles and Accountability

This section should clearly describe:
- the role and remit of the ADP
- chairing arrangements and responsibilities
- ADP membership and partner expectations
- how decisions are taken and recorded
- reporting and accountability routes

Where local arrangements differ:
- these should be clearly explained (e.g. Community Planning Partnerships (CPPs)-led models, non-Integrated Joint Board (IJB) arrangements)

E. Financial Governance and Resource Stewardship

ADPs should explain:
- what resources the ADP oversees or influences
- how funding decisions are made and agreed
- how financial oversight is exercised
- how financial risks are identified and managed
- how ADP financial governance relates to Integration Authority (IA) or partner systems

F. Delivery, Performance and Improvement

This section should describe:
- how the ADP oversees delivery of its priorities
- what performance information is used
- how under-performance or risk is identified
- how support, challenge, and improvement are provided
- how learning is captured and shared

ADPs are encouraged to:
- link to delivery plans, action plans, or performance reports
- avoid including long action lists in the strategic plan itself

G. Lived and Living Experience (LLE)

ADPs should explain:
- how LLE is embedded in governance
- where and how it influences decision-making

- how participation is supported and sustained
- how the impact of involvement is understood and fed back

H. Risk, Escalation and Assurance

This section should set out:
- key strategic risks to delivery
- how risks are identified and reviewed
- escalation routes where risks cannot be managed locally
- how the ADP assures itself and others of effective governance and delivery

I. Review, Refresh and Transparency

ADPs should describe:
- how often the strategic plan will be reviewed
- how updates or refreshes will be agreed
- how progress will be reported publicly
- where stakeholders and the public can access information

J. Optional Annexes

ADPs may choose to include or link to:
- Delivery or action plans
- Needs assessments or profiles
- Performance dashboards
- LLE frameworks
- Risk registers

Annex E: Commitments

Alcohol and Drug Partnership (ADP) Support Resourcing

The Scottish Government (SG) will support enhanced capacity and consistency across ADP chairs and officers, whilst protecting the autonomy and flexibility of local planning and decision-making.

Establishing a Single Point for Sign-Posting Key Information

The SG will investigate the feasibility of maintaining a single online directory of planning documents and reports, from national and local partners, to better facilitate improved public scrutiny of partners at all levels.

Enhanced National Guidance on Alcohol-Related and Drug Related Death Reviews

The SG commits to provide enhanced national guidance on the consistent and effective conduct of alcohol-related and drug-related deaths reviews. This work is currently being led by Public Health Scotland (PHS) and is being undertaken in parallel with efforts to enhance consistency in learning review practice across those disciplines falling under the remit and consideration of the National Public Protection Leadership Group (NPPLG).

ADP Support Communications and Engagement

The SG and COSLA commit to facilitating improved communication and engagement between ADPs as the local coordinating bodies for practical implementation of strategy and delivery, whilst protecting the autonomy and flexibility of local planning and decision-making.

This publication is available at **www.gov.scot**

Any enquiries regarding this publication should be sent to us at

The Scottish Government
St Andrew's House
Edinburgh
EH1 3DG

ISBN: 978-1-80643-984-3 (web only)

Published by The Scottish Government, March 2026

Produced for The Scottish Government by APS Group Scotland, 21 Tennant Street, Edinburgh EH6 5NA
PPDAS1723466 (03/26)