Office for Health Improvement & Disparities

Grant scheme	**Supplemental Substance Misuse Treatment and Recovery Grant**
Local council [SELECT]	**Bracknell Forest**
Year identified as an Enhanced area	**Year 3**
Name (person completing the plan)	**Jillian Hunt**
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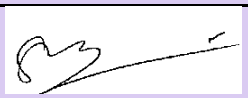
Contact details - phone	**01344 351653**
DPH sign-off on behalf of the local partnership	**Stuart Lines, DPH** 

All tables should be filled out and returned to DrugTreatmentGrants@dhsc.gov.uk by 11 May. If you have questions about how you should fill out the tables, or concerns about being able to meet this date, in the first instance please raise these with your regional OHID team.

Once we have received your return we may contact you for clarifications, or to discuss your plans. In order to be able to conclude the allocation process as quickly as possible we would ask you to be prepared to respond as quickly as possible.

Background
The Supplemental Substance Misuse Treatment and Recovery Grant should be used to address the aims of the treatment and recovery section of the drug strategy.

On a national basis the additional funding should deliver:

- 54,500 new high-quality treatment places, including: 21,000 new places for opiate and crack users; a treatment place for every offender with an addiction; 30,000 new treatment places for non-opiate users and alcohol users; a further 5,000 more young people in treatment
- 24,000 more people in long-term recovery from substance dependence
- 800 more medical, mental health and other professionals
- 950 additional drug and alcohol and criminal justice workers
- sufficient commissioning and co-ordinator capacity in every local council

In developing your plans you should be mindful of the condition of the Public Health Grant that:

[A local council must] have regard to the need to improve the take up of, and outcomes from, its drug and alcohol misuse treatment services, based on an assessment of local need and a plan which has been developed with local health and criminal justice partners.

Treatment capacity guidance note
The guide numbers above are based on the national ambition set out in the drug strategy. The equivalent numbers for your area have been modelled based on the size of your drug and alcohol treatment system and the additional funding that has been awarded.

The significant modelled increases occur in financial years 2023-24 and 2024-25, reflecting your indicative funding trajectory and the suggested focus on improving the capacity and competencies of the workforce in 2022-23.

As the guide numbers are based on the levels of national unmet need, it is important that they are considered alongside your own assessment of need for each of the substance cohorts for adults as well as for young people.

1. You should use OHID's Commissioning Support Pack and other sources of local intelligence to understand your levels of unmet need. Local ambition to increase capacity should then be set accordingly.

2. **Complete all tables in the template**. If you have any questions please contact your regional OHID lead.

3. Cells are colour-coded as follows:

You need to select from this cell
You need to complete these cells
OHID will have pre-filled these cells – do not change
These are cells calculated in the sheet – do not change
These are information/row heading cells
These are information/column heading cells
Deliberately empty cell

4. Please ensure the sums are consistent within the spreadsheet (some figures will display red indicating they are not as expected)

5. Interventions outside the menu can be considered only if they:
- can be shown to deliver the outcomes expected of the grant
- are already developed/established interventions that can be delivered within 2022-25
- have evidence of their effectiveness and cost effectiveness

Please email DrugTreatmentGrants@dhsc.gov.uk as soon as possible if you plan to propose interventions not on the menu.

6. Capital

Under this grant, it is permissible for a capital asset to be created by the local council or service provider in the process of delivering the programme, but it is important that capital spending should not be the focus of the programme. Where you expect to spend on capital items this should be reflected in your detailed plans for 2022-23 and you should be clear how capital assets will allow your system to deliver the aims of the

Please note, any capital asset created will have to be sanctioned by OHID and will subsequently be logged via the Statement of Grant Usage (SOGU), and local council should take steps to protect the asset for future use for the taxpayer, for example in the event of any service or contractual change.

NB There are more detailed guidance notes alongside each table in the rest of this workbook - please read them carefully before completing the table.

Indicative 3 year planned investment

Link back to notes and guidance

Please enter your projected expenditure for 2021-22 and the planned expenditure for the following three years against the categories below

Source	Baseline 2020-21 (actual)	2021-22 (projected)	Year 1 2022-23	Year 2 2023-24	Year 3 2024-25
Adult substance misuse spend categories [1]	£ 700,000	£730,000	£746,000	£746,000	£746,000
Specialist drug and alcohol misuse services for children and young people [2]	£ 37,000	38,000	39,000	39,000	39,000
Additional local investment that contributes substantially to substance misuse treatment and recovery outcomes [3]	89,850	89,850	89,850	89,850	89,850
Supplemental substance misuse treatment and recovery grant			144,526	147,347	206,039
Inpatient detoxification grant			13,809	13,809	13,809
Total		£ 857,850	£ 1,033,185	£ 1,036,006	£ 1,094,698

As set out in the drug strategy and the Public Health Grant (PHG) agreement letter, eligibility for this additional grant funding will be dependent on maintaining existing local council (2020/21) investment in drug and alcohol treatment.

Please fill out the planned investment from the PHG (or Business Rate Retention scheme) for both adults and young people.

If your local council anticipates difficulties in meeting these conditions of additional funding, we recommend an early conversation with your regional Office for Health Improvement and Disparities (OHID) team.

[1] Outturn return to DLUHC. Sum of: treatment for drug misuse in adults, treatment for alcohol misuse in adults,

[2] Outturn return to DLUHC for specialist drug and alcohol misuse services for children and young people
Source: https://www.gov.uk/government/collections/local-authority-revenue-expenditure-and-financing

[3] For example from the police and crime commissioner, CCG, or local council's children's services, National Lottery or other charitable funding

Please provide any detail you think is helpful about additional local investment:

£89,850 is the cost of the two Family Safeguarding Model Adult Substance Misuse Workers who are based within Childrens Social Care. The posts are funded from addiotnal resources within the local authority, not from the Public Health Grant.

National target to increase the number of treatment places by 54,500 a 20% increase

Link back to notes and guidance

Please enter the planned numbers in treatment for each of the next three years for adults (by the three substance groups) and for young people

Capacity	Baseline 2021-22	Year 1 2022-23	Year 2 2023-24	Year 3 2024-25
All adults “in structured treatment”	**405**	26	32	38
Opiates	103	6	8	10
Non opiates (combined non-opiate only and non-opiates and alcohol)	167	11	13	14
Alcohol	135	9	11	14
Young people "in treatment"	**15**	2	3	5

There is a national target to increase the number of treatment places by 54,500 by the end of FY 2024-25. Local councils should agree with their provider/s a three-year trajectory that contributes towards the national ambition. In developing your trajectories, you should draw on your most recent Commissioning Support Pack published on ndtms.net to understand the levels of unmet need in your population for drug and alcohol treatment.

When planning it is important to keep in mind that, when the grant rises, as well as expanding treatment capacity, there is an expectation that the grant will be invested in improving quality – including by reducing caseloads and increasing the professional staff mix. This is reflected in the menu of interventions.

Baseline 2021-22	Year 1 2022-23	Year 2 2023-24	Year 3 2024-25

Partnership plan to reduce drug and alcohol deaths

Link back to notes and guidance

National	2016	%	2017	%	2018	%	2019	%	2020	%
Drug related deaths	2,386	100%	2,310	100%	2,670	100%	2,685	100%	2,830	100%
Alcohol specific deaths	1,671	100%	1,758	100%	1,685	100%	1,710	100%	2,074	100%
Deaths in treatment	2016-17	%	2017-18	%	2018-19	%	2019-20	%	2020-21	%
Death in treatment - opiate users	1,741	100%	1,712	100%	1,897	100%	2,010	100%	2,418	100%
Death in treatment - non-opiate users	172	100%	174	100%	193	100%	178	100%	244	100%
Death in treatment - alcohol only	767	100%	774	100%	799	100%	741	100%	1064	100%
Bracknell Forest number of deaths	**2016**	**%**	**2017**	**%**	**2018**	**%**	**2019**	**%**	**2020**	**%**
Drug specific deaths	2	0%	6	0%	0	0%	0	0%	5	0%
Alcohol specific deaths	0	0%	0	0%	0	0%	0	0%	0	0%
*Deaths in treatment**	2016-17	%	2017-18	%	2018-19	%	2019-20	%	2020-21	%
Death in treatment - opiate users	0	0%	0	0%	0	0%	0	0%	0	0%
Death in treatment - non-opiate users	0	0%	0	0%	0	0%	0	0%	0	0%
Death in treatment - alcohol only	0	0%	0	0%	0	0%	0	0%	0	0%

**if value of 0 returned for death in treatment, this may be due to numbers being suppressed for your area.*

There is a national ambition to prevent nearly 1,000 deaths in the next 3 years, reversing the upward trend in drug deaths for the first time in a decade. Local council and their partners should set out how the grant funding they receive will reduce drug deaths locally, both in and out of treatment.

Local councils should also work to reduce alcohol deaths. In 2020-21, there was a 20% increase in alcohol specific deaths in England, and a 44% increase in deaths (all causes) in people in treatment for alcohol-only compared to 2018-19.

This should be set out in a narrative form, describing system wide approaches to reduce deaths (including among those in the treatment and recovery system), how risk is identified and reported, how deaths and non-fatal overdoses are reviewed, and what resources will be deployed.

Provide narrative on outline 3-year plans to reduce drug and alcohol related deaths, focusing on:

- system wide approaches to reduce deaths
- in and out of treatment populations
- overdose and drug/alcohol related all-cause mortality
- how risk is identified and reported
- how deaths and non-fatal overdoses are reviewed
- what resources and interventions will be deployed.

Alcohol related deaths:

We will work with the local Public Health Team to raise awarenss of the risk associated with excessvie alcohol consumption and train generic staff to be a postion to identify issues and sign post to services.

We will work in partnership with Berkshire colleagues to:
• Collect and collate drug-and alcohol related mortality data
• Monitor and examine patterns and trends, e.g. geographic, demographic, substances implicated in death
• Use data as an indicator to estimate the prevalence of substance-related problems and assess the risks associated with substance abuse
• Inform and facilitate discussion on the prevention of drug or alcohol related deaths, whether accidental or intentional
• Provide data for local commissioning planning

Drug related deaths:

We will continue to commisison, and exand, pharmacies to provide Take Home Naloxone to people acessing the needle exchange service to make sure that people who are not engaging in treatment have the means to prevent overdose.

We will work in partnership with Berkshire colleagues to:
• Collect and collate drug-and alcohol related mortality data
• Identify substances implicated in drug-related deaths – including new drugs and new combinations
• Monitor and examine patterns and trends, e.g. geographic, demographic, substances implicated in death
• Act as an early warning system for new trends in mortality and drug misuse
• Use data as an indicator to estimate the prevalence of substance-related problems and assess the risks associated with substance abuse
• Inform and facilitate discussion on the prevention of drug or alcohol related deaths, whether accidental or intentional
• Provide data for local commissioning planning

Treatment workforce expansion planning

Link back to notes and guidance

Workforce category	Notes	Baseline 2021-22: Number of full time equivalent posts to nearest 0.25FTE, excluding those funded by 2021-22 universal drug treatment grant	Year 1 2022-23 planned recruitment: Number of full time equivalent posts to nearest 0.25FTE - this should include ongoing posts originally funded by 2021-22 universal drug treatment grant
Social workers	Social workers registered to practice on the Social Work England register https://www.socialworkengland.org.uk/umbraco/surface/searchregister/results	0	0
Pharmacists	Pharmacists registered to practice on the General Pharmaceutical Council (GPC) register https://www.pharmacyregulation.org/registers/pharmacist	0	0
Nurses	Nurses registered to practice on the Nursing and Midwifery Council register https://www.nmc.org.uk/registration/search-the-register/	0.25	0.25
Addiction psychiatrists	Doctors registered on the General Medical Council (GMC) specialist register to practice 'substance misuse psychiatry' https://www.gmc-uk.org/registration-and-licensing/the-medical-register	0	0
Other doctors	Doctors registered on the GMC register to practice https://www.gmc-uk.org/registration-and-licensing/the-medical-register	0.75	0
Consultant psychologists	Consultant psychologists registered on the Health and Care Professions Council (HCPC) register https://www.hcpc-uk.org/check-the-register/	0	0
Practitioner psychologists	Practitioner psychologists registered on the HCPC register https://www.hcpc-uk.org/check-the-register/	0	0
Assistant psychologists	Assistant psychologists should only be employed where there is a qualified HCPC-registered psychologist to supervise them.	0	0
Drug and alcohol workers	A paid employee of a local council-commissioned drug and/or alcohol treatment provider who does in-person and digital clinical work, and usually holds a caseload of people in structured treatment including keywork, harm reduction, outreach and psychosocial interventions, with individuals who have, or have had, drug and/or alcohol problems. This includes specialist roles targeting specific need, populations or working in specific settings including: women; the BAME community; LGBT community; mental or physical comorbidities; people involved with the criminal justice system; families; housing and employment support; and GP shared care. Also counted here should be outreach workers who may not carry a caseload or work with people currently in structured treatment but do provide harm reduction and other interventions to people who could, and arguably should, be in treatment.	12	2
Criminal justice drug and alcohol workers (subset of total	A 'drug and alcohol worker' (see previous definition) who works with individuals involved in the criminal justice system in order to facilitate their engagement and retention in treatment, including supporting individuals through a range of criminal justice pathways including out of court disposals, court mandated community sentence treatment requirements and during/after custody/imprisonment.	1	1
Young peoples' drug and alcohol workers (subset of total	A paid employee of a local council-commissioned young peoples' specialist substance misuse service who does face-to-face and digital clinical work, including keywork, harm reduction, outreach and psychosocial interventions, with young people who have, or have had, drug and/or alcohol problems or are at risk of developing problems.	0.5	
Other drug and alcohol workers (subset of total	Definition as in drug and alcohol worker row above, but excluding young people's drug and alcohol workers and criminal justice drug and alcohol workers	10.5	1
Service managers	Drug and alcohol treatment service managers, who do not carry a clinical caseload. Team leaders who do carry a clinical caseload should be included in the row relevant to their training/role, e.g. drug and alcohol worker, nurse.	0	1
Local council commissioners/coordinators/ analysts	Local council-employed adult and young peoples' drug and alcohol treatment commissioners, coordinators and analysts, leading on or supporting any of, but not limited to, the following: commissioning; needs assessments; performance management; partnership coordination; drug and alcohol related death investigations; supporting collaboration, information sharing and joint working arrangements; regional or sub-regional commissioning.	1	0.5

The drug strategy includes an ambition to increase the capicty and quality of the drug and alchol treatment workforce over the next three years. This includes recruiting:

- 800 more medical, mental health and other professionals
- 950 additional drug and alcohol and criminal justice workers
- adequate commissioning and co-ordinator capacity in every local council

Dame Carol Black's review and clinical guidelines recommend treatment systems have multidisciplinary teams, made up of nurses, doctors, addiction psychiatrists, psychologists, pharmacists, and social workers. Your plans should include proposals to ensure treatment systems have all these professions available to them, or initial steps to work towards that if your local council is in a later tranche of increased funding.

Included below is an outline of the national workforce expansion modelling, which informed the calculations for the additional treatment investment across the next three years. It is included here to aid your planning in relation to the relative numbers staff from different groups. The modelling uses the workforce baseline taken from the results of workforce survey undertaken by Dame Carol Black's independent review of drugs in 2020.

Please only include staff in this return who are commissioned to deliver (or in the case of local council commissioners/coordinators to oversee) drug and alcohol treatment and recovery services by the local council.

Please enter full time equivalent numbers (FTE), to the nearest 0.25, as opposed to the number of people employed.

We are aware that the 'doctor' category in this template does not represent the range of skills and experience of doctors who aren't addiction psychiatrists. For this process, we have not split out GPs, physicians, training grades and others. A workforce benchmarking exercise to follow will capture this level of detail, to inform the workforce strategy and future local planning.

Consideration should also be given to how you will support workforce development in inpatient units and residential detoxification. Ensuring contract prices allow for this and regional collaboration or coordination may be part of the solution. OHID, in partnership with HEE will undertake further work in this area.

Please categorise staff according to the role they are employed to deliver. For example, where someone who is a qualified social worker is currently employed as a drug and alcohol worker, they should be categorised as a drug and alcohol worker.

Number of adults with substance misuse treatment need who successfully engage in community-based structured treatment following release from prison/secure estate

Link back to notes and guidance

Please enter as a percentage the planned continuity of care performance for each of the next three years

	Baseline 2021-22	Year 1 2022-23	Year 2 2023-24	Year 3 2024-25
National	37%		75%	
Local planning (%)	73%	73%	75%	75%

The drug strategy sets out a national ambition that by the end of 2024-25 there should be 'a treatment place for every offender with an addiction'.

Local councils should engage with their partners, including police, probation and prison health providers, to optimise access to treatment for individuals referred from custody suites, courts and prisons and ensure that there is a shared understanding of how improved health and reoffending outcomes can be delivered for this cohort.

Using data from the Public Health Outcomes Framework C20 indicator, this table shows continuity of care figures for adult offenders who have a continuing treatment need on discharge from prison and who are successfully engaged into local community treatment services. As you are aware, the continuity of care between prison discharge and engagement in treatment is a fundamental part of reducing reoffending and recidivism. Therefore, we have a national ambition to ensure 3 in 4 prison leavers with a substance misuse issue are engaging in treatment 3 weeks after release by the end of 2023. We have worked with the Ministry of Justice to identify this as a stretching goal to reach that will truly shift the dial. To that end, we need

Proportion of all adults in treatment who start residential rehabilitation (National ambition to achieve 2%, see notes)

Link back to notes and guidance

Please enter the total number of people planned to attend residential rehab for the next three years

	Baseline 2018-21 average	Proportion of adults in resi rehab as a proportion of all adults in treatment	Year 1 2022-23	Year 2 2023-24	Year 3 2024-25
National	3805	1.4%			
Local planning	8	1.8%	9	9	9

As set out in the drug strategy we are implementing mechanisms to help ensure that there is adequate provision of residential rehabilitation in all areas of the country.

You should consider local need, and how to use the grant to increase access to residential rehabilitation over the course of the grant period.

This planning table is populated with the proportion of your drug and alcohol treatment population that started a residential rehabilitation placement averaged over the 3 years 2018 to 2021, benchmarked against a national ambition of 2%, and the number of placements needed to achieve 2%.

If you do not already meet or exceed this ambition there is an expectation that you develop plans to do so, and discuss with your regional OHID team if appropriate.

Outline 3-year plan

Link back to notes and guidance

Main area of development	Cohort	Outline plan for 2022-23	Outline plan for 2023-24	Outline plan for 2024-25
Increased treatment and harm reduction capacity, including inpatient detoxification and residential rehabilitation	Young people (under 18)	1. We will work to improve communication and pathways from and to other young people's services; 2. We will review and expand on evidence-based approaches (harm reduction) as required;	1. We will increase the numbers in treatment via the implementation of new pathways and better communication between organisations; 2. We will review the appropriateness of referrals. 3. To consider the recommendations arising from the Health and Wellbing needs assesment in respect of future planning.	1. We will monitor the effectiveness of the new pathways and communication in respect of the increase in new referrals to the service.
	Adults	1. We will work with the South Central Coast Consortium to review needs and availability across the area to review our pathways into, and out of, our commissioned tier four provision to understand any barriers to access and establish levels of unmet need amongst our treatment population 2. We will sustain the increased capacity in our criminal justice team in respect of the funding provided in 2021/22.	1. We will work the South Central Coast Consortium to implement the findings of the review which may require us to build our capacity to introduce more specialist residential rehabilitation provision; 2. reviewing impact of criminal justice team and make recommendations to continue or change.3. To consider the recommendations arising from the Health and Wellbing needs assesment in respect of future planning.	1. We will analysing data to identify best practices for admittance, referrals, preparation, matching individuals to facilities and completions / discharges; 2. We will consider any recommendations from the criminal justice review and develop an improvement plan if required.
Enhanced treatment quality	Young people (under 18)	1. We will ensure that all staff are competent to deliver a range of evidence based children and young people's interventions; 2. ensuring that there is sufficient time for quality interventions to be undertaken; 3. identifying how to successfully engage individuals in identified cohorts (e.g. girls and young women, those involved in Youth Justice Provision and exploitation, previous and currently looked after children, those with both diagnosed and undiagnosed disabilities including neurodiversity etc.	1.We will develop a plan identifying the professionals needed from a range of disciplines to enhance quality interventions with individuals; 2) build on ACEs training to implement a trauma-informed treatment service.3. To consider the recommendations arising from the Health and Wellbing needs assesment in respect of future planning.	1. Ensuring that staff continue to receive training relevant to their role to enhance their ability to deliver high quality interventions. 2. review trauma-informed approach for effectiveness.
	Adults	1. We will regularly review caseload sizes and mix to ensure that they are balanced across the workforce. 2. We will identify a small cohort of clients to pilot the use ff Budival. 3. We will continue to support the Family Safeguarding Model and provide supervision for the substance misuse adult workers based within Children's Social Care. 4. We will continue to commission and provide training for staff which will include ACE's.	1. We will continue to review caseload size and mix to inform further planning; 2. maintaining regular clinical supervision for all frontline staff; 3. amending or expanding Buivdal provision based on review; 3.building on ACEs training to implement a trauma-informed treatment service. 3. To consider the recommendations arising from the Health and Wellbing needs assesment in respect of future planning.	1. We will develop a range of quality measures in respect of us implementing enhanced treatment approaches 2. reviewing trauma-informed approach for effectiveness.
Expanding and developing the workforce	Young people (under 18)	1. offering accredited professional development to non-clinical treatment workforce. 2. We will participate in the Recruitment and Retention Review in respect of Adult Social Care. 3. We will continue to provide relevant training to partner agencies and departments in the local authority to improve sills, knowledge and understanding in respect of substance misuse.	1. We will work with the Local Authorities Principal Social Worker for Children and Young People and offer placements to individuals completing their Social Work apprenticeship's or degrees	1. Consider whether a specific drugs and alcohol apprenticeship could be developed locally.
	Adults	1. offering accredited professional development to non-clinical treatment workforce. 2. We will participate in the Recruitment and Retention Review in respect of Adult Social Care. 3. We will continue to provide relevant training to partner agencies and departments in the local authority to improve sills, knowledge and understanding in respect of substance misuse.	1. We will work with the Local Authorities Principal Social Worker for Adults and offer placements to individuals completing their Social Work apprenticeship's or degrees	1. Consider whether a specific drugs and alcohol apprenticeship could be developed locally.
Reducing drug related deaths and improving access to mental and physical health care	Young people (under 18)	1. We will engage with any reviews in respect of local children and young people's serious case reviews where drugs and alcohol featured. 2. We will continue to provide training for substance misuse workers, Early Help and CSC staff to enable them to develop a therapeutic approach to children affected by parental substance misuse. 3. We will review the findings of the Health and Wellbeing Needs Assessment in respect of young people with a view to developing a plan in year two.	1) We will producing a detailed full proposal identifying local themes, places and events to target in order to reduce harms to children and young people as per the recommendations from the Health and Wellbeing Needs Assessment	1. We will continue to ensure that harm reduction information, advice and support is available to young people.
	Adults	1. conducting a deep dive into DRD and ARD; 2. developing a Berkshire wide partnership approach to reduce alcohol and drug-related deaths and a Berkshire wide Drug alert system; 3. implement Drug alert plans within year 4. Develop clear pathways between substance misuse service and primary and secondary care	1. Fully implement the ARD/DRD process that has been agreed and ensure that any ARD's and DRD's are reviewed in a timely way and ensure that any learning from reviews is shared with all relevant partners. 2. Review the effectiveness of the pathways between substance misuse services, primary and secondary care, identify any barriers and develop an improvement plan.3. To consider the recommendations arising from the Health and Wellbing needs assesment in respect of future planning.	1. Review the effectiveness of the pan Berkshire ARD/DRD processes and membership of the parentship to identify good practice and share accordingly. 2. Identify any barriers in terms of information sharing, membership of the partnership and develop an improvement plan. 3. Continue to monitor the effectiveness of the health liaison post and identify and share success stories in terms of individuals who have seen improvements in terms of their physical and mental health.
Recovery orientated system of care, including peer-based recovery support services	Adults	1.Supporting the existing local recovery college in identify strengths and gaps and identifying potential funding streams and joint working opportunities to further enhance the service.2.To regularly review that there is active engagement across the breadth of local lived experience individuals and organisations.3.To ensure that the pathways to peer support and recovery services are clear and well publicised.	1.Supporting the existing local recovery college in identify strengths and gaps and identifying potential funding streams and joint working opportunities to further enhance the service.2.To regularly review that there is active engagement across the breadth of local lived experience individuals and organisations.3.To ensure that the pathways to peer support and recovery services are clear and well publicised.	1.Supporting the existing local recovery college in identify strengths and gaps and identifying potential funding streams and joint working opportunities to further enhance the service.2.To regularly review that there is active engagement across the breadth of local lived experience individuals and organisations.3.To ensure that the pathways to peer support and recovery services are clear and well publicised.

You are expected to complete a brief outline 3-year plan, taking account of the menu of interventions, which will form the basis of your detailed plan for 2022-23 (it may be helpful to complete that first).

Your plans will need to show how drug and alcohol treatment services and other services and interventions are aligned and integrated to respond to multiple and complex needs.

It will be possible to modify this outline plan in the future but it is important that your first-year plans form part of a longer-term vision.

Detailed plan for 2022-23

Your allocation	£144,526
Proposed total 2022-23 SSMTR grant spend	£144,526

Link back to notes and guidance
Link to Menu of interventions

Area	Intervention	Your proposal	Detail of staff and consumables	Q1	Q2	Q3	Q4	SSMTR grant spend in 2022-23	% of additional spend in 2022-23
1. System coordination and commissioning	Local partnership coordination and planning capacity to support partnership wide comprehensive assessment of need, strategic planning, and the implementation of partnership plans.	To work with the local public health team in respect of a health and well being needs assessment with a focus on substance misuse. To consider the recommendations and implement any changes required. To revisit and refresh the needs assessment annually and develop plans to implement any recommendations for sign off by the strategic partnership. Develop and manage an East Berkshire strategic partnership that includes all key multi agency partners involved in the drugs and alcohol agenda, to drive forward the 10 Year Drug Strategy aims and objectives. Prioritise the development of an East Berkshire strategic approach and agreed outcome measures to drive commissioning and investment in drug and alcohol services. Undertake a deep dive of DRD and ARD local data, and a review of serious case reviews featuring alcohol and drugs.	0.5 Strategic Partnership Lead (Shared with Bracknell and Slough)	0	1833.33	1833.33	1833.33	£ 5,500	4%
	Capacity to support enhanced local system-wide drug and alcohol related death and non-fatal overdose investigations	To work with public health and the other local authorities in Berkshire to develop a borough wide system for reviewing drug and alcohol related deaths and non-fatal overdose investigations. This will be led by Public health and will be supported by the Strategic Partnership Lead.						£ -	
	Capacity to support collaboration, information sharing and joint working arrangements between drug and alcohol treatment and other key local agencies, to better understand and meet the needs of vulnerable/priority groups.	To employ a Deputy Head of Service to implement the delivery of new interventions and manage performance within the service. There will also be a responsibility to implement any findings from the Health & Wellbeing Needs Assessment directly related to substance misuse	1FTE	0	15,431.67	15,431.67	15,431.67	£ 46,295	32%
								£ -	
								£ -	
2. Enhanced harm reduction provision	Enhanced naloxone provision, including through peer networks and the police (but see exclusions below this table).	We are currently in negotiations with the local police area in respect of police officers carrying take home naloxone. We will continue to discuss this and once agreement has been reached will provide training and THN kits as required.	20 THN kits	£ -	£ 296		£ 296	£ 592	0%
	Enhanced outreach and engagement, (including outreach for people with disabilities and new parents) including targeted street outreach for: • people experiencing rough sleeping and homelessness (aligned with and complementing rough sleeping grant initiatives where relevant) • targeted vulnerable/priority groups including sex workers • crack, heroin users and alcohol users who are not in contact with treatment • young people not accessing services.	To continue to provide THN to the local Rough Sleepers Team for distribution to people who are homeless or in temporary accommodation and may not be engaged with services. To continue to provide THN to a local charity, Pilgrim Hearts Trust, which delivers a service to people who either homeless, at risk of becoming homeless or experiencing povetty. To undertaken a weekly drop in session at the Pilgrims Hearts drop in to try to engage crack, heroin and alcohol users who are not in contact with services, provide needle exchange products and support people who are engaged with treatment services as required. To continue to commission pharmacies to distribute THN kits	50 x Nasal THN kits for distribution via the local service 125 x THN kits Pharmacies Payment to pharmacies to distribute THN 50 THN kits for distribution by RST and Pilgrims Heart Trust	0	2,216.66	£2,216.66	£2,216.72	£ 6,650	5%
								£ -	
								£ -	
								£ -	
3. Increased treatment capacity	Targeted treatment for priority or vulnerable groups, including underserved ethnic groups, women/girls, LGBTQ communities, and people engaged in chemsex.	All of the staff have undertaken chemsex training with a view to being in a position to deliver interventions as required.						£ -	
	Treatment capacity to respond to increased diversionary activity, including through out of court disposals, liaison and diversion and drug testing on arrest and workforce capacity for psycho-educational diversionary interventions for low level drug offences for adults and young people.	We have increased our capacity in respect of working with people who are involved in the criminal justice system. This will allow us to deal with out of court disposals, deliver a drug diversion scheme to young people and provide psychosocial intervention as required.	See costings in D27					£ -	
	Increased/piloted provision of novel long-acting opioid substitution treatments.	We will undertake a scoping exercise in order to identify a cohort of individuals to pilot the provision of long acting OST. This will be dependant on the recruitment of a Health & Wellbeing Nurse.	4 x clients for a six month period (£1,820.25 per client)		£ 2,427	£ 2,427	£ 2,427	£ 7,281	5%
								£ -	
								£ -	
								£ -	
4. Increased integration and improved care pathways between the criminal justice settings, and drug treatment	Improved collaboration and joint working arrangements with police, Liaison and Diversion schemes, courts, probation, and secure settings to: • increase the number of community service treatment requirements particularly DRRs/ATRs and support improved compliance with court mandated orders • increase the engagement and retention in community treatment of individuals referred from prison. Enhanced treatment service capacity to undertake police and court custody assessments to improve pathways into treatment.	1 FTE CJ Police, Prison and Probation Recovery Facilitator who carry out the following regular visits to individuals whilst in custody, to undertake assessments, meet on release and transfer to treatment to improve continuity of care. The worker will also improve collaboration and joint working arrangements with the courts and probation to increase the number of community sentence treatment requirements (CSTRs) and support improved engagement in treatment and compliance in respect of individuals on court mandated orders.	1 FTE	£ -	£ 9,201	£ 9,201	£ 9,201	£ 27,604	19%
	Pathway development, including outreach/in-reach, to respond to co-morbidities or complex needs, including co-occurring mental ill health, respiratory health conditions, liver diseases.	The Health Liaison Recovery Facilitator will work across primary and secondary care and the acute trusts to improve care co-ordination. The worker will also support individuals to access primary care services and accompany them to pre-booked appointments to meet their physical and mental health needs on their release from custodial sentences.	See costings in D41					£ -	
								£ -	
								£ -	
5. Enhancing treatment quality								£ -	
								£ -	
								£ -	
								£ -	
6. Residential rehabilitation and inpatient detoxification	Increased residential rehabilitation placements, to ensure the option is available to everyone who would benefit. (Locally agreed targets should be set against the national benchmark/ambition, as in the planning table) Consideration should be given how to support service expansion and improvement through available capital funds, and through regional or sub-regional commissioning partnerships with other local councils.	We will work with the South Central Coast Consortium to develop a scoping document for an assessment to be undertaken in respect of needs and availability of residential rehabilitation. The findings and recommendations will be used to inform future purchasing plans.	£1,000 for scoping exercise £17,500 for 2 x rehab placements		£ 6,833	£ 5,833	£ 5,833	£ 18,500	13%
								£ -	
								£ -	
								£ -	
7. Better and more integrated responses to physical and mental health issues	Expanded capacity and enhanced capability to deliver comprehensive physical and mental health screening and assessment.	1FTE Health Liaison Recovery Facilitator will work across primary and secondary care and the acute trusts to improve care co-ordination. The worker will establish strong working relationships with the Alcohol Liaison Teams that are base in local hospitals as well as the mental health hospital and seek to engage people prior to their discharge from hospital.	1FTE	£ -	£ 9,201	£ 9,201	£ 9,201	£ 27,604	19%
		The worker will also support individuals to access primary care services and accompany them to pre-booked appointments to meet their physical and mental health needs.						£ -	
								£ -	
								£ -	
8. Enhanced recovery support		We will continue to support Stepping Stones: Bracknell Recovery College to work with people with substance misuse issues, offenders, people with mental health issues and people who are homeless or at risk of losing their accommodation. We will support clients to enrol on course relevant to their needs which will include peer support, Education, Training and routes to Employment. Staff from the local substance misuse service will deliver specific 'Foundations To Recovery' sessions on a rolling basis. The Recovery College received pump priming funding from the local Public Health team so there is no cost at this point in time. Funding to sustain the service in place but this will be regularly reviewed and we may need to provide some funding in year 3.							
								£ -	
								£ -	
9. Other interventions which meet the aims and targets set in the drug strategy								£ -	
								£ -	
								£ -	
10. Expanding the competency and size of the workforce	Recruitment, retention and training initiatives, including: • Training, education, and continuous professional development including training and support for line managers • Health and wellbeing support including initiatives to reduce work-related stress.	The local authority is currently undertaking review in respect of recruitment and retention across Adult Social Care which will include the staff in the substance misuse service. We will continue to commission bespoke training for the staff in the substance misuse service to ensure continuous professional development. The management team will be supported to gain a recognised management qualification to enable them to support the staff. We will identify staff who will complete mental first aid training to be in a better position to support staff suffering from work related stress. The Local Authority provides Health and Wellbeing support which includes counselling and is accessible to all staff in the community substance misuse team.		£ -	£ 1,500	£ 1,500	£ 1,500	£ 4,500	3%
								£ -	
								£ -	
								£ -	

You should outline your proposals and projected spend against the menu of interventions (MOI). You can select interventions from the MOI according to local need, but it is vital that your proposals help to achieve the drug strategy outcomes outlined above and realise your locally agreed targets.

Your plans do not need to include everything in the menu if you already have adequate local provision, but they do need to support the increased treatment capacity and workforce targets over the three years of the grant.

The three-year funding announced in the drug strategy is to enable all areas to begin implementing the recommendations outlined in Dame Carol Black's review, and these are reflected in the MOI.

We are phasing in the additional funding that will be required for full national implementation of Dame Carol Black's relavent recommendations. The first 50 areas will see their funding grow significantly over the course of the following two years. These areas are asked to commence planning now to deliver against the full menu of interventions and drug strategy ambitions.

Areas that are not in this first 50 can also select from all the interventions on the menu as long as they can meet the aims of the 2021-22 grant to reduce drug-related deaths and improve criminal justice pathways into drug treatment. Interventions which are shaded in the MOI table were also in the menu of interventions for the additional funding in 2021-22. Therefore, areas not seeing significant funding increases in 2022-23 and 2023-24 should ensure these inventions are adequately resourced, either from the grant or other funding sources such as the Public Health Grant, before considering other interventions from the MOI.

Every local council will receive increases in funding in 2023-24 and/or 2024-25 and will be expected to plan to implement the full recommendations from Dame Carol Black's review and from the full menu of interventions at slower rate and with a later commencement. However, it is important that the short-term plans in these areas create a foundation for the longer-term ambitions, and whatever can be done in the short term to achieve the longer-term goal is considered.

Interventions outside the menu can be considered only if they:
- can be shown to deliver the outcomes expected in the drug strategy and target the priority cohorts identified in the treatment section of the drug strategy
- can be mobilised and delivered within 2022-23 to 2024-25
- have evidence of effectiveness and cost effectiveness
- comply with legislation and are in line with clinical guidelines
- are not interventions that are being developed and funded as part of separate pilots and programmes of work
- are only modest pump-priming for costs that could be significant and will need to be met from non-treatment budgets in the future

Menu of interventions
Link to Detailed plan 2022-23

Interventions which are shaded in the table were also in the menu of interventions for the additional funding in 2021-22.

Area	Intervention
1. System coordination and commissioning	Increased drug and alcohol treatment commissioning capacity, covering adult and/or young peoples' services.
	Local partnership coordination and planning capacity to support partnership wide comprehensive assessment of need, strategic planning, and the implementation of partnership plans.
	Capacity to support enhanced local system-wide drug and alcohol related death and non-fatal overdose investigations.
	Capacity to support collaboration, information sharing and joint working arrangements between drug and alcohol treatment and other key local agencies, to better understand and meet the needs of vulnerable/priority groups.
	Increased commissioning capacity to support regional or sub-regional commissioning, including for residential rehabilitation and inpatient detoxification.
2. Enhanced harm reduction provision	Enhanced needle and syringe programmes (including more use of low dead space syringes), covering specialist as well as pharmacy-based provision.
	Enhanced naloxone provision, including through peer networks and the police.
	Enhanced outreach and engagement, (including outreach for people with disabilities and new parents) including targeted street outreach for: • people experiencing rough sleeping and homelessness (aligned with and complementing rough sleeping grant initiatives where relevant) • targeted vulnerable/priority groups including sex workers • crack, heroin users and alcohol users who are not in contact with treatment • young people not accessing services.
3. Increased treatment capacity	Additional treatment places for opiate and crack users.
	Additional treatment places for people dependent on alcohol.
	Additional young people's treatment places.
	Additional treatment places for non-opiate drug users.
	Targeted services/provision for parents in need of treatment and support for children of drug and alcohol dependent parents and families.
	Targeted treatment for priority or vulnerable groups, including underserved ethnic groups, women/girls, LGBTQ communities, and people engaged in chemsex.
	Treatment capacity to respond to increased diversionary activity, including through out of court disposals, liaison and diversion and drug testing on arrest and workforce capacity for psycho-educational diversionary interventions for low level drug offences for adults and young people.
	Increased/piloted provision of novel long-acting opioid substitution treatments.
4. Increased integration and improved care pathways between the criminal justice settings, and drug treatment	Enhanced treatment service capacity to undertake police and court custody assessments to improve pathways into treatment.
	Improved collaboration and joint working arrangements with police, Liaison and Diversion schemes, courts, probation, and secure settings to: • increase the number of community service treatment requirements particularly DRRs/ATRs and support improved compliance with court mandated orders • increase the engagement and retention in community treatment of individuals referred from prison.
5. Enhancing treatment quality	Key working/case management quality improvement, including reducing caseload sizes, implementing caseload segmentation approaches, increased clinical supervision and training and development.
	Psychosocial intervention quality improvements, including reducing caseload sizes, implementation of evidence-based programmes, increased/enhanced clinical supervision and training and development.
	Pharmacological intervention quality improvement, including increasing the range of interventions and enhancement of clinical capacity, capability, and expertise.
6. Residential rehabilitation and inpatient detoxification	Increased residential rehabilitation placements, to ensure the option is available to everyone who would benefit. (Locally agreed targets should be set against the national benchmark/ambition, as in the planning table) Consideration should be given how to support service expansion and improvement through available capital funds, and through regional or sub-regional commissioning partnerships with other local councils.
	Increased number of inpatient detoxification placements to meet increasing demand following community treatment expansion, and in addition to the provision commissioned through the dedicated in-patient detoxification grant and multi-area commissioning consortia.
7. Better and more integrated responses to physical and mental health issues	Expanded capacity and enhanced capability to deliver comprehensive physical and mental health screening and assessment.
	Increased capacity for screening for liver fibrosis and establishing pathways with hepatology.
	Pathway development, including outreach/in-reach, to respond to co-morbidities or complex needs, including co-occurring mental ill health, respiratory health conditions, liver diseases.
	Introduce or extend the enhancement of hospital Alcohol Care Teams to also cover drug misuse.
	Enhanced partnership approaches with physical and mental health services, including the co-location of services and interventions.
	Enhanced psychosocial interventions so they effectively assess, manage, and make supported referrals for common mental health problems, including anxiety, depression, and trauma.
8. Enhanced recovery support	Development and expansion of a recovery community and peer support network, including in treatment, to sustain long-term recovery, increase the visibility of recovery and support social integration. This could include: • peer-based recovery support services • recovery community centres • recovery support services in educational settings • facilitating access to mutual aid • recovery housing • long-term recovery management such as recovery check-ups
	Enhanced partnership with collaboration with employment and housing service to improve pathways and integrated system of care.
9. Other interventions which meet the aims and targets set in the drug strategy	Interventions outside the menu of interventions can be considered if they meet the conditions listed in the notes and guidance page. Please email DrugTreatmentGrants@dhsc.gov.uk as soon as possible if you plan to propose interventions not on the menu.
10. Expanding the competency and size of the workforce	Recruitment, retention and training initiatives, including: • Incentives for staff and employers • Improved recruitment and retention, including international recruitment • Competitive pay and benefits packages • Training, education, and continuous professional development including training and support for line managers • Health and wellbeing support including initiatives to reduce work-related stress.
	Capacity in services to support training places for registered professionals, including psychiatrists, psychologists, nurses, and social workers.
	Training and development programmes for peer workers and volunteers.
	Increased number of drug and alcohol workers.
	Increased number of criminal justice drug and alcohol workers.
	Increased number of addiction psychiatrists.
	Increased number of doctors.
	Increased number of: · consultant psychologists · practitioner psychologists · assistant psychologists.
	Increased number of nurses.
	Increased number of pharmacists.
	Increased number of social workers.
	Increased number of service managers
	Increased number of commissioners, coordinators and analysts