Office for Health Improvement & Disparities

Grant scheme	**Supplemental Substance Misuse Treatment and Recovery Grant**
Local council [SELECT]	**Rotherham**
Year identified as an Enhanced area	**Year 1**
Name (person completing the plan)	**Anne Charlesworth & Jessica Brooks**
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DPH sign-off on behalf of the local partnership	

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]	£ 3,052,000	3,016,637	3,079,637	3,077,000	3,077,000
Specialist drug and alcohol misuse services for children and young people [2]	£ 176,000	158,431	139,804	176,000	176,000
Additional local investment that contributes substantially to substance misuse treatment and recovery outcomes [3]					
Supplemental substance misuse treatment and recovery grant		411,000	688,722	1,128,463	2,178,186
Inpatient detoxification grant		53,088	64,077	64,077	64,077
Total		£ 3,639,156	£ 3,972,240	£ 4,445,540	£ 5,495,263

[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:
Please note RMBC is currently out to tender for an all age drug and alcohol service for 2023-24 onwards.

Please note 2021-22 and 2022-23 **Adults substance misuse spend categories** show a slight decrease in spend due to reduced spend against the rehabilitation budget during the COVID 19 Pandemic due to closure of placements and service operating differently .The overall budget has been projected to return to above baseline (2020-21) from 2023-24 onwards.

Please note 2021-22 and 2022-23 **Specialist drug and alcohol misuse services for children and young people** show a slight decrease in spend due to reduced activity in schools and in person group delivery during COVID, this led to a reducing the value of the contract with the Provider. The overall budget has been projected to return to above baseline (2020-21) from 2023-24 onwards.

The current provider has a 5 year contract and the costs submitted as part of the tender were slightly lower for the later years

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”	**1957**	93	221	458
Opiates	1088	25	85	186
Non opiates (combined non-opiate only and non-opiates and alcohol)	330	26	52	104
Alcohol	539	42	84	168
Young people "in treatment"	**34**	5	13	25

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.

Guide for additional numbers in treatment based on national targets

Capacity guidance note

The guide numbers below 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. 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.

Capacity	Baseline 2021-22	Year 1 2022-23	Year 2 2023-24	Year 3 2024-25
All adults “in structured treatment”	1957	62	197	440
Opiates	1088	25	85	186
Non opiates	330	11	48	91
Alcohol	539	26	64	163
Young people "in treatment"	34	5	13	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%
Rotherham number of deaths	**2016**	**%**	**2017**	**%**	**2018**	**%**	**2019**	**%**	**2020**	**%**
Drug specific deaths	18	1%	15	1%	7	0%	20	1%	19	1%
Alcohol specific deaths	14	1%	15	1%	11	1%	14	1%	7	0%
*Deaths in treatment**	2016-17	%	2017-18	%	2018-19	%	2019-20	%	2020-21	%
Death in treatment - opiate users	11	1%	14	1%	17	1%	19	1%	18	1%
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%	10	1%

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

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.

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.

Alcohol related deaths:

In year one, we intend to complete a systematic review of our local alcohol and drug-related deaths, which will include cold case coroner reviews, an audit of Provider deaths in service, and qualitative and quantitative work, to inform our interventions in the following years.

We will also commence a wider partnership review process for drug and alcohol related deaths in Rotherham, and across local LAs, to improve information sharing and learning. This process will utilise a data system (QES) which will also begin in Year 1.

Initially this review process will focus on deaths within the service with a view to extend to those who were not accessing services. Taken together with the drug and alcohol strategy and action plan (also to be developed in year 1), this will then inform a targeted approach across our treatment system and partnership delivery, to support people identified as most vulnerable to alcohol -related harm, e.g. older adults.

This may include a combination of targeted harm reduction initiatives, increased AUDIT-C screening in primary care, fibro scanning, enhanced outreach provision and local public health campaigns.

Drug related deaths:

In addition to the interventions mentioned above, we intend to increase naloxone provision and training across partner organisations such as the police and housing.

Following the local drug and alcohol related death needs assessment, interventions may also include outreach clinics, specialist clinics for people with co-morbidities delivered within the treatment service, and anti-stigma campaigns; but the detail will be planned once the deep dive is complete. We have ensured there is sufficient capacity within our proposal to cover these aspects.

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	5
Pharmacists	Pharmacists registered to practice on the General Pharmaceutical Council (GPC) register https://www.pharmacyregulation.org/registers/pharmacist	2	0.5
Nurses	Nurses registered to practice on the Nursing and Midwifery Council register https://www.nmc.org.uk/registration/search-the-	4.5	2
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	1	0
Other doctors	Doctors registered on the GMC register to practice https://www.gmc-uk.org/registration-and-licensing/the-medical-register	2.5	0.5
Consultant psychologists	Consultant psychologists registered on the Health and Care Professions Council (HCPC) register https://www.hcpc-uk.org/check-the-register/	0	1
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	24.5	6.5
Criminal justice drug and alcohol workers	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	0	4.5
Young peoples' drug and alcohol workers	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	3.5	0
Other drug and alcohol workers	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	21	2
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	4	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	0	3.5

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 (%)	25%	40%	60%	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 all local councils and their partners to set trajectories to make this a reality.

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	9	0.5%	14	26	38

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 be identifying new venues and opportunities to identify young people who require a service offer and using this information to build capacity in the new service offer that commences in April 2023. 2.) the basis of this will be a low threshold offer and one of supporting and training other children's professionals to work with young people where that relationship already exists.	Specialist workers based in family hubs will be leading a new drive on ensuring parental substance misuse and family based interventions to address inter generational patterns of alcohol and drug use. This will include looking at all options for detox and rehab that affect family units. Capacity in the service model will be expanded to reflect an increased caseload but this may also occur elsewhere in the system, resource will be matched with where the system pressures are for YP, e.g. resource on the YOS and on the YP CJ pathway. A coproduction approach will be implemented alongside the prevention and early intervention strategy to inform planning for year 24/25.	Work in the family hubs and across young peoples venues will be generating information about local need to enable the needs assessment to be refreshed to inform the service model. The workforce expansion will need to reflect this identified need, and a review of caseloads, outcomes and throughput will inform resource allocation.
	Adults	We will focus on: 1) Outreach and engagement, we aim to better understand client needs to inform the direction of future upscaling of capacity to align with unmet needs identified; 2) Enhancing harm reduction including naloxone and needle and syringe provision;3) Enhancing treatment capacity with more treatment places and considering extending operating hours as well as looking at how the shared care model can improve access by mapping across the PCN footprints, enabling smaller practices to re-join the scheme post pandemic. 4) Increase assessments for residential rehab in order to meet the targets by commissioning a bespoke caseload audit tool to be applied across existing services but also mental health and adult social care caseloads; 5) Work with our consortia to increase access to detox beds, linking to a local co-ordinator in our provider services. 6) commencing the pathway redesign to eliminate any delays in the client journey through financial assessment and placement.	We will focus on: 1) delivering the 20% increase to meet a wider range of local need. This may result in the identification of more under served groups and the needs of women and both adults and yp with LD will be in focus. 2) implementing the revised pathway for access into detox and rehab , using the specialism of the commissioned service to assess clients from elsewhere in the system to improve outcomes for some of the most complex clients which also links to the programme of work to prevent deaths. 3) capacity and harm reduction capacity to further increase as required but with a focus on a no wrong door approach that enables more services to deliver harm reduction and higher quality referrals into the new service model.	The service model will have established an operational delivery model from front door to recovery and exit, which will require ongoing and close monitoring from the commissioning team and additional resource will be allocated to allow this prior to any more grant allocation. This will review the role of shared care and pharmacy to ensure the right clients are in the right service sector. The caseload audit for rehab will be repeated.
Enhanced treatment quality	Young people (under 18)	The current service is commissioned until March 2023 and has capacity for treatment and harm reduction but is not accessing a wide enough population with the existing offer. Professionals require systematic training to identify young people at risk of harm due to their own and parental alcohol and drug misuse and this needs to be firmly linked with other children's pathways. The improvements in psychological services needs to also be focussed on the 18-25 population pathway to avert entrenched patterns of behaviour and add resource into the transitions pathway.	We will explore the existing digital offer for young people to enhance access and engagement. The strategy will outline a plan with schools and other education venues to enhance the current prevention and harm reduction offer to ensure access to advice and support is available and information is of high quality as a result of the training of other professionals, and ensuring they have rapid access to local support.	Caseloads and delivery of harm reduction work across the Borough will be reviewed and the work in sexual health services reviewed and evaluated .
	Adults	We will focus on:1) Increasing psychological support and trauma informed offer for those already in the system ; 2) Driving improvements arising form the CQC report action plan that focus on service user ownership of their recovery and the plans to achieve this 3) addressing the lack of visible recovery for those in shared care and not part of a recovery community.	1. The new service model will mobilise and bring new opportunities to refresh pathways across criminal justice, employment and housing. 2. There will be continued monitoring of worker caseload in the service to ensure that care plans can be delivered in full, with additional resource targeted at need and multi agency working. 3. The new commissioning capacity will be utilised in service and caseload monitoring to deliver the quality targets in the new contract.	Alongside increased new service users accessing treatment will be increased successful exits balancing the caseload and allowing focused time on recovery. 1. The adults social worker model will be supporting access into a wider range of mental and physical health services for clients with more complex needs 2. we will review the need for liver scanning learning from models elsewhere and with the clinical network.

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.

Expanding and developing the workforce	Young people (under 18)	At present there is no plan to increase the YP workforce in year one as the current service does have capacity and for a small increase in numbers and the drive is to identify additional venues for deployment of outreach where yp already access.	Increase the workforce to deliver the planned activity and the additional numbers. This can be brought forward depending on the presenting need.	Increase the workforce to deliver the planned activity and the additional numbers. This can be brought forward depending on the presenting need.
	Adults	We will focus on: 1) working with our provider to address challenges in recruitment using apprentice level entry schemes; 2) Working with partners to recruit staff in other teams and organisations which may include access to psychological services, ACT, sexual health, family hubs; 3) Continue and expand on bespoke training currently being delivered (to include primary care workforce in screening and alcohol brief interventions)	1)We will be bringing in a recognised recovery model to support the newly awarded service and offer a choice to service users for ongoing support for those who exit the system. This model will work with local voluntary sector and colleges to embed lived experience into the local choices. see also recovery. 2) the service workforce will be expanded with both clinical and recovery focussed staffing to cover the increased numbers presenting and to deliver assertive outreach for those who DNA or disengage.	1) continued monitoring of numbers and need will inform additional investment in capacity and workforce. 2) the wider workforce will continue to be upskilled with the continuation of a structured training programme which includes GPs .
Reducing drug related deaths and improving access to mental and physical health care	Young people (under 18)	1) we intend to complete the started systematic review of our local alcohol and drug-related deaths, which will include cold case coroner reviews, an audit of Provider deaths in service; 2) develop and embed a new process structure, including linking into CDOP, for DRD reviews, supported by a South Yorkshire wide reporting system	We will review service offer in the tenders and look to bolster this with access to additional psychological services for young people	Implementation of learning from DRD reviews and additional support for the mental health pathways (for example additional provision or training for children's and young peoples workforce)
	Adults	1) we intend to complete the started systematic review of our local alcohol and drug-related deaths, which will include cold case coroner reviews, an audit of Provider deaths in service; 2) develop and embed a new process structure for DRD reviews, supported by a South Yorkshire wide reporting system; 3) increase naloxone provision and training for its use across partner organisations such as the police and housing; 4) recruit 2 senior practitioner social workers based in the adults safeguarding hub to develop and implement pathways and navigate care packages for those with complex needs including dual diagnosis.	We will focus on: 1) Actions from learning from DRD reviews and audits; 2) Expending the process to deaths beyond those involved with our drugs and alcohol service; 3) increasing the numbers in shared care which we can see locally has good outcomes for longer term physical health management . 4) increase capacity of the ACT to ensure those presenting into the acute sector are rapidly accessed into services that can manage physical health needs	1) building on the capacity of the social worker posts to include pathways for dual diagnosis with complex physical health needs
Recovery orientated system of care, including peer-based recovery support services	Adults	We will focus on: 1) Developing an asset based "Recovery academy" model with key VCS partners; 2) Supporting our provider to implement actions arising from the CQC report pertaining to recovery and their existing plans of enhancing peer-based recovery support through peer mentoring and recovery champions. ; 3) Develop a recovery housing offer; 4) improve pathways to recovery within the shared care scheme	Focus will be: 1) implementation of the "recovery academy" model that builds partnership engagement to improve successful exits from services 2) Mobilisation of the new service model that has a strong recovery focus	It is essential that at this point of the delivery plan those who can leave the system have done so successfully and those who enter are receiving an offer that engages them in a visible recovery community from the outset. The recovery model will need to continue to adapt to the new challenges facing this vulnerable community and harness the experience of those who have left the system to support that where possible.

Detailed plan for 2022-23

Your allocation	£688,722
Proposed total 2022-23 SSMTR grant spend	£688,722

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	Increased drug and alcohol treatment commissioning capacity, covering adult and/or young peoples' services. Increased commissioning capacity to support regional or sub-regional commissioning, including for residential rehabilitation and inpatient detoxification.	Operational Commissioner role and Commissioning officer role Support with the commissioning of any additional provision from the grant and enhance management of existing services and tender process for new service in commencing 2023 as well as any future needs arising	1 FTE Operational Commissioner (@ £51680 pro rata) 0.5 FTE Commissioning Officer (@ £23088 pro rata)	£-	£ 18,692	£ 18,692	£ 18,692	£ 56,076	8%
	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 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.	A public health specialist to lead on the co-ordination and programme management of work around the drugs and alcohol agenda. Including but not limited to supporting the drug related death, grant, and developing the council strategy of action plan regarding drugs and alcohol. As well as any other work to review data and services as needed e.g. conduct an evidence review to identify effective interventions for children and young people in Rotherham	1 FTE Public Health Specialist (@ £53924)	£-	£13,481	£13,481	£13,481	£ 40,443	6%
	Capacity to support enhanced local system-wide drug and alcohol related death and non-fatal overdose investigations.	Conducting a drug related death review, coroners audit and to put in place a system to review drug related deaths. Included within this is the implementation of a South Yorkshire Wide system and Police role to support.	0.5 FTE Commissioning Officer (@ £23088 pro rata)	£-	£5,772	£5,772	£5,772	£ 17,316	3%
2. Enhanced harm reduction provision	Enhanced naloxone provision, including through peer networks and the police.	Continuing naloxone offer and providing to new groups	300 Naloxone kits	£-	£1,500	£2,253	£1,867	£ 5,620	1%
	Enhanced needle and syringe programmes (including more use of low dead space syringes), covering specialist as well as pharmacy-based provision.	Harm reduction role in provider service for on increasing delivery of clean injecting equipment, increase blood borne virus testing and provide outreach. Safe storage boxes for prescribed drugs/injecting equipment will be offered	0.5 FTE Harm Reduction Worker (@ £17681 pro rata) 250 Safe storage boxes	£-	£6,643	£6,643	£6,643	£ 19,929	3%
	Enhanced outreach and engagement, (including outreach for people with disabilities and new parents) including targeted street outreach	Extra capacity to find clients in a number of settings as identified which could include (young people, marginalised communities, homeless, etc).	0.5 FTE Harm Reduction Worker (@ £17681 pro rata)	£-	£4,420	£4,420	£4,420	£ 13,260	2%
3. Increased treatment capacity	Existing treatment capacity funded via public health grant is meeting sufficient need Any additional capacity needs for specific cohorts or priority groups to be reviewed	We will continue with the contract variation and explore the possibility to add additional opening hours (weekends and evening) to align with alcohol and drugs teams within the local hospital and to allow for extra hours to access prescribing services (following consultation). We will identify additional beneficiaries and needs arising through targeted screening for identification of harmful and hazardous drinking in primary care as well as more generally raising the profile of the service with increased engagement and outreach as specified above (including additional work around safeguarding, sexual health and family hubs workers) may increase referrals. We aim to better understand client needs to inform the direction of future upscaling of capacity to align with unmet needs identified	0.5 FTE Team leader (@ £43484) 0.5 FTE Non Medical Prescribing (@ £ 53042 pro rata) 0.2 FTE Data analyst (@ £28657 pro rata) 0.5 FTE Pharmacy capacity (@ £63102 pro rata) NB these costs include increased prescribing requirements		£35,655	£35,655	£35,655	£ 106,965	16%
	Targeted treatment for priority or vulnerable groups, including underserved ethnic groups, women/girls, LGBTQ communities, and people engaged in chemsex.	Drug and alcohol workers to run clinics within the sexual health service	1 FTE Drug and alcohol worker Band 7 (@ £44732)				£11,184	£ 11,184	2%
	Targeted services/provision for parents in need of treatment and support for children of drug and alcohol dependent parents and families.	Early help hub workers (linking in with fetal alcohol screening and prenatal drinking). The staff will focus on the needs of whole families where a parent(s) is dependent on substances. The staff will support families in; making better choices, improving access to substance misuse treatment, as well as protect/safeguard children and minimise the number and degree of adverse childhood experiences that children experience as a result of the chaotic lives of their parents.	3 FTE Early Help Hub workers Band I (@ £43780 pro rata) n.b hiring in preparation for year 2 only part quarter				£11,183	£ 11,183	2%
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.	Courts and custody is current Sheffield based. We will review the current pathway which includes 3.5 criminal justice workers employed from the Universal Drug Treatment Funding	2 FTE Criminal Justice worker (@ £31512 pro rata)		£17,696	£17,696	£17,695	£ 53,087	8%
	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.	This work will continue with targets on completions of Court disposals, adding the Alcohol Treatment requirement into the service model and setting clear targets for supporting clients leaving prison to have more support We will seek to expand referrals extending beyond DRR and ATRs	1.5 FTE Criminal justice worker (@ £31512 pro rata)		£11,209	£11,209	£11,209	£ 33,627	5%
		In reach prison worker/dedicated co-located role to build relationships with South Yorkshire Prisons cluster. With which we aim to improve our performance of continuity of care from prison to local service, including any identified targeted work e.g. with the women's estate	1 FTE criminal justice worker with responsibility for prison liaison (@ £31512 pro rata)				£6,878	£ 6,878	1%
5. Enhancing treatment quality	Psychosocial intervention quality improvements, including reducing caseload sizes, implementation of evidence-based programmes, increased/enhanced clinical supervision and training and development.	Increase psychological support and trauma informed offer via mental health posts	1 Consultant Psychologist (@ £ 89987 Pro rata)			£ 18,369	£22,496	£ 40,865	6%
	Key working/case management quality improvement, including reducing caseload sizes, implementing caseload segmentation approaches, increased clinical supervision and training and development.	As a result of CQC report there is an additional quality and performance manager for the remaining year of our providers core contract. This role will carry the subsequent action plan improvements		£ -	£ -	£ -	£ -	£ -	0%
6. Residential rehabilitation and inpatient detoxification	Increased residential rehabilitation placements, to ensure the option is available to everyone who would benefit. 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.	A member of staff is appointed to co-ordinate rehab and detox as part of the Public Health Grant. The national target set for residential rehabilitation at 2% over the 3 years equates to 76 Rotherham residents being funded for a placement. This will mean a higher number being assessed for suitability and consideration is being given to a caseload audit tool that can be used in the CGL service as well as other pathways (e.g. through the criminal justice pathway).	0.5 FTE Harm Reduction Worker (@ £17681 pro rata)		£4,420	£4,420	£4,420	£ 13,260	2%
		Cost of Rehab. Including the design and implementation of a caseload audit tool for other stakeholders to identify clients due to the need for a higher number being assessed for suitability which may also include inpatient detox (DMBC will hold the funds for the Consortium and Rotherham will be allocated at least 15 inpatient episodes per year).	14 Rehabilitation placements		£49,191	£49,192	£49,192	£ 147,575	21%
	Friends and Family Support	Develop a package of support (possibly alongside existing structures) for friends and family	Sessional staffing and room hire				£7,548	£ 7,548	1%

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 relevant 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

7. Better and more integrated responses to physical and mental health issues	Enhanced partnership approaches with physical and mental health services, including the co-location of services and interventions.	2 Senior Practitioners, based in interdisciplinary safeguarding teams to develop and implement pathways and navigate care packages for those with complex needs (dual diagnosis of mental health and substance misuse possibly extending to physical health)	2 FTE Mental Health Worker Band K (@ £54259) N.B this is for recruitment for Year 2				£1,800	£	1,800	0%
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	The recent CQC report has specific actions outlined for improving this area of delivery which will form the action plan. Thus there is a number of elements to our proposal including; enhancing peer-based recovery support through peer mentoring and recovery champions through the new recovery support worker role from the Public Health Grant.	0.5 FTE Harm Reduction Worker (@ £17681 pro rata)		£4,420	£4,420	£4,420	£	13,260	2%
		Improve the integration of recovery through the shared care scheme	Room hire, travel costs (bus passes)		£2,982	£2,982	£2,983	£	8,947	1%
		Co-designing recovery support in the community a various settings as part of a "recovery academy" model with the voluntary and community sector	Procurement of services		£20,000	£20,000	£20,000	£	60,000	9%
9. Other interventions which meet the aims and targets set in the drug strategy								£	-	0%
								£	-	0%
10. Expanding the competency and size of the workforce	Recruitment, retention and training initiatives	Address challenges in recruitment using apprentice level entry schemes	No financial allocation, dependent upon underspend in other areas of recruitment					£	-	0%
	Upskilling non-specialist workforce	Continue and expand on bespoke training currently being delivered (to include primary care workforce in screening and alcohol brief interventions)	250 places on training courses		£6,630	£6,630	£6,639	£	19,899	3%

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