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Portsmouth CITY COUNCIL

NOTICE OF MEETING

CABINET MEMBER FOR HEALTH, WELLBEING & SOCIAL CARE

THURSDAY, 3 OCTOBER 2019 AT 4PM

THE EXECUTIVE MEETING ROOM - THIRD FLOOR, THE GUILDHALL

Telephone enquiries to jane.didino@portsmouthcc.gov.uk
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If any member of the public wishing to attend the meeting has access requirements, please notify the contact named above.

Membership

Cabinet Member for Heatlh, Wellbeing & Social Care
Councillor Matthew Winnington (Cabinet Member)

Group Spokespersons
Councillor Graham Heaney
Councillor Luke Stubbs

(NB This agenda should be retained for future reference with the minutes of this meeting).

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A G E N D A

1 Apologies for absence

2 Declarations of members' interests

3 Adult Social Care Older Persons Care Home Strategy (Pages 5 - 8)

Purpose.
The purpose of this report is to inform the Cabinet Member of progress against the decisions taken at the Cabinet Member Decision meeting in November 2018.

RECOMMENDED that the Cabinet Member notes the progress against the decisions taken in November 2018 to provide good quality, sustainable accommodation for Adult Social Care in Portsmouth.

4 Annual performance report for the adult substance misuse service (Pages 9 - 14)

Purpose.
To update the Cabinet Member for Health, Wellbeing and Social Care on the performance of the adult substance misuse service during 2018/19

RECOMMENDED that the contents of this report be noted.

5 Changes to data that Portsmouth provides to the national drug treatment (Pages 15 - 108)

Purpose of report
1. To seek approval from the Cabinet member for Health, Wellbeing and Social Care to reduce the amount of data which is provided by our substance misuse service to the National Drug Treatment Monitoring System (NDTMS).
2. To seek approval to use alternative local measures.

RECOMMENDED that the Cabinet Member:
1. **Approves a reduction in specific treatment data collected and submitted to the NDTMS.**
2. **Approves the additional service improvement and outcome measures which have been developed as part of the Vanguard systems thinking intervention.**

6 Funding for the Re:Fit project (Pages 109 - 144)

Purpose.
To update the Cabinet member for Health, Wellbeing and Social Care on the forthcoming ceasing of lottery funding for the Re:Fit project and to seek funding to maintain a reduced service.

RECOMMENDED that the Cabinet Member:
1. **Approve a funding contribution towards the Pompey in the Community Re:Fit worker post of £29,000 p.a. (total: £58,000) for 2 years from 01 November 2019.**

2. **Approve that in the first instance, funding for this for this project would be identified from any underspend in the current financial year Public Health Grant. In the following financial years, opportunities to fund this expenditure within the relevant year's budget would be sought. Should any funding shortfall be identified, then the funding from the Public Health reserve can be utilised.**

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THIS ITEM IS FOR INFORMATION ONLY
(Please note that "Information Only" reports do not require Equality Impact Assessments, Legal or Finance Comments as no decision is being taken)

Portsmouth CITY COUNCIL

Title of meeting:	Cabinet Member for Health, Wellbeing & Social Care
Subject:	Adult Social Care Older Persons Care Home Strategy
Date of meeting:	3 October 2019
Report by:	Chief Health & Care Portsmouth
Wards affected:	All

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1. Purpose of report

1.1. The purpose of this report is to inform the Cabinet Member of progress against the decisions taken at the Cabinet Member Decision meeting in November 2018.

2. Context

In order to provide a social care service that meets the needs of Portsmouth residents, meets the Council's statutory duties and manages the demands of increasing needs and costs, Adult Social Care (ASC) has been developing a service wide strategy covering changes in the way we work from 2018/19 to 2020/21. Implementing the ASC Strategy will achieve outcomes for residents and work toward financial balance. By 2022, our aim is that ASC in Portsmouth will be:

- Delivering services that have technology at the heart of the care and support offer;
- Working in way that recognises the strengths that people have, and have access to in their networks and communities - and draws on these to meet their needs;
- Working efficiently and responsively, using a reablement approach centred around the needs of the customers;
- Delivered through a market based on individual services to people that meet their needs and help them achieve the outcomes they want to achieve and keep them safe;
- Delivered, (where appropriate) through PCC residential services in one service area to enable quality and maximum effectiveness.

This strategy will enable ASC to be financially stable and sustainable.

These outcomes align to the priorities in the 'Blueprint for health & care in Portsmouth' published in 2015:

- Improve the range of services people can access to maintain their independence
- Give people more control, choice and flexibility over the support they receive

- Do away with multiple assessments and bring services together in the community
- Bring together services for children, adults and older people where there is a commonality of provision, including a family centred approach
- Create better resources and opportunities for vulnerable people and their carers.

2. Recommendations

2.1. It is recommended that the Cabinet Member notes the progress against the decisions taken in November 2018 to provide good quality, sustainable accommodation for Adult Social Care in Portsmouth.

2.2 **Build extra care facilities for people living with dementia in Portsmouth, re-provisioning the Edinburgh House site.**
The Cabinet member's decision meeting on 20th November 2018 approved the implementation of a staffing review, continuing to fund increased staffing levels in the short term whilst reducing the number of beds PCC would require in the future, based on demand data analysis. The Cabinet member also requested that ASC investigate gaps in provision in Portsmouth which resulted in a recommendation that Edinburgh House be closed and the site be re-provisioned to create extra care for people with dementia.

Update
Admissions to Edinburgh House ceased from November 2018 and a process of engagement with existing residents, relatives, staff and wider stakeholders commenced. Residents and their families were offered opportunities to visit other care homes if they wished to. Where a placement was identified by residents/families and the request was made by residents/families, the option to move sooner than the proposed closure date was agreed. ASC had allowed until October 2019 to complete this process to enable people to have time to consider their preferred options. Relatives/residents decided to move more quickly than anticipated and as a consequence the last resident left Edinburgh House on 29th April 2019. Following phase 1 consultation, all staff have been redeployed to other units across the city coinciding with the last resident leaving on 29/4/19.

An application was made to remove the location from Portsmouth City Council's registration with the Care Quality Commission, as part of the statutory process when provision of services change. The building is now boarded up and a demolition programme is in place, estimated to complete December 2019. During this time, engagement between project management and the service will enable the extra care facility to be designed and the build to be tendered.

2.3 **Communication and engagement with existing residents, relatives, staff and wider stakeholders at Hilsea Lodge to enable the home to close in 2020**
Based on analysis of the resources required in Portsmouth the Cabinet member's decision on 20th November 2018 was that Hilsea Lodge be closed, enabling the site to be repurposed.

Update

Following the decision meeting in November 2018, a process of engagement with existing residents, relatives, staff and wider stakeholders commenced. Residents and their families have been offered opportunities to visit other care homes if they wished to. Where a placement has been identified by residents/families and the request made by residents/families, the option to move sooner than the proposed closure date has been agreed in the same way. ASC has allowed until October 2020 to complete this process to enable people to have time to consider their preferred options.

Some of the residents and their families at Hilsea Lodge have chosen to move to alternate accommodation, similarly to Edinburgh House, these moves are led by residents/relatives. Permanent admissions to Hilsea Lodge were therefore ceased. The staff consultation around redeployment due to commence in January 2020 was also brought forward to July 2019, following a direct request from staff and unions.

Since the paper was originally drafted, the last remaining residents of Hilsea Lodge have moved to alternative accommodation and Hilsea Lodge is no longer in use as a residential home as of 23rd September 2019.

Future options for the Hilsea Lodge site need to be explored, however the site will be repurposed to provide for gaps in provision in the city, likely to be extra care, supported living or social housing.

……
Signed by (Director)

Appendices:

Background list of documents: Section 100D of the Local Government Act 1972

The following documents disclose facts or matters, which have been relied upon to a material extent by the author in preparing this report:

Title of document	Location

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Portsmouth CITY COUNCIL

Title of meeting: Cabinet Member for Health, Wellbeing and Social Care

Date of meeting: 3rd October 2019

Subject: Annual performance report for the adult substance misuse service

Report by: Director of Public Health

Wards affected: All

Key decision: No

Full Council decision: No

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1. Purpose

1.1 To update the Cabinet member for Health, Wellbeing and Social Care on the performance of the adult substance misuse service during 2018/19

2. Recommendation

2.1 To note the contents of this report

3. Background Information

3.1 In November 2016 a new contract commenced to deliver the community adult substance misuse treatment in Portsmouth. This is delivered by the Society of St. James, who sub-contract Solent NHS Trust to deliver the medical elements of the provision. The total value of this contract in 2018/19 was £2,577,708.

3.2 This is an extensive service which provides the following elements of provision:

- Needle exchange and provision of other clean equipment to prevent the spread of blood borne viruses.
- Outreach work with homeless and other vulnerable drug users at risk of drug related death
- Support from Recovery workers, who will support the service user to develop and implement a recovery plan
- Substitute medication, such as methadone or buprenorphine, which reduce and stop the use of illicit street drugs, provided by a consultant psychiatrist, Dr and nursing staff.
- Generation of prescriptions and liaison with pharmacies to provide supervised consumption
- Access to specific alcohol support workers
- Therapeutic support groups
- Detoxification, either home or residential

- Community 'day rehab', providing an intensive programme of support for service users who have recently completed a detoxification
- Residential rehabilitation
- Hospital liaison workers for those with drug, alcohol and homelessness issues.
- Supply of Naloxone, the heroin antidote, along with training for staff, drug users and carers.

3.3 During 2018 and into 2019 the service has undergone a Vanguard systems thinking review which has led to a change in the data which is collected and how it is collected. The service is now less process driven and more focused on ensuring the needs of service users are the priority.

4. Performance

4.1 During 2018/19 there has been a significant increase in the number of service users accessing drug and alcohol treatment, as highlighted in Table 1. In total there was an additional 140 service users reported to the National Drug Treatment Monitoring System (NDTMS), with additional service users who either opted out of NDTMS or were not receiving a structured treatment intervention (i.e. they may have been receiving support from a key worker, but not receiving substitute prescribing or attending therapy groups). Table 2 highlights the numbers of successful completions, where someone leaves treatment drug or alcohol free, or no longer with problematic use.

Table 1: Numbers receiving treatment (reported to NDTMS), with additional non-NDTMS reported for 2018/19.

Main substances used	**2017/18**	**2018/19**	**2018/19 including non-NDTMS clients**
Alcohol only	163	218	292
Alcohol and non-opiate	49	73	87
Non-opiate only	52	61	88
Opiate	692	744	759
Total	956	1096	1226

Table 2: Successful completions (Reported to NDTMS)

Main substances used	**2017/18**	**2018/19**
Alcohol only	54/163	89/218
Alcohol and non opiate	14/49	30/73
Non-opiate only	20/52	28/61
Opiate	45/692	42/744
Total	133	189

Leaving treatment drug / alcohol free, or no opiate or cocaine use, occasional alcohol use.

4.2 Re-presentations

One performance measure monitored by Public Health England is 're-presentations'. This is the number of service users that leave treatment as a successful completion which re-present to treatment within 6 months. Substance misuse is a relapsing condition and it may take service users many attempts to eventually live drug free. Table 3 highlights the change in performance from 2017/18 to 2018/19. The relatively low numbers of re-presentations mean that small changes can mean bigger percentage changes. Whilst opiate representations performance is worse than the previous year, all the other categories are improved, with increased numbers of completions and lower percentages of re-presentations.

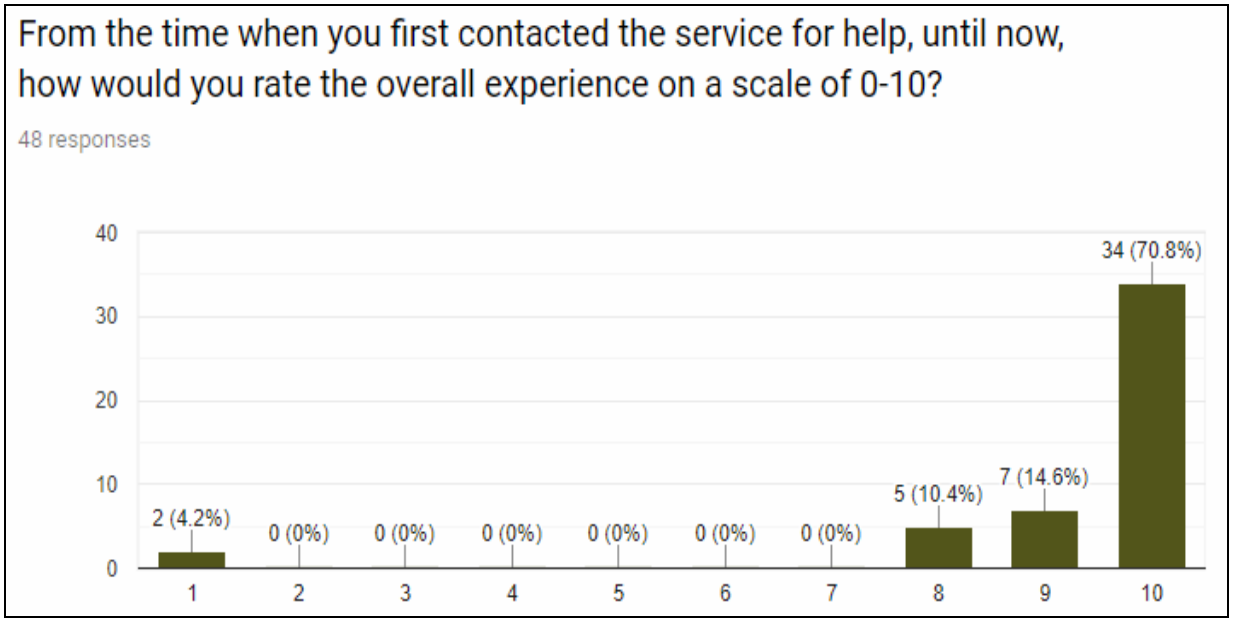
Table 3: Re-presentations in Portsmouth 2017/18 and 2018/19

Substance	2017/18	2018/19
Opiate	4/27 14.8%	5/22 22.7%
Non-opiate	0/8 0.0%	0/17 0.0%
Alcohol	5/26 19.2%	4/62 6.5%
Alcohol and non-opiate	1/8 12.5%	2/17 11.8%

4.3 Service user satisfaction

A service user satisfaction measure was introduced during 2018/19 as part of the Vanguard systems thinking work. Service users are asked to rate their satisfaction with the service at relevant points in their journey, for example prior to discharge or after a demand has been met. They are asked to scale the service from 1- 10 and explain what they think could have done differently if they didn't score a 10. Results are shown in the chart below.

The purpose of this measure is to help better understand and improve the service. Managers are tasked with looking at this measure and acting on the issues raised.



Person who scored 1:
John said the service was slow and disorganized. He was unhappy as he attended the service to be told that his appointment was not at 15:00 (which is what was detailed on his prison release letter) and that it was 16:00. This error was because admin had booked him in for 15:00 and informed the prison of this but it was not recorded on the paper diary which meant another client was booked into the 15:00 slot.

Sample of other comments:
"You called me a fair bit at the beginning to check in and less when I needed it (less). Really helpful." – Scored 10

“Felt very relaxed and comfortable and everything was explained well and clearly. Was very pleased to be met initially by the person who would be my key worker so I did not have to explain my story again to someone else.”

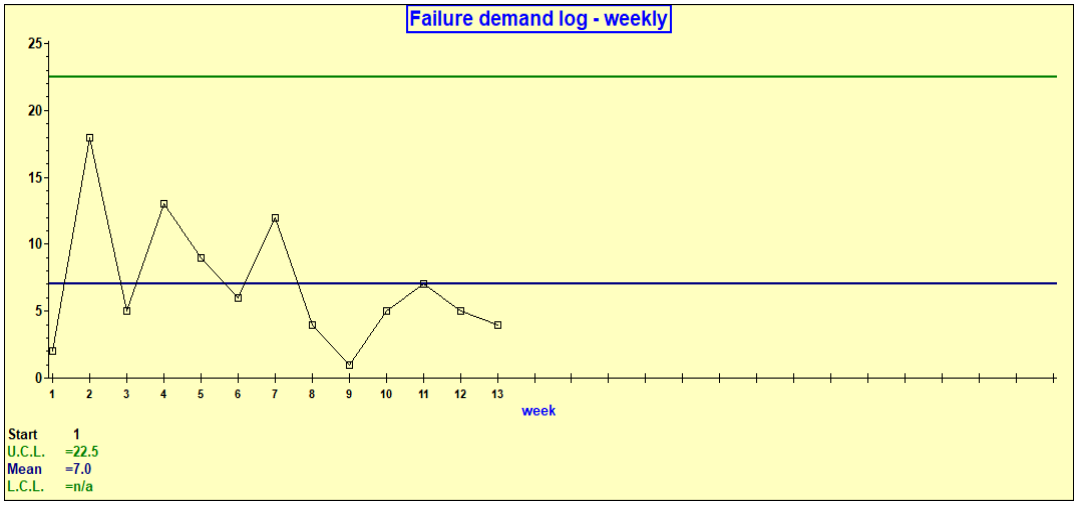
“The service has always treated with me respect and helped me at some desperate times. The score has a lot to do with you, because you have really helped me a lot over the years. I am really grateful to you and the service generally.”

“It has helped me complete my DRR which has kept me out of prison. Was using cocaine 6 days a week now only 2. Friendly staff that are welcoming. Funny, happy key worker who makes time for me.”

During psychosocial work, NVQ in health and social care never happened despite asking for it several times but never heard back. If it wasn't for this I would have scored a 10.

4.4 Failure Demand
Part of the Vanguard method is to log 'failure demand'. Failure demand is where a customer 'demand', typically calling into the Recovery Hub or a phone call, occurs due to the service not completing what was expected of it. Chart 1 below highlights the number of failure demands covering the period of introduction of this measure and the end of the year, there is a downward trend as the service responds to recorded failure demands. Through recording failure demand, the service has been able to identify that the process for generating prescriptions and these being dispensed by pharmacies was a common cause of problems. The service has subsequently commenced a Vanguard 'check' on this process to see what improvements can be made.

Chart 1: Failure demand log covering period of introduction of the measure up to 31/3/19



The time taken to provide a service user with a prescription for substitute medication has significantly reduced over the course of the year. This is a key measure, as it is important to engage a heroin user quickly on substitute medication at the point they access to increase engagement. At the beginning of the Vanguard process the average number of days it took from first presentation at the Recovery Hub to receipt of the prescription was 8.6 days. Since rolling out the new way of working, this has been brought down to an average of just 1.9 days.

4.5 Harm Reduction

An important function of substance misuse services is to minimise the harm that drug users cause to themselves and others. This including providing clean equipment that reduces the spread of blood borne viruses and providing a drug which is a heroin overdose antidote. Harm reduction activities save lives and prevent early deaths.

Needle exchange
Demand for clean needles increased during 2018/19, with a total of 158,785 needles being distributed, an increase of 8.3% on the previous year (n. 146,550). There was also an increase in some of the other safer injecting equipment provided, such as citric acid, water, spoons, but a reduction in the number of condoms distributed. The return of bins increased so that 3355 (50.5%) of the 6633 distributed were returned, up from a return rate of 41.8% the year before.

Naloxone
255 Naloxone kits were distributed in Portsmouth during the year. Naloxone is an opiate overdose antidote which can bring about a recovery from an overdose whilst an ambulance is called. Naloxone has been used a number of times in our supported housing projects to prevent overdoses becoming deaths. Service users have also reported using the drug to save the lives of friends.

5. Staff sickness

The average number of sick days amongst staff at the Recovery Hub was 7.79 days per employee.

6. Conclusion

The Society of St. James has been delivering the single substance misuse contract since November 2016. At the time they had to make significant changes to a substance misuse treatment system which had seen around 40% reduction in funding since 2013/14. These reductions had an obvious impact on delivery and the numbers of people engaged in treatment reduced. However in 2018 the provider, with the support of Portsmouth City Council, undertook a Vanguard systems thinking review, seeking to reduce waste, improve efficiency and the client experience. During 2018/19 the service has been able to work with significantly more people with substance misuse issues. The service is now measuring service user satisfaction and 'failure demand' in order to seek to make continuous improvement to delivery.

7. Equality impact assessment

No EIA completed as this is reporting on an existing service.

8. Legal implications

There are no legal implications arising from the recommendation in this report.

9. Director of Finance's comments

As this report is for information purposes only, no finance comments are required

……
Signed by: Director of Public Health

Appendices:

None

Background list of documents: Section 100D of the Local Government Act 1972

The following documents disclose facts or matters, which have been relied upon to a material extent by the author in preparing this report:

Title of document	Location

Portsmouth CITY COUNCIL

Title of meeting: Cabinet Member for Health, Wellbeing and Social Care

Date of meeting: 3rd October 2019

Subject: Changes to data that Portsmouth provides to the national drug treatment monitoring system

Report by: Director of Public Health

Wards affected: All

Key decision: No

Full Council decision: No

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1. Purpose of report

1.1 To seek approval from the Cabinet member for Health, Wellbeing and Social Care to reduce the amount of data which is provided by our substance misuse service to the National Drug Treatment Monitoring System (NDTMS). To seek approval to use alternative local measures.

2. Recommendation

2.1 The Cabinet member approves a reduction in specific treatment data collected and submitted to the NDTMS.

2.2 The Cabinet member approves the additional service improvement and outcome measures which have been developed as part of the Vanguard systems thinking intervention.

3. Background Information

3.1 **National Drug Treatment Monitoring System (NDTMS)**

The NDTMS state that their data *helps drug and alcohol treatment demonstrate the outcomes it achieves for the people it treats, and in doing so aids accountability for the money invested in it. NDTMS is a national standard and is applicable to young people and adults within community and secure setting based treatment providers.* (Appendix 1)
The data items contained in the NDTMS dataset are intended to support the following (Appendix 1):

1. Provide measurements that support the outcome and recovery focus of the Government's drug strategy, such as:

- proportion of clients successfully completing treatment
- proportion of clients that do not return to treatment following a successful completion

- value for money
- housing and employment
- health and quality of life outcomes
- support for children and families of drug and alcohol dependents

2. Provide information which can be used to monitor how effective drug and alcohol treatment services are and help to plan and develop services that better meet local needs

3. Produce statistics and support research about drug and alcohol use treatment

4. Provide measurements to support the Public Health Outcomes Framework

3.2 NDTMS require a comprehensive dataset, which is reviewed frequently, usually annually. The Current dataset is O, having begun in the early-mid 2000s with dataset A. In most cases additional fields have been added each year, with others revised. The full details of dataset O fields are in Appendix 1, page 13 to 41.

3.3 This level of data capture, data processing and cleaning required is a significant burden on our substance misuse treatment providers.

3.4 Since 2013/14 the funding available to substance misuse treatment in Portsmouth has reduced from £4.7 million in 2013/14 to £3 million in 2019/20. Through recommissioning and pro-active contract management the service has implemented efficiencies and service reduction to manage this funding reduction. Nationally the substance misuse treatment sector has seen significant reductions in funding of approximately 18% since 2013/14[1]. During this period of reducing resources the NDTMS data requirement has not been reduced, meaning the data burden is greater proportionately.

3.5 Whilst NDTMS does have mandatory data fields, completing NDTMS itself is not a mandated function for Public Health.

4. Systems thinking intervention

4.1 During late 2017 and 2018 our substance misuse service providers, the Society of St. James and Solent NHS Trust, working with Portsmouth City Council, undertook a Vanguard systems thinking intervention. This looked at the processes and delivery of the Recovery Hub. The outcome and progress from this intervention was reported to the Cabinet member on the 29th January 2019[2]. This included a changed assessment process, to a more narrative assessment focused on the needs of the client, rather than the process needs of the service. The new service purpose (from the customer's viewpoint) was "Help me to make my life better".

4.2 This process has led the service providers to seek to reduce data collection which does not support the purpose of the service. There was data which the intervention found did not aid the service's purpose. Whilst some of this data would be required for monitoring, such as data that captures protected

[1] https://www.bbc.co.uk/news/uk-england-44039996 Accessed 04/09/19
[2] https://democracy.portsmouth.gov.uk/ieListDocuments.aspx?CId=475&MId=4208&Ver=4 Accessed 04/09/19

characteristics (e.g. gender, ethnicity etc.), and other data which is required for effective service planning and safeguarding, other data could be removed without any impact on the service user or service.

4.3 The Vanguard method has a key principle in redesigning service provision, which is 'Pull not push' - Clients are enabled to 'pull' value from the system, which in turn responds readily when they place a demand. The system does not 'push' unnecessary and unwanted processes and procedures onto the client. It was found that some of the data demands were pushed by the service and were not necessary to support them and were often unwanted by the client.

5. Changes to data reporting

5.1 It is proposed by the service provider and the Public Health team that the following mandatory data fields are no longer completed as they do not add value to the service user at assessment:

- Time since last paid employment
- Age of first use of problem substance
- Severity of Alcohol Dependence Questionnaire (SADQ)

The reason for proposing the top two fields are not completed is that they are not reliable, as service users struggle with recall, and they do not help to determine the treatment options at assessment. For example, service users in our treatment services are typically aged 30 plus and may have first used a problem drug in their late teens, their recall will be unreliable and does not impact on the treatment they require at this point.

The SADQ is a 20 question screening tool[3]. Whilst this would still be used prior to a detoxification, the service felt it was not helpful during an assessment to add significantly more questions.

5.2 It is also proposed that the Treatment Outcome Profile (TOP) is no longer recorded at assessment and subsequent reviews and at treatment exit. The TOP form, Appendix 2, captures self-reported data from service users in the following areas:

- Substance use
- Injecting behaviour
- Crime
- Health & Social Functioning.

There are up to 27 different fields to complete, some with scaling questions. Self-reported questionnaires may potentially have issues with reliability, as they rely on service users to accurately recall substances they have consumed over the past 28 days. There may also be various reasons a service user will not be honest about their substance use or criminality, due to potential consequences to them.

[3] https://webarchive.nationalarchives.gov.uk/20171114113622/https://www.alcohollearningcentre.org.uk/Topics/Latest/Severity-of-Alcohol-Dependence-Questionnaire-SADQ/ Accessed 04/09/19

It is recommended that a TOP is completed at the beginning of treatment and subsequently every 12 weeks. During the Vanguard 'check' phase, the intervention found that the TOP was leading to a lot of waste work, with staff chasing service users to complete the forms and reluctance on part of service users to complete the forms again. The service questioned the reliability of the answers. They also found that reviews were more focused on process and meeting the needs of the service ('push'), rather than focusing on what was important for the client ('pull').

5.3 NDTMS have informed us they do not have the power to 'make' the providers complete NDTMS data, they can only advise and ensure that they are aware of the implications of not maintaining your data quality/completeness. NDTMS have highlighted the benefits of TOP:

- Providers and commissioners benefit from benchmarking and needs assessment reporting
- TOP should be used as a motivational tool to use with clients
- The TOP Outcomes reports are available for commissioners and the providers and show a comparison of the start TOP to the review/ exit TOP and are therefore able to show how much better clients are doing during/ at the end of treatment
- TOP data is essential to feed in to the Value for Money tools such as the social return on investment tool and the commissioning tool developed for local authorities
- NDTMS is very frequently used to support national policy and business cases. National negotiations about issues such as the future of local authority funding use NDTMS data, as well as business cases for additional grant funding for the sector, such the capital grants and innovation funds.

5.4 During the systems thinking intervention roll out, new measure have been introduced which align with the Vanguard methodology, these are included in the *Annual performance report for the adult substance misuse service* provided to the cabinet member on the same date as this report. These measures include service user satisfaction and the recording of 'failure demands'.

5.5. Public Health are keen to maintain measures which show the impact the service is having on substance use, and quality of life. The service has introduced the following measures:

Substance use
Instead of asking service users to report on their substance use in the TOP questions, we have asked their recovery worker to categorise this area based on what they have observed/ screened / had reported over the continuum of the previous 12 weeks.

This service reports that this gives a clearer picture than the TOP questions and is less subjective and prone to recall bias. The most recent data from this measure is in Table 1 below.

Table 1: Level of substance misuse over the past 12 weeks

	Substance use over last 12 weeks	
Abstinent count	280	31%
Better count	183	20%
Don't know count	103	12%
Same count	270	30%
Worse count	57	6%
	Total = 893	

Quality of life

We are obviously interested in ascertaining whether we are helping to improve the quality of life for our service users. The service trialled different measures to capture changes in 'quality of life' and found that questions which used the term 'quality of life' were not specific enough to be meaningful to our service users and did not give an understanding of what is working / not working. Using the principle of 'action based learning' the service adapted this measure and decided to ask a question which is explicitly linked to the service purpose, "Help me to make my life better". The data collected to date relating to this measure is detailed in Table 2. These measures will be tracked over a period of time for each individual, recording changes and trends. This also allows supervisors to work with Recovery workers to understand why service users' lives are not getting better.

Table 2: Is the work we are doing helping you to make your life better?

Response	**Count**	**Percentage**
Better	180	67%
Don't know	37	14%
Same	45	17%
Worse	6	2%
Total	268	

5.6 Whilst these measures are new, they have been tested as part of the Vanguard systems intervention. However, they are not validated by objective academic research. We will seek to work with academic partners to assess whether these measures provide an objective appraisal of the service performance and an improvement in outcomes for service users.

6. Conclusion

The substance misuse sector nationally have seen significant reductions in funding over the past 6 years, however the national data requirements have not reduced and place a disproportionate burden on services seeking to maximise client engagement and support. Portsmouth City Council and our service providers have engaged in a systems thinking intervention which has sought to remove work that does not add value to the client, or which the client has not sought. We have identified some data fields within the NDTMS dataset which sit in this category and are seeking permission to no longer provide these.

5. Equality impact assessment

No EIA completed, this decision does not alter the data collected and monitored related to protected characteristics.

6. Legal implications

As the provision of data to NDTMS is not mandatory it is open to the Cabinet Member to consider the recommendation and make a decision based on the considerations set out in the report.

7. Director of Finance's comments

There are no financial implications relating to this report.

……
Signed by: Director of Public Health

Appendices:

1. National Drug Treatment Monitoring System (NDTMS) Adult drug and alcohol treatment business definitions Core dataset O, 2019
2. Treatment Outcome Profile form

Background list of documents: Section 100D of the Local Government Act 1972

The following documents disclose facts or matters, which have been relied upon to a material extent by the author in preparing this report:

Title of document	Location
Systems intervention in substance misuse.	https://democracy.portsmouth.gov.uk/ieListDocuments.aspx?CId=475&MId=4208&Ver=4

Public Health England

Protecting and improving the nation's health

National Drug Treatment Monitoring System (NDTMS)

Adult drug and alcohol treatment business definitions

Core dataset O

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-leading science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health and Social Care, and a distinct delivery organisation with operational autonomy. We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.

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Revision history

Version	Author	Purpose/reason
13.03	L Hughes	**Minor amendments:** • CIRHCVAS & CIRHCVPCR - updatability amended from 'If information changes a new CIR should be completed' to 'If a test is done during the treatment episode a CIR should be completed to show the result of the most recent test, even if the result is the same as a previous test'. • 'Referred to hep C treatment' definition clarified in appendix J.3 • Added that client name should be updated if the client legally changes their name • NATION – clarified that Kosovo should be recorded as Serbia as per NHS data dictionary • Recovery support intervention – take home naloxone and training – clarified definition to explain that this should only be recorded when naloxone is issued.
13.02	L Hughes	**Minor amendments:** • Revision history pre CDS-O moved to 'Revision History Pre CDS-O' document
13.01	L Hughes	**Minor amendments:** • 'No' added to 'early help' table in appendix F • 'Facilitated access to mutual aid' definition clarified in appendix J.3
13.0	L Hughes	**CDS O** **New reference data items:** • ETHNIC – 'value is unknown' added • PC – default code for NFA added – ZZ99 3VZ • EHCSC & CIREHCSC – 'Client declined to answer' added • MTHTN & CIRMTHTN – 'Client declined to answer' added • CRTMHN & CIRCRTMHN – 'Client declined to commence treatment for their mental health need' added • DISRSN – 'Onward referral offered and refused' added **Dropped headers:** • PSYOTHR (Client involved in other treatment sub interventions related to psychosocial)

Version	Author	Purpose/reason
		• RECOTH (Client provided with any other recovery support elements) **Dropped reference data items:** • RFLS – 'PRU' removed as this is covered by 'Alternative education' **Amendments:** • AGNCY, CLIENT and CLIENTID moved to 'client' section rather than 'episode' • Postcode (PC) amended to clarify that the postcode should be truncated • MTHTN – amended to reflect that suicide risk refers to current risk only • MTHTN – definition of 'Identified space in a health-based place of safety' added • Appendix C added • Added to Appendix I guidance for transfers to secure hospitals • Links to NTA website updated to gov.uk • Expanded accommodation need examples

Revision history prior to CDS-O can be found in the Revision History Pre CDS-O document available from your regional NDTMS team.

Contents

1. Introduction

The National Drug Treatment Monitoring System (NDTMS) data helps drug and alcohol treatment demonstrate the outcomes it achieves for the people it treats, and in doing so aids accountability for the money invested in it. NDTMS is a national standard and is applicable to young people and adults within community and secure setting based treatment providers.

This document defines the items to be collected and utilised by the NDTMS.

Previously drug and alcohol business definitions have been provide in separate documents. For the first time, this document contains definitions that are applicable to both drug and alcohol clients aged 18 or over in community treatment. Information and definitions relating to data collection from young people and secure settings can be found at: https://www.gov.uk/government/collections/alcohol-and-drug-misuse-treatment-core-dataset-collection-guidance

This document is intended to be a definitive and accessible source for use. It is not intended to be read from end to end, rather as a reference document, which is utilised by a variety of readers, including:

- interpreters of data provided from PHE systems
- suppliers of systems to PHE
- suppliers of systems which interface to PHE systems
- PHE/National Drug Treatment Monitoring System (NDTMS) personnel

This document should not be used in isolation. It is part of a package of documents supporting the NDTMS dataset and reporting requirements.

Please read this document in conjunction with:

- **NDTMS CSV File Format Specification** – defines the format of the CSV file used as the primary means of inputting the core dataset into NDTMS
- **NDTMS technical definition** – provides the full list of fields that are required in the CSV file and the verification rules for each item
- **NDTMS geographic information** – provides locality information, for example DAT of residence and local authority codes
- **NDTMS reference data** – provides permissible values for each data item

To assist with the operational handling of CSV input files, each significant change to the NDTMS dataset is allocated a letter.

The current version (commonly referred to as the NDTMS dataset O) for national data collection will come into effect on 1 April 2018.

2. Purpose of NDTMS

The data items contained in the NDTMS dataset are intended to support the following:

1. provide measurements that support the outcome and recovery focus of the government's drug strategy, such as:

    - proportion of clients successfully completing treatment
    - proportion of clients that do not return to treatment following a successful completion
    - value for money
    - housing and employment
    - health and quality of life outcomes
    - support for children and families of drug and alcohol dependents

2. provide information which can be used to monitor how effective drug and alcohol treatment services are and help to plan and develop services that better meet local needs

3. produce statistics and support research about drug and alcohol use treatment

4. provide measurements to support the Public Health Outcomes Framework

3. Data entities

The data items listed in this document may be considered as belonging to 1 of 7 different sections, which are used throughout this document. These are:

1. **Client details** – details pertaining to the client including initials, date of birth, gender, ethnicity and nationality.
2. **Episode details** – details pertaining to the current episode of treatment including information gained at triage such as geographic information, protected characteristics information, problem substance/s, parent and child status, BBV, etc. A treatment episode includes time spent in treatment at 1 provider, where they record 1 triage date and 1 discharge date but can (and in most circumstances will) include multiple treatment interventions. Multiple treatment episodes make up a treatment journey (see Appendix I for treatment journey definition).
3. **Treatment intervention details** – details regarding which high-level intervention/s the client has received and the relevant dates.
4. **Sub intervention details (SIR)** – details regarding which sub modalities the client has received since treatment start or since the last SIR. SIRs should be completed at least every 6 months (but can be completed more frequently if this would be of use locally) and at discharge from treatment. They should be completed retrospectively and can be completed by the keyworker/admin without the client present.
5. **Time in treatment** – information relating to the time the client spends in treatment. A new time in treatment record should be completed when this information changes during the episode of treatment.
6. **Outcomes Profile** – either the Treatment Outcome Profile (TOP), Young Person Outcome Profile (YPOR) or the Alcohol Outcomes Profile (AOR). The TOP should be completed at treatment start, every 6 months during treatment and at discharge. The AOR and the YPOR should be completed at treatment start and at discharge. All outcomes profiles can be completed more frequently if deemed of use locally. These should be completed by the keyworker with the client to review their substance use behaviour and thoughts in the last 28 days.
7. **Client Information Review (CIR) –** the CIR contains updateable information for some of the episode level questions, including parental status and children information, BBV information and mental health. As this information changes, it should not be updated in the episode but a CIR should be completed with all relevant fields updated as and when required.

In general, all data is required. Some fields are required at treatment start others should be provided as and when the client progresses through their treatment (see section 5).

NDTMS is a consented to dataset meaning that all clients should give explicit consent for their information to be shared with NDTMS. For further details, please refer to the NDTMS confidentiality guidance: https://www.gov.uk/government/publications/confidentiality-guidance-for-drug-and-alcohol-treatment-providers-and-clients

4. Reporting alcohol treatment to NDTMS

Alcohol dataset

Services that treat both drug and alcohol clients are required to collect and report to NDTMS the full adult community dataset. Services that deliver only alcohol treatment are permitted to submit just the alcohol dataset if they choose to (although are encouraged to submit the full dataset). The alcohol dataset is a subset of the full dataset and is listed in full in Appendix O.

Alcohol Outcomes Record (AOR)

The AOR was developed after consultation with the alcohol treatment field as the minimum dataset for measuring outcomes for alcohol clients in structured treatment. All items on the AOR should be completed for alcohol clients at both treatment start and exit. Localities may also complete outcomes information at care plan review to monitor progress if they wish. All of the items on the AOR are also included on the TOP and should localities wish to complete TOP for alcohol clients this will be accepted in place of an AOR.

Structured alcohol treatment

Structured alcohol treatment consists of a comprehensive package of concurrent or sequential specialist alcohol-focused interventions. It addresses multiple or more severe needs that would not be expected to respond, or have already not responded, to less intensive or non-specialist interventions alone.

Structured treatment requires a comprehensive assessment of need, and is delivered according to a recovery care plan, which is regularly reviewed with the client. The plan sets out clear goals which include change to substance use, and how other client needs will be addressed in 1 or more of the following domains: physical health; psychological health; social well-being; and, when appropriate, criminal involvement and offending. All interventions must be delivered by competent staff, within appropriate supervision and clinical governance structures.

Structured alcohol treatment provides access to specialist medical assessment and intervention, and works jointly with mental and physical health services and safeguarding and family support services according to need.

In addition to pharmacological and psychosocial interventions that are provided alongside, or integrated within, the key working or case management function of structured treatment, service users should be provided with the following as appropriate:

- information and immunisation
- advocacy
- appropriate access and referral to healthcare and health monitoring
- crisis and risk management support
- education
- training and employment support
- family support
- mutual aid/peer support

Brief interventions – what to report to NDTMS

One-off brief interventions for alcohol use should not be reported to NDTMS, but, brief treatment comprising multiple planned Extended Brief Intervention (EBI) sessions can be recorded under the psychosocial sub-intervention ‘motivational interventions’. It is expected that an assessment of need and a care planned approach is undertaken, as a precursor to any series of sessions with a treatment goal of abstinence or reducing consumption. See Appendix N for further information on brief interventions and what can be reported to NDTMS.

5. NDTMS dataset fields

1. Client details		
Field description	**CSV Header**	**Definition**
Initial of client's first name	FINITIAL	The first initial of the client's first name – for example Max would be 'M'. If a client legally changes their name this should be updated on your system. This will create a mismatch at your next submission for which you should select 'replace' or 'delete'.
Initial of client's surname	SINITIAL	The first initial of the client's surname – for example Smith would be 'S', O'Brian would be 'O' and McNeil would be 'M'. If a client legally changes their name this should be updated on your system. This will create a mismatch at your next submission for which you should select 'replace' or 'delete'.
Client birth date	DOB	The day, month and year that the client was born.
Client sex	SEX	The client sex at registration of birth.
Ethnicity	ETHNIC	The ethnicity that the client states as defined in the Office of Population Censuses and Surveys (OPCS) categories. If a client declines to answer, then 'not stated' should be used. If client does not know then 'Value is unknown' should be used.
Nationality	NATION	Country of nationality at registration of birth. Kosovo should be recorded as Serbia as per NHS data dictionary.
Agency code	AGNCY	A unique identifier for the treatment provider that is defined by the regional NDTMS team – for example L0001.
Client reference	CLIENT	A unique number or ID allocated by the treatment provider to a client. The client reference should remain the same within a treatment provider for a client during all treatment episodes. (NB: this must not hold or be composed of attributers, which might identify the individual).
Client ID	CLIENTID	A mandatory, unique technical identifier representing the client, as held on the clinical system used by the treatment provider. NB: this should be a technical item, and must not hold or be composed of attributers, which might identify the individual. A possible implementation of this might be the row number of the client in the client table.

2. Episode details		
Field description	**CSV Header**	**Definition**
Software system and version used	CMSID	A mandatory, system identifier representing the clinical system and version used at the provider, for example, agencies using the data entry tool would have DET V7.0 populated in the field.
Consent for NDTMS	CONSENT	Whether the client has agreed for their data to be shared with PHE. Informed consent must be sought from all clients and this field needs to be completed for all records triaged after 1 April 2006. It does not need to be completed for clients triaged before this date (it is assumed that all records previously returned have been consented for).
DAT of residence	DAT	The partnership area or upper tier local authority in which the client normally resides (as defined by the postcode of their normal residence). If the client is resident in Scotland, Wales, Northern Ireland or outside of the UK record the code that reflects this. If a client states that they are of No Fixed Abode (denoted by having an accommodation need of NFA) then for a structured community provider the partnership (DAT) of the treatment provider should be used as a proxy; and for residential treatment providers the DAT of the referring partnership should be used as a proxy. Note – although the accommodation need is the status at the start of the episode, the DAT of residence is the current situation. See NDTMS Geographic Information document for a list of DAT codes: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/669776/Geographic_information_for_the_National_Drug_Treatment_Monitoring_System__NDTMS_.pdf
Local Authority	LA	The local authority in which the client currently resides (as defined by the postcode of their normal residence). If a client states that they are of No Fixed Abode (denoted by having an accommodation need of NFA) then for a structured community provider the local authority of the treatment provider should be used as a proxy; and for residential treatment providers the local authority of the referring partnership should be used as a proxy. Note – although the accommodation need is the status at the start of the episode, the local authority is the current situation. See NDTMS Geographic Information document for a list of LA codes: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/669776/Geographic_information_for_the_National_Drug_Treatment_Monitoring_System__NDTMS_.pdf

2. Episode details		
Field description	**CSV Header**	**Definition**
Postcode	PC	The postcode of the client's place of residence. The postcode should be truncated by your system when extracted for NDTMS (the final 2 characters of the postcode should be removed, for example, 'NR14 7UJ' would be truncated to 'NR14 7'). If a client states that they are of no fixed abode or they are normally resident outside of the UK then the default postcode ZZ99 3VZ should be recorded (and truncated on extract).
Episode ID	EPISODID	A mandatory, unique technical identifier representing the episode, as held on the clinical system used at the treatment provider. NB: this should be a technical item, and should not hold or be composed of attributers, which might identify the individual. A possible implementation of this might be the row number of the episode in the episode table.
Referral date	REFLD	The date that the client was referred to the service for this episode of treatment. For example, it would be the date a referral letter was received, the date a referral phone call or fax was received or the date the client self-referred. For scenario examples and how this date is used in waiting times calculations please see Appendix B.
Referral source	RFLS	The source or method by which a client was referred for this treatment episode.
Triage date	TRIAGED	The date that the client made a first face-to-face presentation to this treatment provider for treatment. This could be the date of triage/initial assessment though this may not always be the case. If the client is in non-structured treatment, and during this time, it is established that there is a requirement for structured treatment, the non-structured episode should be closed and a new structured episode should be opened in which the triage date should reflect the date that they are starting their structured treatment. This will ensure that waiting times for structured treatment can be accurately calculated.
Previously treated	PREVTR	Has the client ever received structured drug or alcohol treatment at this or any other treatment provider?
Accommodation need	ACCMNEED	The accommodation need refers to the housing need of the client in the 28 days prior to treatment start. Appendix D within this document describes the reference data for this item and the relevant definitions for adult services.
Sexual orientation	SEXUALO	The sexual orientation that the client states. If a client declines to answer, then 'not stated' should be used.
Religion or belief	RELIGION	The religion or belief of the client. If a client declines to answer, then 'not stated' should be used.

2. Episode details		
Field description	**CSV Header**	**Definition**
Disability 1	DISABLE1	Whether the client considers themselves to have a disability. If a client declines to answer, then 'not stated' should be used. If the client has no disability, then 'no disability' should be entered. Refer to Appendix E for disability definitions.
Disability 2	DISABLE2	Whether the client considers themselves to have a second disability. If a client declines to answer, then 'not stated' should be used. If the client has no second disability, then 'no disability' should be entered. Refer to Appendix E for disability definitions.
Disability 3	DISABLE3	Whether the client considers themselves to have third a disability. If a client declines to answer, then 'not stated' should be used. If the client has no third disability, then 'no disability' should be entered. Refer to Appendix E for disability definitions.
Employment status	EMPSTAT	The current employment status of the client. If a client declines to answer, then 'not stated' should be used.
Time since last paid employment	TSLPE	How long has it been (in years) since the client was last in paid legal employment? This can include cash in hand work. If a client declines to answer then 'client declined to answer' should be used.
Pregnant	PREGNANT	Is the client pregnant?
Parental status	PRNTSTAT	The parental status of the client – whether or not the client is a 'parent' and whether none of, some of or all of the children they are responsible for live with the client. A child is a person who is under 18 years old. See Appendix F for data items and definitions.
Children	CHILDWTH	The number of children under 18 that live in the same household as the client at least 1 night a week. The client does not necessarily need to have parental responsibility for the children. Due to this being a numerical field please record code '98' as the response if the client has declined to answer.

2. Episode details		
Field description	**CSV Header**	**Definition**
Children receiving early help or in contact with children's social care	EHCSC	Are the client's children/ any children living with the client receiving early help or in contact with children's social care? This question applies to the client's children aged under 18 (regardless of whether this child lives with the client or not) and to children aged under 18 living with the client (regardless of whether this is the child of the client or not). If more than 1 option applies, then please select the 1 that is considered the priority from the perspective of the treatment service/keyworker. If client declines to answer record 'client declined to answer'. See Appendix F for data items and definitions.
Problem substance number 1	DRUG1	The substance that brought the client into treatment at the point of triage/initial assessment, even if they are no longer actively using this substance. If a client presents with more than 1 substance the provider is responsible for clinically deciding which substance is primary. 'Poly drug' should no longer be used in this field. Instead, the specific substances should be recorded in each of the problem substance fields.
Age of first use of problem substance number 1	DRUG1AGE	The age (in years) that the client recalls first using the problem substance Number 1.
Route of administration of problem substance number 1	ROUTE	The route of administration of problem substance Number 1 recorded at the point of triage/initial assessment.
Problem substance number 2	DRUG2	An additional substance that brought the client into treatment at the point of triage/initial assessment, even if they are no longer actively using this substance. 'Poly drug' should no longer be used in this field. Instead, the specific substances should be recorded in each of the problem substance fields. If no additional substance, 'no second drug' should be recorded.

2. Episode details		
Field description	**CSV Header**	**Definition**
Problem substance number 3	DRUG3	An additional substance that brought the client into treatment at the point of triage/initial assessment, even if they are no longer actively using this substance. 'Poly drug' should no longer be used in this field. Instead, the specific substances should be recorded in each of the problem substance fields. If no additional substance, 'no third drug' should be recorded.
Care plan start date	CPLANDT	Date that a care plan was created and agreed with the client for this treatment episode.
Injecting status	INJSTAT	Is the client currently injecting, have they ever previously injected or never injected.
Drinking days	ALCDDAYS	Number of days in the 28 days prior to initial assessment that the client consumed alcohol.
Units of alcohol	ALCUNITS	Typical number of units consumed on a drinking day in the 28 days prior to initial assessment.
SADQ score	SADQ	The Severity of Alcohol Dependence Questionnaire (SADQ) is a short, self-administered, 20-item questionnaire designed by the Addiction Research Unit, Maudsley Hospital to measure severity of dependence on alcohol. The score of the questionnaire (0-60) should be recorded if the service uses this tool. If the score is unknown or another tool is used please complete with 98 information not available and use 99 when a client declines to answer. For further information on SADQ please see: https://www.alcohollearningcentre.org.uk/Topics/Latest/Severity-of-Alcohol-Dependence-Questionnaire-SADQ/
Hep B intervention status	HEPBSTAT	Within the current treatment episode, whether the client was offered a vaccination for hepatitis B, and if that offer was accepted by the client. For further information on recording BBV details please refer to the 'Recording NDTMS data about blood-borne virus interventions' document: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/669749/Guidance_for_recording_data_about_blood-borne_virus_interventions_on_the_NDTMS.pdf

2. Episode details		
Field description	**CSV Header**	**Definition**
Hep B vaccination count	HEPBVAC	The number of hepatitis B vaccinations given to the client within the current treatment episode, or whether the course of vaccinations was completed. Vaccinations can be provided by the treatment provider or elsewhere, such as in primary care. Where the treatment provider completing NDTMS, or a partner treatment provider, provides 1 or more vaccinations to a client that actually completes the course, then 'course completed' should be recorded rather than the number of vaccinations. For further information on recording BBV details please refer to the 'Recording NDTMS data about blood-borne virus interventions' document: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/669749/Guidance_for_recording_data_about_blood-borne_virus_interventions_on_the_NDTMS.pdf
Hep C intervention status	HEPCSTAT	Within the current treatment episode, whether the client was offered a test for hepatitis C, and if that offer was accepted by the client. For further information on recording BBV details please refer to the 'Recording NDTMS data about blood-borne virus interventions' document: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/669749/Guidance_for_recording_data_about_blood-borne_virus_interventions_on_the_NDTMS.pdf
Hep C tested	HEPCTD	Has the client been tested for hepatitis C? This test may be within the current treatment episode or previously to the episode. If the response is 'Yes' the 'Hep C – latest test date' should be completed. For further information on recording BBV details, please refer to the 'Recording NDTMS data about blood-borne virus interventions' document: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/669749/Guidance_for_recording_data_about_blood-borne_virus_interventions_on_the_NDTMS.pdf
Hep C latest test date	HEPCTSTD	Date that the client was last tested for hepatitis C. This test may be within the current treatment episode or previously to the episode. If the exact date is not known then the first of the month should be used if that is known. If only the year is known then 1 January for that year should be used. For further information on recording BBV details, please refer to the 'Recording NDTMS data about blood-borne virus interventions' document: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/669749/Guidance_for_recording_data_about_blood-borne_virus_interventions_on_the_NDTMS.pdf

2. Episode details		
Field description	**CSV Header**	**Definition**
Hep C antibody test status	HCVAS	What is the result of the client's hep C antibody test? This is the first test (before PCR test) which looks for hep C antibodies in the client's blood. For further information on recording BBV details, please refer to the 'Recording NDTMS data about blood-borne virus interventions' document: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/669749/Guidance_for_recording_data_about_blood-borne_virus_interventions_on_the_NDTMS.pdf
Hep C PCR test status	HCVPCR	What is the result of the client's hep C PCR test? The PCR test is usually the second test (after antibody test) which looks at whether the hep C virus is reproducing in the client's body. For further information on recording BBV details, please refer to the 'Recording NDTMS data about blood-borne virus interventions' document: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/669749/Guidance_for_recording_data_about_blood-borne_virus_interventions_on_the_NDTMS.pdf
Drug treatment health care assessment date	HLCASSDT	The date that the initial health care assessment was completed in accordance to defined local protocols. The full scope and depth of the assessment will vary according to the presenting needs of the client, but should include an initial assessment of the client's physical health and mental health needs. Any arising needs should form part of the care plan, and would be directly responded to by the treatment provider itself or, where health needs are more specialised (eg dental care, sexual health), a formal referral is made to an appropriately qualified professional and followed up and reviewed by the drug or alcohol worker as part of the on-going delivery of the care plan. See Appendix G for further information on drug treatment health care assessment.
TOP care coordination	TOPCC	Does the treatment provider currently have care coordination responsibility for the client in regards to completing the TOP information when appropriate during the client's time in structured treatment? If the client is being treated at more than 1 provider then the services must decide which 1 completes the TOP.

2. Episode details		
Field description	**CSV Header**	**Definition**
Mental health treatment need	MTHTN	Does the client have a mental health treatment need? Mental health treatment need includes: • common mental illness (eg anxiety, depression) either current diagnosis or currently experiencing symptoms/ behaviours consistent with (where the symptoms are not considered to be simply due to acute psychoactive effects of substances consumed or due to current withdrawals) • serious mental illness (eg psychosis, schizophrenia, personality disorder) – either current diagnosis, or currently experiencing symptoms/ behaviour consistent with (where the symptoms are not considered to be simply due to acute psychoactive effects of substances consumed or due to current withdrawals) • mental health crisis (person is currently suicidal or indicating a risk of harm to self or others). This is determined either by the client's self-report or by formal assessment. If client declines to answer, then record 'Client declined to answer'.
Receiving treatment for mental health need	CRTMHN	Is the client receiving treatment for their mental health needs? This could include pharmacological and/or talking therapies/psychosocial support. See Appendix H for options and definitions. If more than 1 treatment option applies, then please select the one that is considered the priority from the perspective of the treatment service/keyworker.
Discharge date	DISD	The date that the client was discharged ending the current structured treatment episode. If a client has had a planned discharge then the date agreed within this plan should be used. If a client's discharge was unplanned then the date of last face-to-face contact with the treatment provider should be used. If a client has had no contact with the treatment provider for 2 months then for NDTMS purposes it is assumed that the client has exited treatment and a discharge date should be returned at this point using the date of the last face-to-face contact with the client. It should be noted that this is not meant to determine clinical practice and it is understood that further work beyond this point to re-engage the client with treatment may occur. Note: this process should be used for clients triaged after 1 April 2006 and records should not be amended retrospectively. If a client is discharged from treatment and then represents for further treatment at a later date, the expectation is that the client should be reassessed and a new episode created with a new triage date. If this proves burdensome, we can accept the re-opening of the client's previous episode (by removing discharge date and discharge reason) as long as the gap between discharge from the old episode and representation is less than 21 calendar days. In this scenario, the previous modalities should remain closed and new modalities should be opened.

2. Episode details		
Field description	**CSV Header**	**Definition**
Discharge reason	DISRSN	The reason why the client's episode of structured treatment was ended. For discharge codes and definitions see Appendix I.

3. Treatment intervention details		
Field description	**CSV Header**	**Definition**
Treatment intervention	MODAL	The treatment intervention a client has been referred for/commenced within this treatment episode as defined in Appendix J of this document. A client may have more than 1 treatment intervention running sequentially or concurrently within an episode and may have more than 1 of the same type running concurrently as long as the setting in each are different.
Date referred to intervention	REFMODDT	The date that it was mutually agreed that the client required this intervention of treatment. For the first intervention in an episode, this should be the date that the client was referred into the treatment system requiring a structured intervention. For subsequent interventions, it should be the date that both the client and the keyworker agreed that the client is ready for this intervention. For scenario examples and how this date is used in waiting times calculations please see Appendix B of this document.
Intervention setting	MODSET	Each provider has their own default setting. If a client is being treated in a setting other than their default then this field should be populated. This could include where treatment is being delivered by a provider that does not normally report to NDTMS. If this field is left blank the default setting will be assumed. See Appendix K for a definition of the different setting types.
Intervention ID	MODID	A mandatory, unique technical identifier representing the intervention, as held on the clinical system used at the treatment provider. (Note: this should be a technical item, and should not hold or be composed of attributers, which might identify the individual). A possible implementation of this might be the row number of the intervention in the modality table.

3. Treatment intervention details		
Field description	**CSV Header**	**Definition**
Date of first appointment offered for intervention	FAOMODDT	The date of the first appointment offered to commence this intervention. This should be mutually agreed to be appropriate for the client.
Intervention start date	MODST	The date that the stated treatment intervention commenced, ie the client attended for the appointment.
Intervention end date	MODEND	The date that the stated treatment intervention ended. If the intervention has had a planned end then the date agreed within the plan should be used. If it was unplanned then the date of last face to face contact date within the intervention should be used.
Intervention exit status	MODEXIT	Whether the exit from the treatment intervention was planned (mutually agreed), unplanned (client dropped out) or withdrawn (service withdrawn by provider).

4. Sub intervention review (SIR) details		
Field description	**CSV Header**	**Definition**
Sub intervention assessment date	SUBMODDT	The date that the sub intervention review was completed.
Sub interventions received	Various headers (see Appendix J)	The sub interventions that have been received since the previous review was completed. If it is the first review then it will be the sub interventions since the client commenced their latest treatment episode. Sub interventions should be submitted at a minimum of every 6 months while a client remains in 1 or more of the 3 high-level intervention types (psychosocial, pharmacological or recovery support). When a client finishes structured treatment, a sub-intervention review should be completed to cover the period since the start of treatment or last review (whichever is the latter). See Appendix J for the sub intervention types.
Sub intervention ID	SUBMID	A mandatory, unique technical identifier representing the sub intervention, as held on the clinical system used at the treatment provider. NB: this should be a technical item, and should not hold or be composed of attributers, which might identify the individual.

5. Time in treatment details		
Field description	**CSV Header**	**Definition**
Time in treatment assessment date	TITDATE	The date that the time in treatment will commence from. Where this is a first occurrence, the date field should be populated with the intervention start date of the first structured intervention, all subsequent occurrences should capture the date at which there was a change in the time in treatment threshold.
Time in treatment	TITREAT	The time per week that the client will be spending in structured treatment. This will take into account the time receiving any combination of pharmacological, psychosocial and recovery support interventions. If a client is only receiving recovery support then the time in treatment is not expected to be returned. See Appendix K for the definitions of time in treatment.
Time in treatment ID	TITID	A mandatory, unique technical identifier representing the time in treatment, as held on the clinical system used at the treatment provider. (NB: this should be a technical item, and should not hold or be composed of attributers, which might identify the individual).

6. Outcomes profile – TOP/ AOR		
Field description	**CSV Header**	**Definition**
Treatment Outcomes Profile (TOP or AOR) date	TOPDATE	Date of most recent outcome review. In each review all outcomes data should reflect the 28 days prior to this date. See Appendix M for further details and outcomes process maps.
TOP ID	TOPID	A mandatory, unique technical identifier representing the TOP, as held on the clinical system used at the treatment provider. (NB: this should be a technical item, and should not hold or be composed of attributers, which might identify the individual). A possible implementation of this might be the row number of the TOP in the TOP table.
Treatment stage	TRSTAGE	Stage of treatment that the TOP data relates to eg start, review, exit, post-exit
Alcohol use	ALCUSE	Number of days in previous 28 days that client has used alcohol.
Consumption	CONSMP	Typical number of alcohol units consumed on a drinking day in the last 28 days.
Opiate use	OPIUSE	Number of days in previous 28 days that client has used opiates.
Crack use	CRAUSE	Number of days in previous 28 days that client has used crack.
Cocaine use	COCAUSE	Number of days in previous 28 days that client has used powder cocaine.
Amphetamine use	AMPHUSE	Number of days in previous 28 days that client has used amphetamines.
Cannabis use	CANNUSE	Number of days in previous 28 days that client has used cannabis.
Other drug use	OTRDRGUSE	Number of days in previous 28 days that client has used another problem drug.
Tobacco use	TOBUSE	Number of days in previous 28 days that the client smoked tobacco, in whatever form (ready-made cigarettes, hand-rolled cigarettes, cannabis joints with tobacco, cigars, pipe tobacco, shisha/ water pipes, etc.), but not including nicotine replacement therapy and e-cigarettes.
Injected	IVDRGUSE	Number of days in previous 28 days that client has injected non-prescribed drugs.
Sharing	SHARING	Has client shared needles or paraphernalia (spoon, water or filter) in previous 28 days? On the TOP form, this is displayed as 2 questions, but only 1 response is used for NDTMS. See NDTMS reference data document.
Shoplifting	SHOTHEFT	Number of days in previous 28 days that client has been involved in shop theft.
Selling drugs	DRGSELL	Number of days in previous 28 days that client has been involved in selling drugs.

6. Outcomes profile – TOP/ AOR		
Field description	**CSV Header**	**Definition**
Other theft	OTHTHEFT	Has client has been involved in: theft from or of a vehicle, property theft or burglary or been involved in fraud, forgery or handling stolen goods in previous 28 days. On the TOP form, this is displayed as 3 questions, but only 1 response is used for NDTMS. See NDTMS reference data document.
Assault/violence	ASSAULT	Has client committed assault/violence in previous 28 days?
Psychological health status	PSYHSTAT	Self-reported psychological health (anxiety, depression, problem emotions and feelings) score in previous 28 days of 0-20, where 0 is poor and 20 is good.
Paid work	PWORK	Number of days in previous 28 days that client has attended paid work. Includes legal work only.
Unpaid work	UPDWORK	Number of days in the previous 28 days that the client has participated in unpaid work as part of a structured work placement. Structured work placements provide experience in a particular occupation or industry for people facing barriers to employment and are part of an education or training course, or package of employment support. Unpaid work differs from volunteering in that the client is the main beneficiary. If volunteering, the main beneficiary it is another person, group or organization.
Days volunteered	DAYSVOLN	Number of days in previous 28 days that the client has volunteered. Volunteering is engaging in any activity that involves spending time, unpaid, doing something that aims to benefit another person, group or organization.
Education	EDUCAT	Number of days in previous 28 days that client has attended for education eg school, college, university.
Physical health status	PHSTAT	Self-reported physical health (extent of physical symptoms and bothered by illness) score in previous 28 days of 0-20, where 0 is poor and 20 is good.
Acute housing problem	ACUTHPBM	Has client had an acute housing problem (been homeless) in previous 28 days?
At risk of eviction	HRISK	Has client been at risk of eviction within previous 28 days?
Unsuitable housing	UNSTHSE	Has the client been in unsuitable housing in the previous 28 days? Unsuitable housing includes where accommodation may be overcrowded, damp, inadequately heated, in poor condition or in a poor state of repair. Unsuitable housing is likely to have a negative impact on health and wellbeing and / or on the likelihood of achieving recovery.

6. Outcomes profile – TOP/ AOR		
Field description	**CSV Header**	**Definition**
Quality of life	QUALLIFE	Self-reported quality of life score (able to enjoy life, gets on with family and partner, etc.) in previous 28 days of 0-20, where 0 is poor and 20 is good.

7. Client information review (CIR)		
Field description	**CSV Header**	**Definition**
Client information review (CIR) date	CIRDT	The date that the most recent client information review took place. **The client information review should be completed at least annually but is recommended to be completed following each care plan review and any information updates reported to NDTMS.**
CIR ID	CIRID	A mandatory, unique technical identifier representing the CIR, as held on the clinical system used at the treatment provider. (NB: this should be a technical item, and should not hold or be composed of attributers, which might identify the individual).
CIR Pregnant	CIRPREGNANT	Is the client pregnant? **This should be recorded if the client's pregnancy status has changed since it was recorded at treatment start or since their last client information review.**
CIR Parental Status	CIRPRTST	The parental status of the client – whether or not the client is a 'parent' and whether none of, some of or all of the children they are responsible for live with the client. A child is a person who is under 18 years old. See Appendix F for data items and definitions. **This should be recorded if the client's parental status has changed since it was recorded at treatment start or since their last client information review.**
CIR Children living with client	CIRCLDWT	The number of children under 18 that live in the same household as the client at least 1 night a week. The client does not necessarily need to have parental responsibility for the children. Due to this being a numerical field please record code '98' as the response if the client has declined to answer. **This should be recorded if the number of children living with the client has changed since it was recorded at treatment start or since their last client information review.**

7. Client information review (CIR)		
Field description	**CSV Header**	**Definition**
CIR Children receiving early help or in contact with children's social care	CIREHCSC	Are the client's children/ any children living with the client receiving early help or in contact with children's social care? See Appendix F for definitions of the different responses. This question applies to the client's children aged under 18 (regardless of whether this child lives with the client or not) and to children aged under 18 living with the client (regardless of whether this is the child of the client or not). If more than 1 option applies, then please select the one that is considered the priority from the perspective of the treatment service/keyworker. If client declines to answer record 'client declined to answer'. **This should be recorded if the situation has changed since it was recorded at treatment start or since their last client information review.**
CIR Mental health treatment need	CIRMTHTN	Does the client have a mental health treatment need? Mental health treatment need includes: • common mental illness (eg anxiety, depression) either current diagnosis or currently experiencing symptoms/behaviours consistent with (where the symptoms are not considered to be simply due to acute psychoactive effects of substances consumed or due to current withdrawals) • serious mental illness (eg psychosis, schizophrenia, personality disorder) – either current diagnosis, or currently experiencing symptoms/ behaviour consistent with • mental health crisis (person is currently suicidal or indicating a risk of harm to self or others, history of self-harm/suicide attempts/harm to others) This is determined either by the client's self-report or by formal assessment. If client declines to answer, then record 'Client declined to answer'. **This should be recorded if the client's mental health need has changed since it was recorded at treatment start or since their last client information review.**

7. Client information review (CIR)		
Field description	**CSV Header**	**Definition**
CIR Receiving treatment for mental health need	CIRCRTMHN	Is the client receiving treatment for their mental health needs? This could include pharmacological and/or talking therapies/psychosocial support. See Appendix H for options and definitions. If more than 1 treatment option applies, then please select the 1 that is considered the priority from the perspective of the treatment service/keyworker. **This should be recorded if the client's situation has changed since it was recorded at treatment start or since their last client information review.**
CIR Hep B intervention status	CIRHEPBSTAT	Within the current treatment episode, whether the client was offered a vaccination for hepatitis B, and if that offer was accepted by the client. **This should be recorded if the client's hep B status has changed since it was recorded at treatment start or since their last client information review.** For further information on recording BBV details please refer to the 'Recording NDTMS data about blood-borne virus interventions' document: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/669749/Guidance_for_recording_data_about_blood-borne_virus_interventions_on_the_NDTMS.pdf
CIR Hep B vaccination count	CIRHEPBVAC	The number of hepatitis B vaccinations given to the client within the current treatment episode, or whether the course of vaccinations was completed. This should be recorded if the number of vaccinations received by the client has changed since it was recorded at treatment start or since their last client information review. Vaccinations can be provided by the treatment provider or elsewhere, such as in primary care. Where this, or a partner treatment provider, provides 1 vaccination to a client but this actually completes the course, then 'course completed' should be recorded rather than 'one vaccination'. **This should be recorded if the number of vaccinations received by the client has changed since it was recorded at treatment start or since their last client information review.** For further information on recording BBV details please refer to the 'Recording NDTMS data about blood-borne virus interventions' document: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/669749/Guidance_for_recording_data_about_blood-borne_virus_interventions_on_the_NDTMS.pdf

7. Client information review (CIR)		
Field description	**CSV Header**	**Definition**
CIR Hep C intervention status	CIRHEPCSTAT	Within the current treatment episode, whether the client was offered a test for hepatitis C, and if that offer was accepted by the client. **This should be recorded if the client's hep C status has changed since it was recorded at treatment start or since their last client information review.** For further information on recording BBV details please refer to the 'Recording NDTMS data about blood-borne virus interventions' document: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/669749/Guidance_for_recording_data_about_blood-borne_virus_interventions_on_the_NDTMS.pdf
CIR Hep C tested	CIRHEPCTD	Has the client been tested for hepatitis C? **This should be recorded if the client's hep C tested status has changed since it was recorded at treatment start or since their last client information review.** If the response is 'Yes' the 'Hep C – latest test date' should be completed. For further information on recording BBV details please refer to the 'Recording NDTMS data about blood-borne virus interventions' document: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/669749/Guidance_for_recording_data_about_blood-borne_virus_interventions_on_the_NDTMS.pdf
CIR Hep C antibody status	CIRHCVAS	What is the result of the client's hepatitis C antibody test? This is the first test (before PCR test) which looks for hep C antibodies in the client's blood. **This should be recorded if the client's (PCR) RNA status has changed since it was recorded at treatment start or since their last client information review.** For further information on recording BBV details please refer to the 'Recording NDTMS data about blood-borne virus interventions' document: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/669749/Guidance_for_recording_data_about_blood-borne_virus_interventions_on_the_NDTMS.pdf

7. Client information review (CIR)		
Field description	**CSV Header**	**Definition**
CIR Hep C (PCR) RNA status	CIRHCVPCR	What is the result of the client's hepatitis C PCR test? The PCR test is the second test (after antibody test) which looks at whether the Hep C virus is reproducing in the client's body. **This should be recorded if the client's (PCR) RNA status has changed since it was recorded at treatment start or since their last client information review.** For further information on recording BBV details please refer to the 'Recording NDTMS data about blood-borne virus interventions' document: www.gov.uk/government/uploads/system/uploads/attachment_data/file/669749/Guidance_for_recording_data_about_blood-borne_virus_interventions_on_the_NDTMS.pdf

6. Data collection guidance and field updateability

The NDTMS dataset consists of fields that are updateable (such as the client's postcode) and fields that should not change and should be completed as per the start of the episode (such as the client's sexuality). For some episode fields we require the most up to date information and these updates should be made on the CIR form, so that the episode field can give us a baseline to monitor change. The tables below detail for each data item whether it is updateable during the episode of treatment or whether the information reported should be as per the start of the episode.

1. Client details	
Field description	**Guidance**
Initial of client's first name	MUST be completed. If not, record rejected. Should not change (ie as at start of episode), unless client legally changes their name. If changed will create a validation mismatch.
Initial of client's surname	MUST be completed. If not, record rejected. Should not change (ie as at start of episode), unless client legally changes their name. If changed will create a validation mismatch.
Client birth date	MUST be completed. If not, record rejected. Should not change (ie as at start of episode). If changed will create a validation mismatch.
Client sex at registration of birth	MUST be completed. If not, record rejected. Should not change (ie as at start of episode). If changed will create a validation mismatch.
Ethnicity	Should not change (ie as at start of episode).
Nationality	Should not change (ie as at start of episode).
Agency code	MUST be completed. If not, record rejected. This is populated by your software system. Should not change. If changed will create a validation mismatch.

1. Client details	
Field description	**Guidance**
Client reference number	Should not change and should be consistent across all episodes at the treatment provider.
Client ID	MUST be completed. If not, record rejected. This is populated by your software system. Should not change.

2. Episode details	
Field description	**Guidance**
Software system and version used	MUST be completed. If not, record rejected. This is populated by your software system. May change (ie current situation).
Consent for NDTMS	Client must give consent before their information can be sent to NDTMS. May change (ie current situation).
DAT of residence	MUST be completed. If not, data may be excluded from performance monitoring reports. May change (ie current living situation).
Local authority	MUST be completed. May change (ie current living situation).
Postcode	May change (ie current living situation).
Episode ID	MUST be completed. If not, record rejected. This is populated by your software system. Should not change.
Referral date	MUST be completed. If not data may be excluded from performance monitoring reports. Should not change. If changed will create a validation mismatch.

2. Episode details	
Field description	**Guidance**
Triage Date	MUST be completed. If not data may be excluded from performance monitoring reports. Should not change.
Previously treated	Should not change (ie as at start of episode).
Accommodation need	Should not change (ie as at start of episode).
Sexual orientation	Should not change (ie as at start of episode).
Religion	Should not change (ie as at start of episode).
Disability 1	Should not change (ie as at start of episode).
Disability 2	Should not change (ie as at start of episode).
Disability 3	Should not change (ie as at start of episode).
Employment status	Should not change (ie as at start of episode).
Time since last paid employment	Should not change (ie as at start of episode).
Pregnant	Should not change (ie as at start of episode). Updates to this field should be made on Client Information Review.
Parental status	Should not change (ie as at start of episode). Updates to this field should be made on Client Information Review.
Children living with client	Should not change (ie as at start of episode). Updates to this field should be made on Client Information Review.
Children receiving early help or in contact with children's social care	Should not change (ie as at start of episode). Updates to this field should be made on Client Information Review.
Problem substance number 1	MUST be completed. If not, record rejected. Should not change (ie as at start of episode).

2. Episode details	
Field description	**Guidance**
Age of first use of problem substance number 1	Should not change (ie as at start of episode).
Route of administration of problem substance number 1	Should not change (ie as at start of episode).
Problem substance number 2	Should not change (ie as at start of episode).
Problem substance number 3	Should not change (ie as at start of episode).
Referral source	Should not change (ie as at start of episode).
Care plan started date	MUST be completed when intervention start date given. Should not change (ie as at start of episode).
Injecting status	Should not change (ie as at start of episode).
Drinking days	Should not change (ie as at start of episode).
Units of alcohol	Should not change (ie as at start of episode).
What is the client's SADQ score?	Should not change (ie as at start of episode).
Hep B intervention status	Should not change (ie as at start of episode). Updates to this field should be made on Client Information Review.
Hep B vaccination count	Should not change (ie as at start of episode). Updates to this field should be made on Client Information Review.
Hep C intervention status	Should not change (ie as at start of episode). Updates to this field should be made on Client Information Review.
Hep C tested	Should not change (ie as at start of episode). Updates to this field should be made on Client Information Review.

2. Episode details	
Field description	**Guidance**
Hep C latest test date	May change (ie current situation).
Hep C antibody test status	Should not change (ie as at start of episode). Updates to this field should be made on Client Information Review.
Hep C PCR test status	Should not change (ie as at start of episode). Updates to this field should be made on Client Information Review.
Drug treatment health care assessment date	Should not change (to be completed when initial health care assessment is completed).
TOP care coordination	May change (ie current situation).
Does the client have a mental health treatment need?	Should not change (ie as at start of episode). Updates to this field should be made on Client Information Review.
Is the client receiving treatment for their mental health need?	Should not change (ie as at start of episode). Updates to this field should be made on Client Information Review
Discharge date	Discharge date required when client is discharged. ALL structured modalities MUST now have end dates. Discharge reason MUST be given.
Discharge reason	Discharge reason required when client is discharged. Discharge date MUST be given. Should only change from 'null' to populated as episode progresses.

3. Treatment intervention details	
Field description	**Guidance**
Treatment intervention	Required as soon as intervention is known. Should not change (ie as at intervention start). If changed will create a validation mismatch.

3. Treatment intervention details	
Field description	**Guidance**
Intervention ID	MUST be completed. If not, record rejected. This is populated by your software system. Should not change.
Intervention setting	Can be left blank for default setting. Should not change (ie as at intervention start).
Date referred to intervention	Waiting times calculated from this field. MUST be completed for all interventions. Should not change. If changed will create a validation mismatch.
Date of first appointment offered for intervention	Waiting times calculated from this field. Should not change.
Intervention start date	Required field when client starts intervention. Trigger for waiting times to be calculated. Should only change from 'null' to populated as episode progresses. If changed will create a validation mismatch.
Intervention end date	Required field when client completes intervention or is discharged. Should only change from 'null' to populated as episode progresses.
Intervention exit status	Required field when client completes intervention or is discharged. Should only change from 'null' to populated as episode progresses.

4. Sub interventions review (SIR) details	
Field description	**Guidance**
Sub intervention assessment date	Must be completed each time a sub intervention review is completed. Should not change. If changed will create a validation mismatch.
Sub interventions (various headers)	Should not change (ie as at sub intervention review date).
Sub intervention ID	MUST be completed if any items in this section (SIR) are not null. If not, record rejected. This is populated by your

	software system. Should not change.

5. Time in treatment details	
Field description	**Guidance**
Time in treatment assessment date	Must be completed for each time in treatment return. If not, record rejected. Should not change. If changed will create a validation mismatch.
Time in treatment	Should not change (ie as at time in treatment date).
Time in treatment ID	MUST be completed if any items in this section above are not null. If not, record rejected. Should not change.

6. Outcomes profile – TOP/ AOR/ YPOR	
Field description	**Guidance**
Treatment Outcomes Profile (TOP) date	Should not change (ie as at TOP date). If changed will create a validation mismatch.
TOP ID	MUST be completed if any items in this section (TOP) are not null. If not, record rejected. This is populated by your software system. Should not change.
Treatment stage	Should not change (ie as at TOP date).
Alcohol use	Should not change (ie as at TOP date).
Consumption (Alcohol)	Should not change (ie as at TOP date).
Opiate use	Should not change (ie as at TOP date).
Crack use	Should not change (ie as at TOP date).

6. Outcomes profile – TOP/ AOR/ YPOR	
Field description	**Guidance**
Cocaine use	Should not change (ie as at TOP date).
Amphetamine use	Should not change (ie as at TOP date).
Cannabis use	Should not change (ie as at TOP date).
Other drug use	Should not change (ie as at TOP date).
Tobacco use	Should not change (ie as at TOP date).
IV drug use (Injected)	Should not change (ie as at TOP date).
Sharing	Should not change (ie as at TOP date).
Shoplifting	Should not change (ie as at TOP date).
Selling drugs	Should not change (ie as at TOP date).
Other theft	Should not change (ie as at TOP date).
Assault/violence	Should not change (ie as at TOP date).
Psychological health status	Should not change (ie as at TOP date).
Paid work	Should not change (ie as at TOP date).
Unpaid work	Should not change (ie as at TOP date).
Volunteering	Should not change (ie as at TOP date).
Education	Should not change (ie as at TOP date).
Physical health status	Should not change (ie as at TOP date).
Acute housing problem	Should not change (ie as at TOP date).
Housing risk	Should not change (ie as at TOP date).
Unsuitable housing	Should not change (ie as at TOP date).

6. Outcomes profile – TOP/ AOR/ YPOR	
Field description	**Guidance**
Quality of life	Should not change (ie as at TOP date).

7. Client information review (CIR) information	
Field description	**Guidance**
Client information review (CIR) date	Must be completed each time a client information review is completed. Should not change – if changed will create a validation mismatch.
CIR ID	MUST be completed if any items in this section (CIR) are not null. If not, record rejected. Should not change.
CIR Pregnant	Should not change. (ie as at client information review date). If information changes a new CIR should be completed.
CIR Parental Status	Should not change. (ie as at client information review date). If information changes a new CIR should be completed.
CIR Children living with client	Should not change. (ie as at client information review date). If information changes a new CIR should be completed.
CIR Children in contact with early help or children's' social care	Should not change. (ie as at client information review date). If information changes a new CIR should be completed.
CIR Mental health treatment need	Should not change. (ie as at client information review date). If information changes a new CIR should be completed.
CIR Receiving help for mental health treatment need	Should not change. (ie as at client information review date). If information changes a new CIR should be completed.

7. **Client information review (CIR) information**	
Field description	**Guidance**
CIR Hep B intervention status	Should not change. (ie as at client information review date). If information changes a new CIR should be completed.
CIR Hep B vaccination count	Should not change. (ie as at client information review date). If information changes a new CIR should be completed.
CIR Hep C intervention status	Should not change. (ie as at client information review date). If information changes a new CIR should be completed.
CIR Hep C tested	Should not change. (ie as at client information review date). If information changes a new CIR should be completed.
CIR Hep C antibody status	Should not change. (ie as at client information review date). If a test is done during the treatment episode a CIR should be completed to show the result of the most recent test, even if the result is the same as a previous test.
CIR Hep C (PCR) RNA status	Should not change. (ie as at client information review date). If a test is done during the treatment episode a CIR should be completed to show the result of the most recent test, even if the result is the same as a previous test.

Where items are designated as ‘should not change’ this does not include corrections or moving from a null in the field to it being populated.

Appendix A

Definition of structured treatment and recovery support

If 1 or more pharmacological interventions and/or 1 or more psychosocial interventions are selected then the treatment package is a structured treatment intervention, if the following definition of structured treatment also applies.

Structured treatment definition
Structured drug and alcohol treatment consists of a comprehensive package of concurrent or sequential specialist drug- and alcohol-focused interventions. It addresses multiple or more severe needs that would not be expected to respond, or have already not responded, to less intensive or non-specialist interventions alone. Structured treatment requires a comprehensive assessment of need, and is delivered according to a recovery care plan, which is regularly reviewed with the client. The plan sets out clear goals which include change to substance use, and how other client needs will be addressed in 1 or more of the following domains: physical health; psychological health; social well-being; and, when appropriate, criminal involvement and offending. All interventions must be delivered by competent staff, within appropriate supervision and clinical governance structures. Structured drug and alcohol treatment provides access to specialist medical assessment and intervention, and works jointly with mental and physical health services and safeguarding & family support services according to need. In addition to pharmacological and psychosocial interventions that are provided alongside, or integrated within, the key working or case management function of structured treatment, service users should be provided with the following as appropriate: • harm reduction advice and information • BBV screening and immunisation • advocacy • appropriate access and referral to healthcare and health monitoring • crisis and risk management support • education • training and employment support • family support and mutual aid/peer support

Definition of recovery support

Recovery support definition
Recovery support covers a range of non-structured interventions that run alongside or after structured treatment and are designed to reinforce the gains made in structured treatment and improve the client's quality of life in general. Recovery support can include mutual aid and peer support, practical help such as housing or employment support and onward referrals to services such as smoking cessation or domestic violence services.

Appendix B – Waiting times

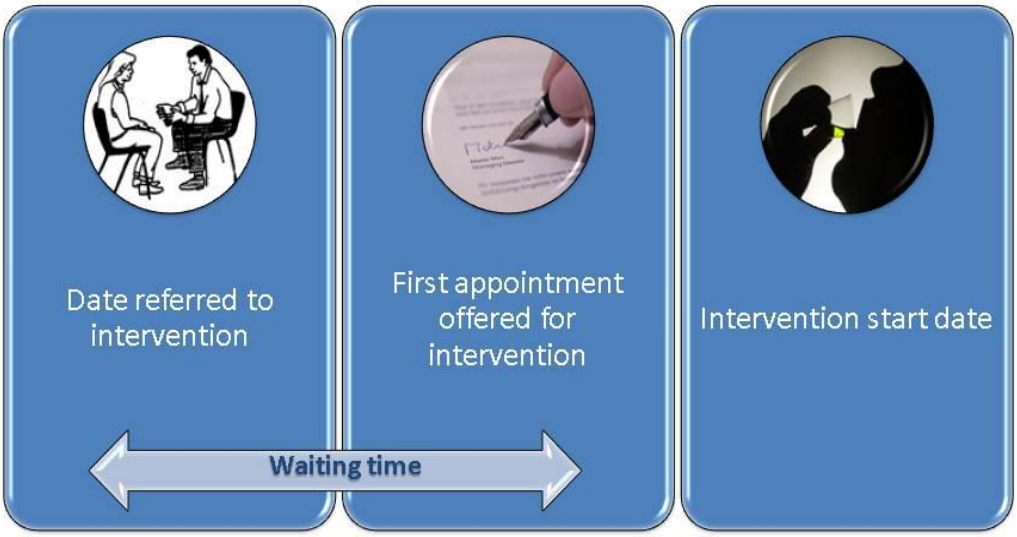
A waiting time is the period from the date a person is referred for a specific treatment intervention and the date of the first appointment offered. Referral for a specific treatment intervention typically occurs within the treatment provider at, or following, assessment.

This is measured to ensure that clients are being offered treatment in a timely fashion and to ensure that there is sufficient access to treatment. Long waiting times may indicate a lack of capacity in the treatment system. Any waits over 3 weeks are reported in performance reports. Waiting times are calculated in days.

Waiting times are measured as the difference in days between the ‘Date referred to Intervention’ and the ‘Date of first appointment offered for intervention’. If the ‘Date of first appointment offered for intervention’ is not present then the ‘Intervention start date’ is used instead.

When measuring waiting times for treatment providers, it will be calculated from the ‘Referral date’ or ‘Date referred to Intervention’ (whichever is later) at that specific treatment provider, to the ‘First appointment offered for intervention’ at that treatment provider.

The ‘Referral date’ recorded by a treatment provider may be later than the ‘Date referred to Intervention’ if the initial contact of a client entering the treatment system is an external organization such as GP, criminal justice system, mental health service (please see scenario 2 below).



N.B. if first appointment offered date is left blank the waiting time will be calculated to the intervention start date which can cause longer waiting times to be generated.

Waiting times will only be calculated when a client actually commences an intervention, ie when the intervention start date is present in the data.

If the ‘Intervention start date’ and the ‘Referral date’ are the same as the earliest in a client’s treatment journey, the waiting time will count as a first intervention.

If the ‘Intervention start date’ is greater than the earliest ‘Intervention start date’ in the client’s treatment journey, or the ‘Intervention start date’ is equal to the earliest ‘Intervention start date’ in the client’s treatment journey but the ‘Referral date’ is greater than the earliest ‘Referral date’, the waiting time will count as a subsequent intervention.

At provider level, if the intervention start date is the earliest intervention start date of the episode then it is a first intervention, otherwise it is a subsequent intervention.

Waiting times scenario 1: self-referral

Key point – the agency ‘referral date’ and the ‘date referred to modality’ are the same.

Referral date = 1 April 2016.

Date referred to intervention = 1 April 2016.

Date of first appointment offered for intervention = 15 April 2016.

Intervention start date = 22 April 2016.

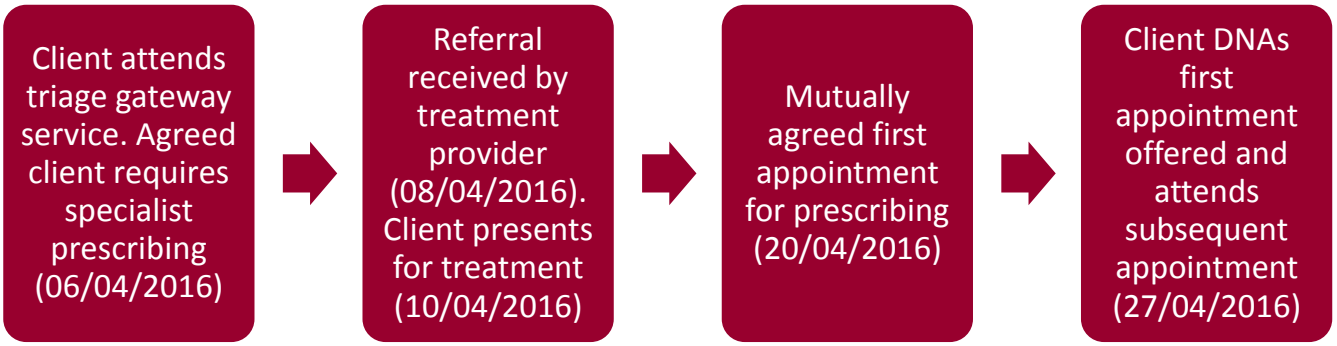
Waiting times calculations:

Partnership = Date of first appointment offered for intervention (15 April 2016) - Date referred to intervention (1 April 2016) = 14 days.

Provider = Date of first appointment offered for intervention (15 April 2016) - Referral date/Date referred to intervention (1 April 2016) = 14 days.

Waiting times scenario 2: referral from an external organisation

Key point – the agency 'referral date' is after the 'date referred to intervention', therefore the 'referral date' is used.



Referral date = 8 April 2016.

Date referred to intervention = 6 April 2016.

Date of first appointment offered for intervention = 20 April 2016.

Intervention start date = 27 April 2016.

Waiting times calculations:

Partnership = Date of first appointment offered for intervention (20 April 2016) - Date referred to intervention (6 April 2016) = 14 days.

Provider = Date of first appointment offered for intervention (20 April 2016) - Referral date (8 April 2016) = 12 days. NOTE: As the referral date is later than the referred to intervention date. Then the referral date is used to calculate the provider waiting time.

Appendix C – Referral sources for adults

The referral source is the source or method by which a client was referred for this treatment episode.

Definitions of each referral source are provided below. Treatment providers reporting to the NDTMS should select the code that best reflects the service, which referred the client into treatment. For example, for a young person who is a child looked after and has mental health needs, and is referred to treatment by a crime prevention service, 'crime prevention' should be used as the referral source.

Code	Text	Comments
4	Self	Self-referral by client.
69	Self-referred via health professional	Self-referred following advice from a health professional.
3	GP	Referrals from general medical practitioners.
1	Drug service statutory	A statutory drug service will normally be a National Health Service (NHS) service but can also be a treatment service provided by social care, the local authority, probation or police.
63	Arrest referral	Arrest Referral services engage with clients whose offending is linked to drugs or alcohol misuse at the point of arrest.
70	Community Rehabilitation Company (CRC)	A Community Rehabilitation Company (CRC) is the term given to a private-sector supplier of Probation and Prison-based rehabilitative services for offenders in England and Wales. A number of CRCs were established in 2015 as part of the Ministry of Justice's (MoJ) Transforming Rehabilitation (TR) strategy for the reform of offender rehabilitation.
65	Criminal justice other	Any other criminal justice pathway not covered by the other options provided.
2	Drug service non-statutory	These may be private treatment companies, charities or voluntary organisations.
6	DRR	Drug Rehabilitation Requirement – formally Drug Treatment and Testing order (DTTO).
57	ATR	Alcohol treatment requirement (applicable to primary alcohol clients only)
71	National Probation Service	
72	Liaison and Diversion	From https://www.england.nhs.uk/commissioning/health-just/liaison-and-diversion/ Liaison and Diversion (L&D) services identify people who

		have mental health, learning disability, substance misuse or other vulnerabilities when they first come into contact with the criminal justice system as suspects, defendants or offenders. The service can then support people through the early stages of criminal system pathway, refer them for appropriate health or social care or enable them to be diverted away from the criminal justice system into a more appropriate setting, if required
11	Psychiatry services	
19	Social Services	
16	Education service	
12	Community care assessment	
9	A&E	Accident and Emergency services
14	Employment service	
10	Syringe exchange	
18	Connexions	Connexions was a UK governmental information, advice, guidance and support service for young people aged 13 to 19 (up to 25 for young people with learning difficulties and/or disabilities), created in 2000 following the Learning and Skills Act.[1] There were Connexions Centres around the country - usually several in each county - which offered support and advice on topics including education, housing, health, relationships, drugs, and finance.
13	Prison	
73	Children's Social Services	Where Social Services are in contact with a child and subsequently refer an adult for treatment.
20	CLA - Children Looked After	Any referrals from services designated to ensure the needs of children and young people who are registered as 'looked after child' are met.
21	Sex worker project	
22	Hospital	Referrals from hospitals (not including A&E departments).
23	Psychological services	
24	Relative	Parents, siblings and other relatives.
25	Concerned other	Carers, friends, boyfriends or girlfriends who are connected to the client in a personal rather than a professional capacity and have referred the client to treatment.
32	Community alcohol team	
36	Outreach	Referrals from services which provide active outreach to address homelessness, anti-social behaviour, child exploitation or other issues

53	Job centre plus	
56	Employer	Applicable to primary alcohol clients only
58	Peer	ie other service user (applicable to primary alcohol clients only)
15	Other	

Appendix D – Accommodation need guidance for adult services

The accommodation need for adult clients has been defined with high-level reference data. The following provides guidance as to the sub-categories that make up the high-level view:

Code	Text	Comments
1	NFA - urgent housing problem	Lives on streets/ rough sleeper Uses night shelter (night-by-night basis)/ emergency hostels Sofa surfing/ sleeps on different friend's floor each night
2	Housing problem	Staying with friends/ family as a short term guest Night winter shelter Direct Access short stay hostel Short term B&B or other hotel Placed in temporary accommodation by Local Authority Squatting
3	No housing problem	Owner occupier Tenant – private landlord/ housing association/ Local Authority/ registered landlord/ arm's length management Approved premises Supported housing/ hostel Traveller Own property Settled mainstream housing with friends/family Shared ownership scheme

Appendix E - Disability definitions

Code	Text	Comments
1	Behaviour and emotional	Should be used where the client has times when they lack control over their feelings or actions.
2	Hearing	Should be used where the client has difficulty hearing, or need hearing aids, or need to lip-read what people say.
3	Manual dexterity	Should be used where the client experiences difficulty performing tasks with their hands.
4	Learning disability	Should be used where the client has difficulty with memory or ability to concentrate, learn or understand which began before the age of 18.
5	Mobility and gross motor	Should be used where the client has difficulty getting around physically without assistance or needs aids like wheelchairs or walking frames; or where the client has difficulty controlling how their arms, legs or head move.
6	Perception of physical danger	Should be used where the client has difficulty understanding that some things, places or situations can be dangerous and could lead to a risk of injury or harm.
7	Personal, self-care and continence	Should be used where the client has difficulty keeping clean and dressing the way they would like to.
8	Progressive conditions and physical health	Should be used where the client has any illness which affects what they can do, or which is making them more ill, which is getting worse, and which is going to continue getting worse (such as HIV, cancer, multiple sclerosis, fits etc.)
9	Sight	Should be used where the client has difficulty seeing signs or things printed on paper, or seeing things at a distance.
10	Speech	Should be used where the client has difficulty speaking or using language to communicate or make their needs known.
XX	Other	Should be used where the client has any other important health issue including dementia or autism.
NN	No disability	
ZZ	Not stated	Client asked but declined to provide a response.

Appendix F – Safeguarding questions' definitions

Parental status

Parental status should include biological parents, step-parents, foster parents, adoptive parents and guardians. It should also include *de facto* parents where a client lives with the parent of a child or the child alone (for example, clients who care for younger siblings or grandchildren) and have taken on full or partial parental responsibilities.

Data item name	Definition
All the children live with client	The client is a parent of 1 or more children under 18 and all the client's children (who are under 18) reside with them full time.
Some of the children live with client	The client is a parent of children under 18 and some of the client's children (who are under 18) reside with them, others live full time in other locations.
None of the children live with client	The client is a parent of 1 or more children under 18 but none of the client's children (under 18) reside with them, they all live in other locations full time.
Not a parent	The client is not a parent of any children under 18.
Client declined to answer	Only use where client declines to answer.

Early help or in contact with children's social care

Are the client's children or any of the children living with the client receiving early help or in contact with children's social care? If more than 1 option applies, then please select the 1 that is considered to be the priority from the perspective of the treatment service/ keyworker.

Data item name	Definition
Early help	The needs of the child and family have been assessed and they are receiving targeted early help services as defined by Working Together to Safeguard Children 2015 (HM Govt.)
Child in need	The needs of the child and family have been assessed by a social worker and services are being provided by the local authority under Section 17 of the Children Act 1989
Has a child protection plan	Social worker has led enquiries under Section 47 of the Children Act 1989. A child protection conference has determined that the child remains at continuing risk of ' significant harm' and a multi-agency child protection plan

	has been formulated to protect the child
Looked after child	Arrangements for the child have been determined following statutory intervention and care proceedings under the Children Act 1989. Looked after children may be placed with parents, foster carers (including relatives and friends), in children's homes, in secure accommodation or with prospective adopters
No	Children are not receiving early help nor are they in contact with children's social care.
Client declined to answer	Question was asked but client declined to answer.

Appendix G – Drug treatment healthcare assessment

There is an expectation that all service users within specialist drug treatment providers receive a general healthcare assessment. The aims and expected content of such an assessment are described in the latest version of the clinical guidelines, Drug misuse and dependence: UK guidelines on clinical management, but are also summarised below.

Purposes/aims:

- to identify unmet health needs and address these through care planning
- to ensure account is taken of health problems which could interact with drug treatment
- as a means of attracting and retaining patients into drug treatment
- to improve drug treatment outcomes such as abstinence and relapse prevention in line with current evidence
- to create opportunities for harm minimisation interventions

The intention is first to define a universal healthcare assessment, which should be carried out by all agencies on all drug users.

All drug users presenting to specialist drug agencies should receive as part of their assessment:

Verbal health assessment

General – health questions should address, for example:

- current illnesses/symptoms particularly epilepsy, asthma, liver disease
- prescribed/ OTC (over the counter) drugs
- cigarette smoking
- sexual health (risks and STD history)
- current use of/need for contraception
- dental health
- diet and weight loss

Drug-related – health questions should address, for example.

For all clients:

- blood-borne virus testing and results (HIV, HBV, HCV)
- hepatitis immunisation status (HBV, HAV) and other immunisations (Tetanus, TB)
- history of fits/blackouts
- history of overdose

Drug smokers:

- smoking methods
- wheezing/breathlessness/coughing/sputum/haemoptysis/chest pain

For past and current injectors:

- injecting status and problems
- history of skin infection/cellulitis/ulcer/abscess
- history of septicemia/endocarditis
- history of DVT/ PE/other thrombosis

Basic physical health assessment by examination

All clients should be offered examination of:

- injection sites
- any current concerns related to wound infections and skin swellings

Appendix H – Mental health treatment definitions

Code	Text	Comment
1	Already engaged with the community mental health team/ other mental health services	To include secondary mental health services (CMHT, Inpatient mental health services) or other mental health service (eg other NICE recommended treatment delivered in third or private sector).
2	Engaged with Improved Access to Psychological Therapy (IAPT)	To include IAPT or other primary care based mental health service.
3	Receiving mental health treatment from GP	To include any pharmacological treatment for mental health condition received from GP.
4	Receiving any NICE-recommended psychosocial or pharmacological intervention provided for the treatment of a mental health problem in drug and alcohol services	This refers to mental health treatment provided in drug and alcohol services and can include pharmacological interventions (for the mental health problem), or existing psychosocial interventions and recovery support interventions: • existing psychosocial sub- intervention “Evidence-based psychological interventions for co-existing mental health problems” • existing recovery support sub-intervention “Evidence-based mental health focused psychosocial interventions to support continued recovery” NB: this as currently defined should follow completion of structured substance misuse treatment
5	Has an identified space in a health-based place of safety for mental health crises	Section 136 of the Mental Health Act allows for someone believed by the police to have a mental disorder, and who may cause harm to themselves or another, to be detained in a public place and taken to a safe place where a mental health assessment can be carried out. A place of safety could be a hospital, care home, or any other suitable place. Further information and a map of health based places of safety can be found here: http://www.cqc.org.uk/help-advice/mental-health-capacity/map-health-based-places-safety
6	Treatment need identified but no treatment being received	
99	Client declined to commence	Client was referred for treatment but treatment

	treatment for their mental health need	commencement was declined by client.

If more than 1 treatment option applies, then please select the 1 that is considered to be the priority from the perspective of the treatment service/keyworker.

Appendix I – Adult discharge codes and discharge scenarios

Below are the current discharge reasons and their definitions.

Data item name	Definition
Treatment completed – drug free	The client no longer requires structured drug (or alcohol) treatment interventions and is judged by the clinician not to be using heroin (or any other opioid, prescribed or otherwise) or crack cocaine or any other illicit drug.
Treatment completed - alcohol free	The client no longer requires structured alcohol (or drug) treatment interventions and is judged by the clinician to no longer be using alcohol.
Treatment completed – occasional user (not heroin and crack)	The client no longer requires structured drug or alcohol treatment interventions and is judged by the clinician not to be using heroin (or any other opioid, prescribed or otherwise) or crack cocaine. There is evidence of use of other illicit drug use but this is not judged to be problematic or to require treatment.
Transferred – not in custody	The client has finished treatment at this provider but still requires further structured drug and/ or alcohol treatment interventions and the individual has been referred to an alternative non-prison provider for this. This code should only be used if there is an appropriate referral path and care planned structured drug and/ or alcohol treatment pathways are available.
Transferred – in custody	The client has received a custodial sentence or is on remand and a continuation of structured treatment has been arranged. This will consist of the appropriate onward referral of care planning information and a two-way communication between the community and prison treatment provider to confirm assessment and that care planned treatment will be provided as appropriate.
Onward referral offered and refused	The client requires further structured drug and/or alcohol treatment interventions. A referral to another secure setting provider or a community provider was offered but client refused the transfer.
Incomplete – dropped out	The treatment provider has lost contact with the client without a planned discharge and activities to re-engage the client back into treatment have not been successful.
Incomplete – treatment withdrawn by provider	The treatment provider has withdrawn treatment provision from the client. This item could be used, for example, in cases where the client has seriously breached a contract leading to their discharge; it should not be used if the client has simply 'dropped out'.
Incomplete – retained in custody	The client is no longer in contact with the treatment provider as they are in prison or another secure setting. While the treatment provider has confirmed this, there has been no formal two-way communication between the treatment provider and the criminal justice system care provider leading to continuation of the appropriate assessment and

	care- planned structured drug/alcohol treatment.
Incomplete – treatment commencement declined by the client	The treatment provider has received a referral and has had a face-to-face contact with the client after which the client has chosen not to commence a recommended structured treatment intervention.
Incomplete – client died	During their time in contact with structured treatment the client died.

Additional 'transferred' discharge codes for use by residential rehabilitation and inpatient detoxification providers only

The dataset includes 4 'transferred' discharge codes for use by residential rehabilitation and inpatient detox providers only in order for NDTMS to more accurately record the discharge status of clients leaving a residential or inpatient facility.

Residential and inpatient providers should use these codes instead of the 'transferred' codes above. Unlike the above 'transferred' discharge codes that record the status of a client within the treatment system at the point of discharge from a provider, the residential and inpatient codes additionally record the outcome of the residential programme and where further structured treatment is required.

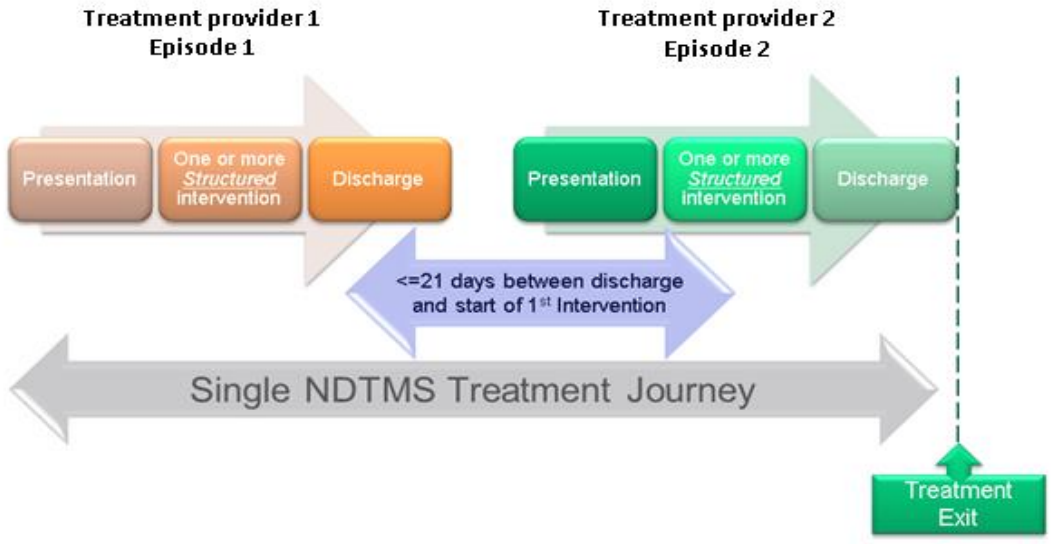
This allows residential and inpatient providers to record where clients have successfully completed the treatment programme and have been transferred for continued structured treatment either at a second stage residential provider or at a community provider.

Data item name	Definition
Transferred – treatment programme completed at the residential/inpatient provider – additional residential treatment required	The client has completed the structured treatment programme at the provider by meeting the goals of their care plan. Although they have finished treatment at this provider, they still require continued structured treatment interventions and have been transferred to another residential provider for this. This code should only be used if there is an appropriate referral path and care planned structured treatment pathways are available.
Transferred – treatment programme completed at the residential/inpatient provider – additional community treatment required	The client has completed the structured treatment programme at the provider by meeting the goals of their care plan. Although they have finished treatment at this provider, they still require continued structured treatment interventions and have been transferred to a community provider for this. This code should only be used if there is an appropriate referral path and care planned structured treatment pathways are available.
Transferred – treatment programme not completed at the residential/inpatient provider – additional residential treatment required	The client has not completed the structured treatment programme at the provider because they have not met the goals of their care plan. They require continued structured treatment interventions and have been referred to another residential provider for this. This code should only be used if there is an appropriate referral path and care planned structured treatment

	pathways are available.
Transferred – treatment programme not completed at the residential/inpatient provider – additional community treatment required	The client has not completed the structured treatment programme at the provider because they have not met the goals of their care plan. They require continued structured treatment interventions and have been referred to a community provider for this. This code should only be used if there is an appropriate referral path and care planned structured treatment pathways are available.

Discharging clients as 'transferred'

When a discharge reason of 'transferred' is selected, the expectation is that there should be two-way communication between the transferring provider and the receiving provider to ensure continuity of the client's care. If the client commences a structured treatment intervention at the receiving provider within 21 days of their discharge date from the transferring provider then NDTMS count this as a successful transfer and the client continues their treatment within the same treatment journey. If they do not start a structured treatment intervention elsewhere within 21 days of their discharge date they will be recorded as an unsuccessful transfer and their treatment journey will end. If the client should represent for treatment after more than 21 days then they will be deemed to have started a new treatment journey. Please see diagram below.



Treatment journey

A treatment journey consists of 1 or more episodes of structured treatment, at 1 or more providers, where there has been less than 21 days break between treatment episodes. A treatment journey ends once a client has been exited entirely from structured drug/ alcohol treatment once all structured interventions and the episode have been closed. A client may be discharged from 1 provider but if they continue

structured treatment (within 21 days of discharge) at another provider, their NDTMS treatment journey is continued.

If a client is discharged from treatment with a discharge reason of ‘treatment completed’ this indicates that the client has no further structured treatment need. Therefore, this should only be used at the end of a client’s treatment journey when they have completed structured treatment at all providers.

Transfers to secure hospitals (Broadmoor, Rampton and Ashworth)

Secure hospitals are not part of the secure estate, as overseen by HMPPS, rather they are overseen by the NHS. Therefore, clients transferred to secure hospitals should have their discharge reason recorded as ‘Transferred not in Custody’.

Appendix J – Definitions of interventions and sub interventions

There are 3 high-level intervention types. For adults these are:

- pharmacological interventions
- psychosocial interventions
- recovery support interventions

Each high-level intervention has a number of sub-interventions that will explain the detail of what has been delivered while the client is in the high-level intervention (described below).

The intervention types and sub-interventions are not mutually exclusive and should be used in combination to describe the full package of treatment and care being provided to a client.

Data will be collected retrospectively on what interventions have been provided in the last 6 months. However, the return is not limited to once every 6 months and may be updated more frequently. It should also be made on discharge. Providers may wish to integrate the collection of sub intervention information into the regular care plan review process so that, where the information is known, it can be returned alongside the TOP data.

J.1 Pharmacological sub interventions

Basis of pharmacological intervention	Definition	CSV File Header
Assessment and stabilisation	Prescribing of a receptor agonist (such as methadone), or partial agonist (such as buprenorphine), or other pharmacotherapy specific to substance misuse, to stabilise use of illicit drug(s), following and alongside continuing appropriate assessment. It also includes re-induction onto opioid substitution treatment prior to prison release, in the limited circumstances where this is appropriate.	PHSTBL
Withdrawal	Prescribing of an agonist or partial agonist or other medication, usually up to 12 weeks in the community and 28 days as an inpatient, to facilitate medically assisted withdrawal and to manage withdrawal symptoms.	PHWTH

Maintenance	Prescribing of substitute medications under a stable dose regimen to medically manage physiological dependence and minimise illicit drug use. Maintenance prescribing may be provided to support the individual in achieving or sustaining medication assisted recovery.	PHMAIN
Relapse prevention	Prescribing medication for drug and/or alcohol relapse prevention support (such as naltrexone as part of opioid relapse prevention therapy).	PHRELPR
Alcohol withdrawal	Client's alcohol prescribing intention is withdrawal.	APHWITH
Alcohol relapse prevention	Client's alcohol prescribing intention is relapse prevention	APHREPR
Unsupervised methadone	Client prescribed unsupervised methadone ie methadone that is taken away to be consumed without supervision at every dispense or most dispenses in the week. Physeptone should be recorded as methadone.	PHUSMET
Supervised methadone	Client prescribed supervised methadone ie methadone consumption is supervised at every dispense or most dispenses in the week. Physeptone should be recorded as methadone.	PHSUPMET
Unsupervised buprenorphine	Client prescribed unsupervised buprenorphine ie mono-buprenorphine that is taken away to be consumed without supervision at every dispense or most dispenses in the week. Subutex should be recorded as buprenorphine.	PHUSBUP
Supervised buprenorphine	Client prescribed supervised buprenorphine ie mono-buprenorphine consumption is supervised at every dispense or most dispenses in the week. Subutex should be recorded as buprenorphine.	PHSUPBUP
Unsupervised buprenorphine/ naloxone	Client prescribed unsupervised buprenorphine/naloxone (eg Suboxone) ie buprenorphine-naloxone combined product that is taken away to be consumed without supervision at every dispense or most dispenses in the week.	PHUSBUNAL
Supervised buprenorphine/ naloxone	Client prescribed supervised buprenorphine/naloxone (eg Suboxone) ie buprenorphine-naloxone combined product consumption is supervised at every dispense or most dispenses in the week.	PHSUPBUNAL
Diamorphine	Client prescribed diamorphine ie injectable ampoules to be taken away or injected under supervision.	PHDIAM
Naltrexone	Client prescribed naltrexone to prevent relapse to either alcohol or opiate use (or, rarely, both) or to limit the amount of alcohol a client drinks.	PHNALT
Chlordiazepoxide	Client prescribed chlordiazepoxide to treat acute alcohol withdrawal (do not record chlordiazepoxide prescribed to treat anxiety or for any other purpose).	PHCHLOR
Acamprosate	Client prescribed acamprosate.	PHACAMP
Nalmefene	Client prescribed nalmefene.	PHNALME

Disulfiram	Client prescribed disulfiram.	PHDISULF
Prescribed other medication	Client prescribed other medication ie any other medication not listed above but used for the treatment of drug or alcohol misuse or dependence or withdrawal or associated symptoms but not for unconnected illnesses and their symptoms.	PHOTHER

J.2 Psychosocial sub interventions

Psychosocial sub intervention	Definition	CSV File Header
Motivational interventions	Motivational interventions aim to help service users resolve ambivalence for change, and increase intrinsic motivation for change and self-efficacy through a semi-directive style and may involve normative feedback on problems and progress. They may be focused on substance specific changes and/or on building recovery capital. Motivational interventions can be delivered in groups or one-to-one and may involve the use of mapping tools. Motivational interventions require competences over and above those required for key working, and delivery within a clinical governance framework that includes appropriate supervision. Motivational interviewing and motivational enhancement therapy are both forms of motivational interventions.	PSYMOTI
Contingency management	Contingency management (CM) provides a system of reinforcement or incentives designed to motivate behaviour change and/or facilitate recovery. CM aims to make target behaviours (such as drug use) less attractive and alternative behaviours (such as abstinence) more attractive. CM requires competences over and above those required for key working, and delivery within a clinical governance framework that includes appropriate supervision.	PSYCNMG
Family and social network interventions	Family and social network interventions engage 1 or more of the client's social network members who agree to support the client's treatment and recovery. The interventions use psychosocial techniques that aim to increase family and social network support for change, and decrease family and social support for continuing drug and/or alcohol use. These interventions may involve the use of mapping tools. They require competences over and above those required for key working, and delivery within a clinical governance framework that includes appropriate supervision. Examples: social behaviour and network therapy (SBNT), community reinforcement approach (CRA), behavioural couples therapy (BCT) and formal family therapy.	PSYFSNI
Cognitive and behavioural based relapse prevention interventions (substance misuse specific)	Cognitive and behavioural based relapse prevention interventions develop the service user's abilities to recognise, avoid or cope with thoughts, feelings and situations that are triggers to substance use. They include a focus on coping with stress, boredom and relationship issues and the prevention of relapse through specific skills, eg drug refusal, craving management. They can be delivered in groups or one-to-one and may involve the use of mapping tools. They require competences over and above those required for key working, and delivery within a clinical governance framework that includes appropriate	PSYCGBH

Psychosocial sub intervention	Definition	CSV File Header
	supervision. Examples: CBT based relapse prevention (which may include mindfulness and 'third wave' CBT), behavioural self-control (alcohol).	
Evidence-based psychological interventions for co-existing mental health disorders	NICE guidelines for mental health problems generally recommend a stepped care approach. Low intensity psychological intervention for co-existing mental health problems, include guided self-help or brief interventions for less severe common mental health problems. High intensity psychological therapies (such as cognitive behavioural therapy) are recommended for moderate and severe problems. Typically formulation - based and delivered by clinicians with specialist training who are registered with a relevant professional/regulatory body. They can be delivered in groups or one-to-one. Both low and high intensity interventions require additional competences for the worker and delivery within a clinical governance framework that includes appropriate supervision.	PSYMNTH
Psychodynamic therapy	A type of psychotherapy that draws on psychoanalytic theory to help people understand the developmental origins of emotional distress and behaviours such as substance misuse, by exploring unconscious motives, needs, and defences. Psychodynamic therapy requires additional competences for the worker and delivery within a clinical governance framework that includes appropriate supervision. Therapists should be registered with an appropriate professional/regulatory body.	PSYDNMC
12-step work	A 12-step intervention for recovery from addiction, compulsion or other behavioural problems. Interventions are delivered within a clinical governance framework that includes appropriate supervision. The aim of 12-step work is to facilitate service users to complete some or all of the 12 steps.	PSYSTP
Counselling – BACP Accredited	A systematic process that gives individuals an opportunity to explore, discover and clarify ways of living more resourcefully, with a greater sense of well-being. This requires additional competences for the worker and delivery within a clinical governance framework that includes appropriate supervision.	PSYCOUN

J.3 Recovery support sub interventions

During structured treatment, recovery support interventions should be recorded for interventions delivered alongside and/or integrated with a psychosocial or pharmacological intervention.

Recovery support interventions can also be delivered and recorded outside of structured treatment, following the recording of an exit from structured treatment.

Recovery support sub intervention	Definition	CSV File header
Peer support involvement	A supportive relationship where an individual who has direct or indirect experience of drug or alcohol problems may be specifically recruited on a paid or voluntary basis to provide support and guidance to peers. Peer support can also include less formal supportive arrangements where shared experience is the basis but generic support is the outcome (eg as a part of a social group). This may include mental health focused peer support where a service user has co-existing mental health problems. Where peer support programmes are available, staff should provide information on access to service users, and support access where service users express an interest in using this type of support.	RECPEER
Facilitated access to mutual aid	Staff provide a service user with information about mutual aid groups and facilitate their initial contact by, for example, making arrangements for them to meet a group member, arranging transport and/or accompaniment to the first session and dealing with any subsequent concerns (see Facilitating Access to Mutual Aid). These groups may be based on 12-step principles (such as Alcoholics Anonymous, Narcotics Anonymous and Cocaine Anonymous) or another approach (such as SMART Recovery). It is not sufficient to simply provide a client with a leaflet.	RECMAID
Family support	Staff have assessed the family support needs of the individual/family as part of a comprehensive assessment, or on-going review of their treatment package. Agreed actions can include arranging family support for the family in their own right or family support that includes the individual in treatment.	RECFMSP
Parenting support	Staff have assessed the family support needs of the individual as part of a comprehensive assessment, or on-going review of their treatment package. Agreed actions can include a referral to an in-house parenting support worker where available, or to a local service which delivers parenting support.	RECPRNT
Housing support	Staff have assessed the housing needs of the individual as part of the comprehensive assessment, or on-going recovery care planning process, and has agreed goals that include specific housing support actions by the treatment	RECHSE

Recovery support sub intervention	Definition	CSV File header
	service, and/or active referral to a housing agency for specialist housing support. Housing support covers a range of activities that either allows the individual to maintain their accommodation or to address an urgent housing need.	
Employment support	Staff have assessed the employment needs of the individual as part of the comprehensive assessment, or on-going recovery care planning process, and agreed goals that include specific specialised employment support actions by the treatment service, and/or active referral to an agency for specialist employment support. Where the individual is already a claimant with Jobcentre Plus or the Work Programme, the referral can include a three-way meeting with the relevant advisor to discuss education/employment/training (ETE) needs. The referral can also be made directly to an ETE provider.	RECEMP
Education and training support	Staff have assessed the education and training related needs of the individual as part of the comprehensive assessment, or on-going recovery care planning process and agreed goals that include specific specialised education and training support actions by the treatment service, and/or active referral to an agency for specialist education & training support. Where the individual is already a claimant with Jobcentre Plus or the Work Programme, the referral can include a three-way meeting with the relevant advisor to discuss ETE needs. The referral can also be made directly to an ETE provider.	RECEDUT
Supported work projects	Staff have assessed the employment related needs of the individual as part of the comprehensive assessment, or on-going recovery care planning process and agreed goals that include the referral to a service providing paid employment positions where the employee receives significant on-going support to attend and perform duties.	RECWPRJ
Recovery check-ups	Following successful completion of formal substance misuse treatment there is an agreement for periodic contact between a treatment provider and the former participant in the structured treatment phase of support. The periodic contact is initiated by the service, and comprises a structured check-up on recovery progress and maintenance, checks for signs of lapses, sign posting to any appropriate further recovery services, and in the case of relapse (or marked risk of relapse) facilitates a prompt return to treatment services.	RECCHKP
Evidence-based psychosocial interventions to support relapse prevention	Evidence based psychosocial interventions that support on-going relapse prevention and recovery, delivered following successful completion of structured substance misuse treatment. These are interventions with a specific substance misuse focus and delivered within substance misuse services.	RECRLPP

Recovery support sub intervention	Definition	CSV File header
Complementary therapies	Complementary therapies aimed at promoting and maintaining change to substance use, for example through the use of therapies such as acupuncture and reflexology that are provided in the context of substance misuse specific recovery support.	RECCMPT
Mental health interventions	Evidence-based psychosocial interventions for common mental health problems that support continued recovery by focusing on improving psychological well-being that might otherwise increase the likelihood of relapse to substance use. These are delivered following successful completion of structured substance misuse treatment and may be delivered by services outside the substance misuse treatment system following an identification of need for further psychological treatment and a referral by substance misuse services.	RECGNH
Smoking cessation	Specific stop-smoking support has been provided by the treatment service, and/or the individual has been actively referred to a stop smoking service for smoking cessation support and take-up of that support is monitored. Suitable support will vary but should be more than very brief advice to qualify as an intervention here. It will most commonly include psychosocial support and nicotine replacement therapy, and will be provided by a trained stop smoking advisor.	RECSMOC
Referred to Hep C treatment	Client referred to a specialist (directly or through a GP) for treatment of hepatitis C, ideally supported to attend appointment(s) but regardless of whether treatment is agreed and provided. 'Referred' should be interpreted broadly here and does not necessarily require a formal, documented process, especially where hepatology doctors and/or nurses are working within the drug service and contact between them and service users might be direct. However, there should still be some assurance that the client has been properly linked to potential hepatitis treatment and, if agreed and provided, will be supported in it – whether by hepatologists, drug workers or peers.	RECHEPC
Domestic abuse/ violence support	Staff have assessed service user needs in relation to domestic abuse/violence as part of the comprehensive assessment or on-going recovery care planning process. There are agreed goals that include support actions by the treatment service, and/or active referral to a specialist domestic abuse service. These services may include MARAC; community or refuge support providing safety planning, legal advice, advocacy and therapeutic interventions for victims/survivors and their children. Perpetrators of domestic abuse/violence may attend a perpetrator programme.	RECDOMV
Take home	Provision of take home naloxone and training to reduce	RECTHNAL

Recovery support sub intervention	Definition	CSV File header
Naloxone and training information	overdose deaths from heroin and similar drugs. This should be used to record that the client has been issued with Naloxone (eg if the client still has previously issued naloxone when the SIR is completed it should not be endorsed).	

Appendix K – Setting

Each provider has their own default setting. If a client is being treated in a setting other than their default then the 'setting' field should be populated. This could include where treatment is being delivered by a provider that does not normally report to NDTMS. If this field is left blank the default setting will be assumed.

Setting	Definition
Community	A structured drug and alcohol treatment setting where residence is not a condition ofengagement with the service. This will include treatment within community drug andalcohol teams and day programmes (including rehabilitation programmes where residence in a specified location is not a condition of entry).
Inpatient unit	An inpatient unit provides assessment, stabilisation and/or assisted withdrawal with 24-hour cover from a multidisciplinary clinical team who have had specialist training in managing addictive behaviours[1]. In addition, the clinical lead in such a service comesfrom a consultant in addiction psychiatry or another substance misuse medical specialist. The multi-disciplinary team may include psychologists, nurses, occupationaltherapists, pharmacists and social workers. Inpatient units are for those alcohol or drugusers whose needs require supervision in a controlled medical environment.
Primary care	Structured substance misuse treatment is provided in a primary care setting with a General Practitioner, often with a special interest in addiction treatment, having clinicalresponsibility.
Secure setting	Structured drug and alcohol treatment delivered by a locally commissioned substancemisuse team within the prison establishment providing the full range of drug and alcohol interventions in line with the evidence base articulated in the Patel Report[2].
Residential	A structured drug and alcohol treatment setting where residence is a condition of receiving the interventions. Although such programmes are usually abstinence based,prescribing for relapse prevention or for medication assisted recovery are also options.The programmes are often, although not exclusively, aimed at people who have had difficulty in overcoming their dependence in a community setting. A residential programme may also deliver an assisted withdrawal programme. This should be sufficiently specialist to qualify as a 'medically monitored' inpatient service –and it should meet the standards and criteria detailed in guidance from the SpecialistClinical Addictions Network[1]. This level of support and monitoring of assisted withdrawal is most appropriate for individuals with lower levels of dependence and/orwithout a range of associated medical and psychiatric problems. Within the residential setting, people will receive multiple interventions and

[1] SCAN (2006). Inpatient Treatment of Drug and Alcohol Misusers in the National Health Service

[2] Patel K (2010) Reducing Drug-Related Crime and Rehabilitating Offenders – Recovery and rehabilitation for drug usersin prison and on release: recommendations for action. London: House of Lords

Setting	Definition
	supports (some of which are described by the intervention codes) in a coordinated and controlledenvironment. The interventions and support provided in this setting will normally comprise both professionally delivered interventions and peer-based support, as well as work and leisure activities.
Recovery house	A recovery house is a residential living environment, in which integrated peer-supportand/or integrated recovery support interventions are provided for residents who wherepreviously, or are currently, engaged in treatment to overcome their drug and alcoholdependence. The residences can also be referred to as dry-houses, third-stage accommodation or quasi-residential. Supported housing that does not provide such integrated substance misuse peer orrecovery support as part of the residential placement is not considered a recoveryhouse for this purpose. Recovery houses may be completely independent, or associated with a residentialtreatment provider or housing association. Some will require 'total abstinence' as acondition of residence whereas others may accept people in medication assistedrecovery who are otherwise abstinent.

Appendix L – Time in treatment

Time in treatment covers the time spent in an average week in structured treatment on 1 or more of the interventions defined above. The time will usually be that actually spent but may include service user absence, within the programme's stipulated attendance requirements.

Interventions included in calculating the time should be exclusively made up of the pharmacological, psychosocial and recovery support interventions that are delivered alongside structured treatment (as defined earlier), but not recovery support only interventions. A client receiving only recovery support interventions would not be in structured treatment.

In deciding which threshold to record for a fractional time spent in treatment, the actual time should be rounded up to the nearest whole hour, for example,14.5 hours rounds up to 15 hours, so would be recorded as 'high'.

Threshold	Definition
Standard (14 hours or less per week)	One or more of the interventions defined above is received by, or made available to, the service user for 14 hours or less per week. This can include service user absence, within the programme's stipulated attendance requirements. Interventions should be exclusively made up of a combination of pharmacological, psychosocial and recovery support interventions, as defined here, but not recovery support only interventions.
High (More than 14 hours and less than 25 hours)	One or more intervention types defined above is received by, or made available to, the service user for more than 14 and less than 25 hours per week. This can include service user absence, within the programme's stipulated attendance requirements. This could include non-residential or residential rehabilitation programmes, including services previously recorded as structured day programmes. Interventions should be exclusively made up of a combination of pharmacological, psychosocial and recovery support interventions, as defined here, but not recovery support only interventions.
Very high (25 or more hours per week)	One or more intervention types defined above is received by, or made available to, the service user for 25 or more hours per week. This can include service user absence, within the programme's stipulated attendance requirements. This could include non-residential or residential rehabilitation programmes, including services previously recorded as structured day programmes. Interventions should be exclusively made up of a combination of pharmacological, psychosocial and recovery support interventions, as defined here, but not recovery support only interventions.

Appendix M – Outcomes process maps for TOP and AOR

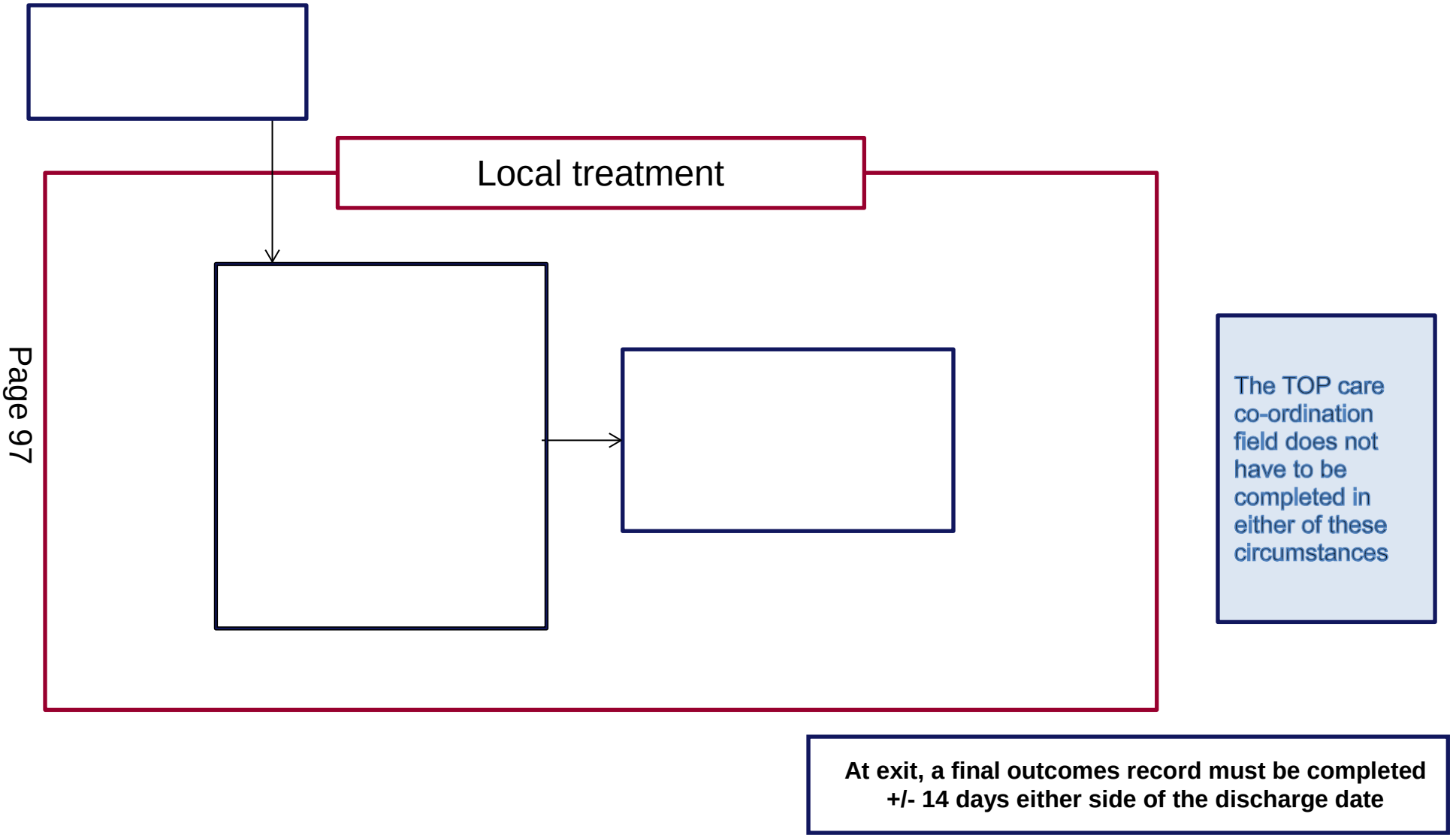
The following process maps outline the steps for recording outcomes information for alcohol clients via the Treatment Outcomes Profile (TOP) and the Alcohol Outcomes Record (AOR).

Each client attending an adult service with a primary problem substance of alcohol should have either a TOP or an AOR completed depending on the outcome record of choice for the service.

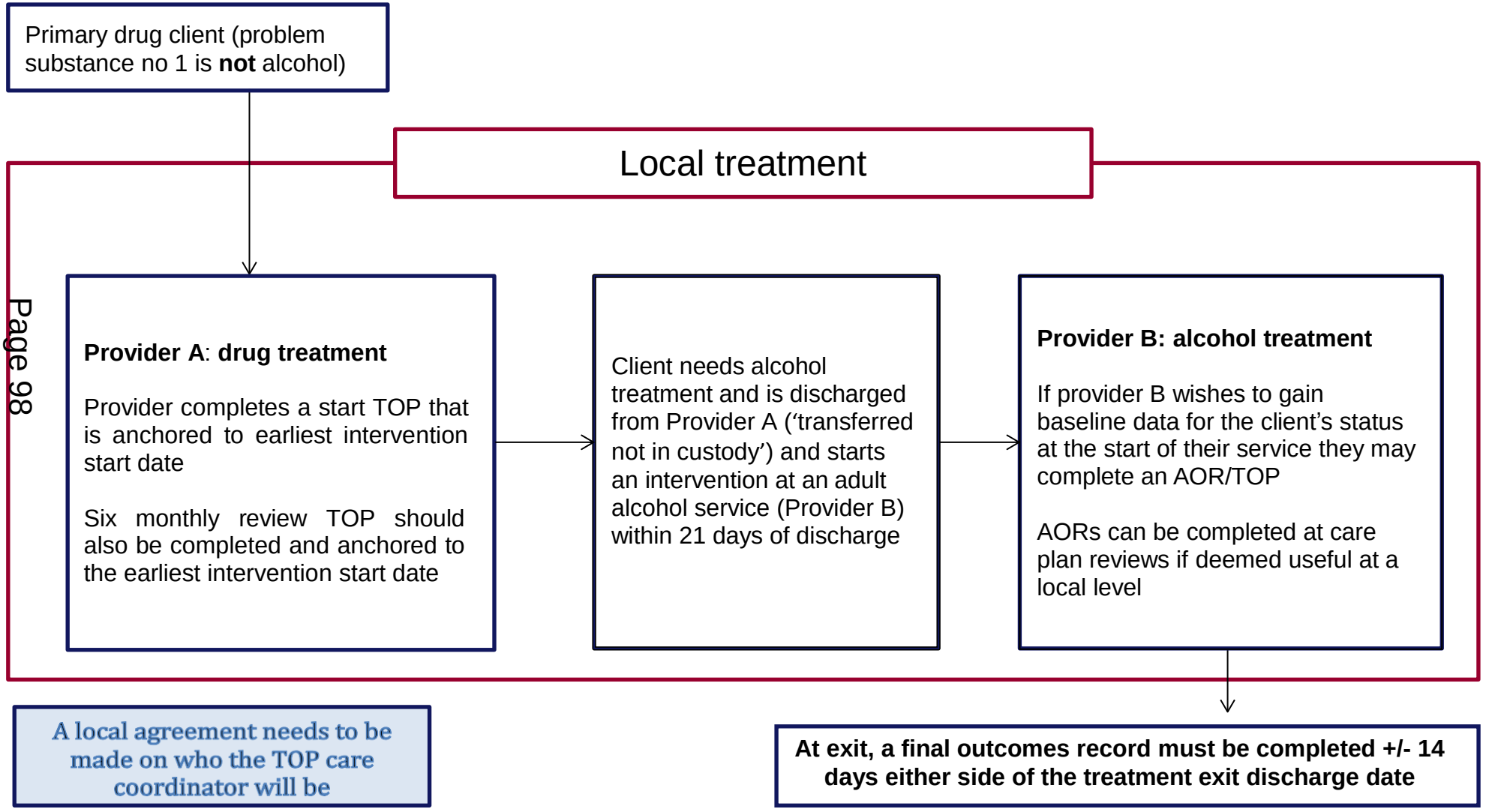
All drug clients at adult services should have a TOP completed.

Examples are provided below for clients who are transferring between alcohol and drug treatment episodes and between adult and young people's services.

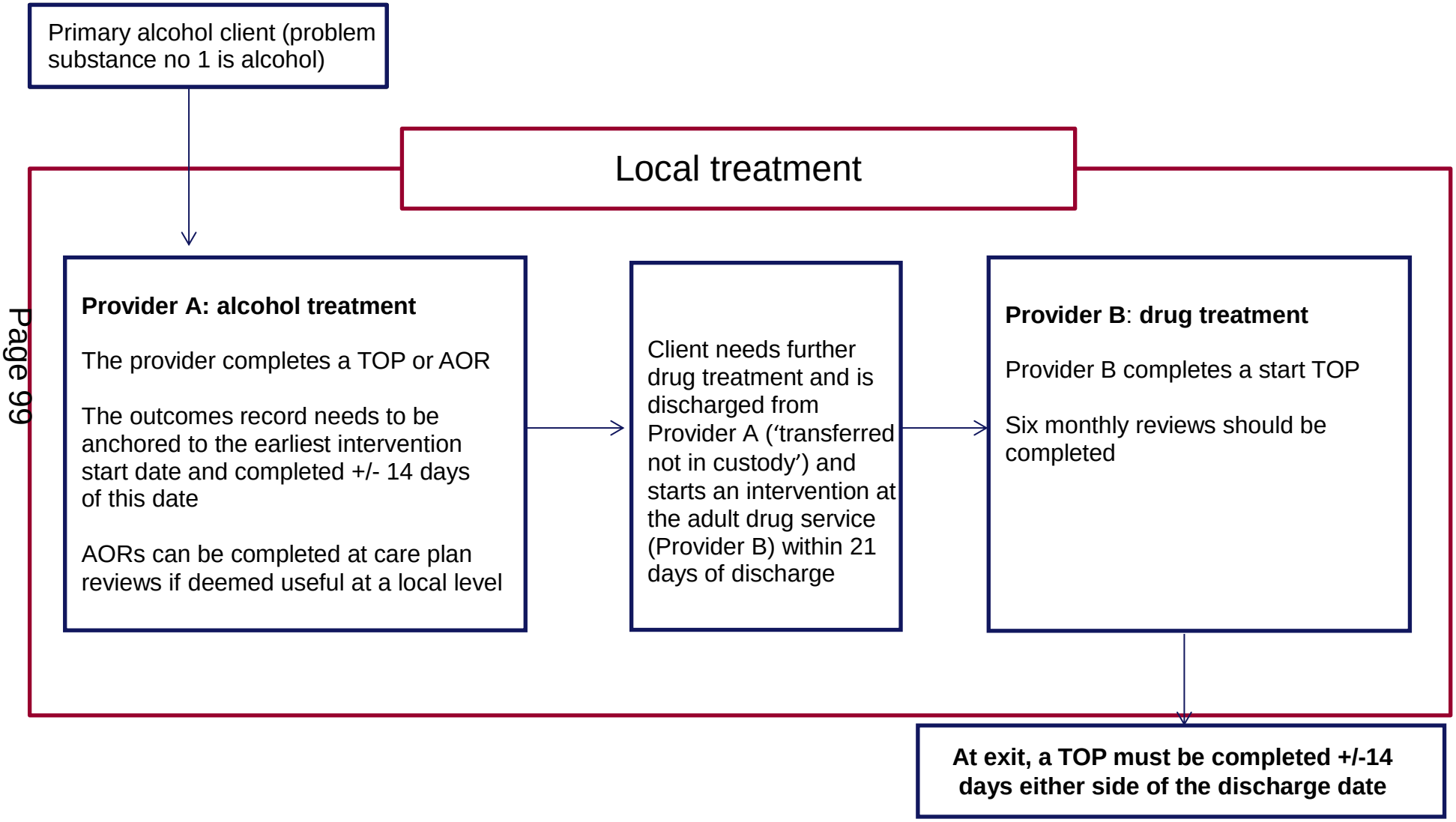
M.1 Process map for completing Alcohol Outcome Record (AOR)



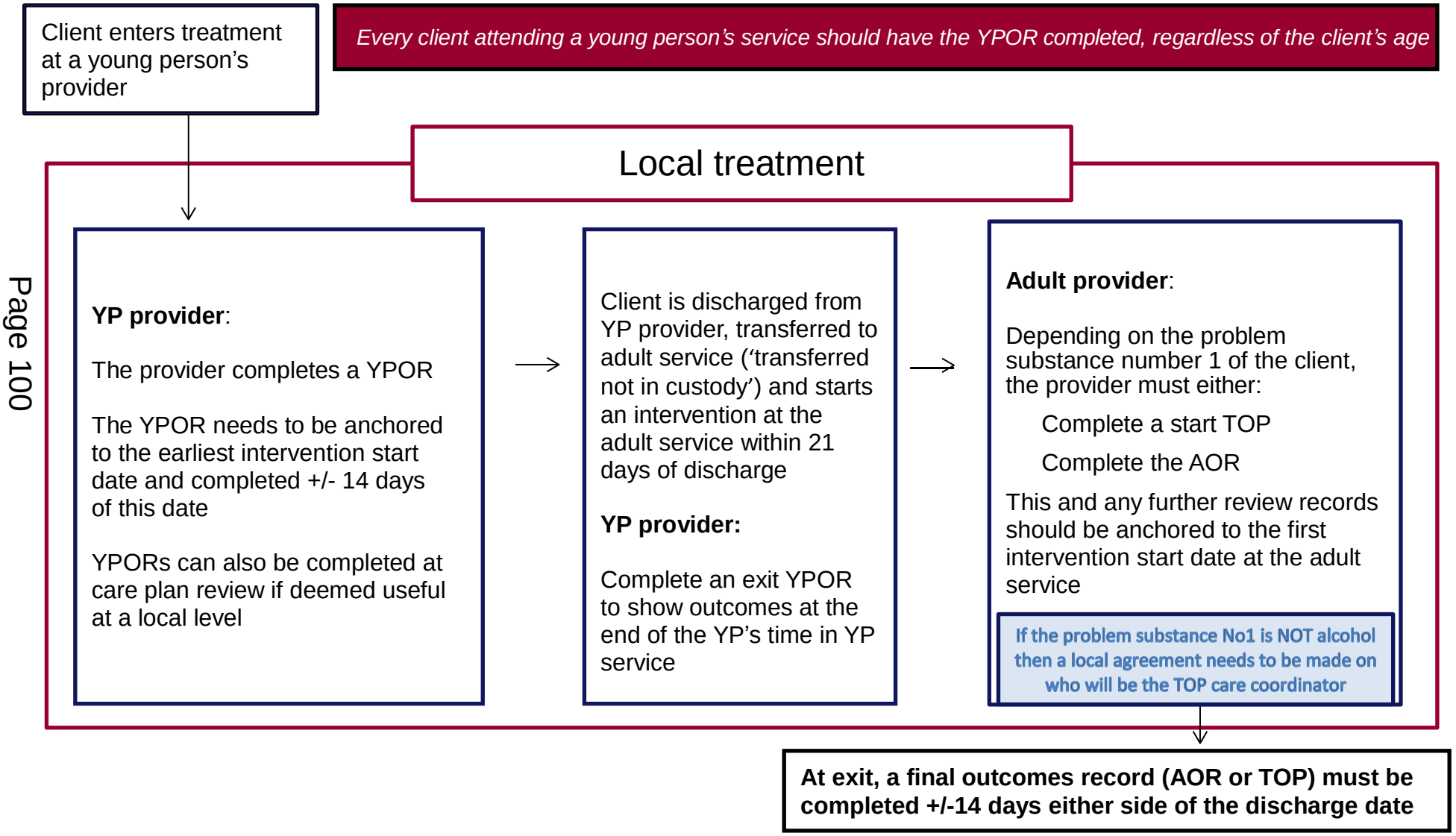
M.2 Process map for clients transferring between adult services and changing problem substance from drug to alcohol



M.3 Process map for clients transferring between adult services and changing problem substance from alcohol to drug



M.4 Process map example for clients being transferred from a YP service to an adult service



Appendix N – Brief interventions

NICE PH24 (www.nice.org.uk/guidance/ph24) describes Extended Brief Interventions (EBIs) for alcohol use as follows.

Who is the target population?
Adults who have not responded to structured brief advice on alcohol and require an extended brief intervention or would benefit from an extended brief intervention for other reasons.

Who should take action?
NHS and other professionals in the public, private, community and voluntary sector who are in contact with adults and have received training in extended brief interventions techniques.

What action should they take?
Offer an extended brief intervention to help people address their alcohol use. This could take the form of motivational interviewing or motivational-enhancement therapy. Sessions should last from 20 to 30 minutes. They should aim to help people to reduce the amount they drink to low-risk levels, reduce risk-taking behaviour as a result of drinking alcohol or to consider abstinence.

Follow up and assess people who have received an extended brief intervention. Where necessary, offer up to 4 additional sessions or referral to a specialist alcohol treatment service.

What to report to NDTMS?
One-off brief interventions should not be reported to NDTMS, but, brief treatment comprising multiple planned Extended Brief Intervention (EBI) sessions can be recorded under the psychosocial sub-intervention ‘motivational interventions’. It is expected that an assessment of need and a care planned approach is undertaken as a precursor to any series of sessions with a treatment goal of abstinence or reducing consumption.

See table below for further information:

Identification and Brief Advice (IBA)/ Screening and Brief Intervention (SBI) IBA and SBI refer to an AUDIT screen followed by an explanation of the results and 5 or so minutes of brief lifestyle advice or (as a minimum) an information leaflet.	Commissioners may wish to record IBA/SBI locally but they **should not be recorded on NDTMS.**
A single Extended Brief Intervention (EBI) A single 20-30 minute session as described by NICE	Commissioners may wish to record single EBIs locally but they **should not be recorded on NDTMS.**
Multiple planned Extended Brief Interventions (EBIs) should be considered brief treatment More than one and up to 4 additional sessions are planned. It is expected that: 1. treatment is based on a comprehensive assessment of need 2. treatment is delivered according to a recovery care plan, which sets out clear goals which include change to substance use and is regularly reviewed with the client 3. the recovery care plan sets out clear goals for other needs of the client which address 1 or more of the domains that form part of the Treatment Outcome Profile 4. all interventions must be delivered by competent staff	This would constitute structured treatment and **should be reported to NDTMS** under the psychosocial sub intervention 'motivational interventions'.

Appendix O - Alcohol dataset data items

Services that treat alcohol clients only are permitted to collect only the alcohol dataset should they choose to do so. Should alcohol services decide that they would prefer to submit this minimum dataset rather than the full NDTMS dataset they should include all of the data items listed below:

Field description	CSV file header
Initial of client's first name	FINITIAL
Initial of client's surname	SINITIAL
Client birth date	DOB
Client sex at registration of birth	SEX
Ethnicity	ETHNIC
Nationality	NATION
Agency code	AGNCY
Software system and version used	CMSID
Consent for NDTMS	CONSENT
DAT of residence	DAT
Local authority	LA
Postcode	PC
Client ID	CLIENTID
Client reference number	CLIENT
Episode ID	EPISODID
Referral date	REFLD
Triage date	TRIAGED
Accommodation need	ACCMNEED
Sexual orientation	SEXUALO
Religion	RELIGION
Disability 1	DISABLE1
Disability 2	DISABLE2
Disability 3	DISABLE3
Employment status	EMPSTAT
Time since last paid employment	TSLPE
Pregnant	PREGNANT
Parental status	PRNTSTAT

Field description	CSV file header
Children living with client	CHILDWTH
Are any of the client's children (biological, step, foster, adoptive, guardian) or any of the children living with the client receiving early help or are they in contact with children's social care?	EHCSC
Problem substance No 1	DRUG1
Age first use of problem substance No 1	DRUG1AGE
Problem substance No 2	DRUG2
Problem substance No 3	DRUG3
Referral source	RFLS
Care plan started date	CPLANDT
Drinking days	ALCDDAYS
Units of alcohol	ALCUNITS
What is the client's SADQ score?	SADQ
Does the client have a mental health treatment need	MTHTN
Is the client receiving treatment for their mental health need(s)	CRTMHN
Discharge date	DISD
Discharge reason	DISRSN
Treatment intervention	MODAL
Intervention ID	MODID
Intervention setting	MODSET
Date referred to intervention	REFMODDT
Date of first appointment offered for intervention	FAOMODDT
Intervention start date	MODST
Intervention end date	MODEND
Intervention exit status	MODEXIT
Sub intervention assessment date	SUBMODDT
Sub intervention ID	SUBMID
Client's prescribing intention is assessment and stabilisation	PHSTBL
Client's prescribing intention is maintenance	PHMAIN
Client's prescribing intention is withdrawal	PHWTH
Client's prescribing intention is relapse prevention	PHRELPR
Client's alcohol prescribing intention is withdrawal	APHWITH
Client's alcohol prescribing intention is relapse prevention	APHREPR
Client prescribed unsupervised methadone	PHUSMET

Field description	CSV file header
Client prescribed supervised methadone	PHSUPMET
Client prescribed unsupervised buprenorphine	PHUSBUP
Client prescribed supervised buprenorphine	PHSUPBUP
Client prescribed unsupervised buprenorphine/naloxone (eg Suboxone)	PHUSBUNAL
Client prescribed supervised buprenorphine/naloxone (eg Suboxone)	PHSUPBUNAL
Client prescribed diamorphine	PHDIAM
Client prescribed naltrexone	PHNALT
Client prescribed chlordiazepoxide	PHCHLOR
Client prescribed acamprosate	PHACAMP
Client prescribed nalmefene	PHNALME
Client prescribed disulfiram	PHDISULF
Client prescribed other medication	PHOTHER
Client involved with motivational interventions	PSYMOTI
Client involved with contingency management (drug focused)	PSYCNMG
Client involved with family and social network interventions	PSYFSNI
Client involved with cognitive and behavioural based relapse prevention interventions (substance misuse specific)	PSYCGBH
Evidence-based psychological intervention for co-existing mental health disorders	PSYMNTH
Client involved with psychodynamic therapy	PSYDNMC
Client involved with 12-step work	PSYSTP
Client involved in counselling – BACP accredited	PSYCOUN
Client provided with peer support involvement	RECPEER
Client provided with facilitated access to mutual aid	RECMAID
Client provided with family support	RECFMSP
Client provided with parenting support	RECPRNT
Client provided with housing support	RECHSE
Client provided with employment support	RECEMP
Client provided with education and training support	RECEDUT
Client provided with supported work projects	RECWPRJ
Client provided with recovery check ups	RECCHKP
Client provided with evidence-based psychosocial interventions to support relapse prevention	RECRLPP
Client provided with complementary therapies	RECCMPT
Client provided with mental health interventions	RECGNH
Client provided with smoking cessation interventions	RECSMOC

Field description	CSV file header
Client referred to Hep C treatment	RECHEPC
Has there been facilitation to domestic abuse/violence support?	RECDOMV
Client provided with take home Naloxone and training information	RECTHNAL
Time in treatment assessment date	TITDATE
Time in treatment ID	TITID
Time in treatment	TITREAT
Treatment Outcomes Profile (TOP) date	TOPDATE
TOP ID	TOPID
Treatment stage	TRSTAGE
Alcohol use	ALCUSE
Consumption (alcohol)	CONSMP
Tobacco use	TOBUSE
Psychological health status	PSYHSTAT
Physical health status	PHSTAT
Client information review date	CIRDT
CIR ID	CIRID
CIR Pregnant	CIRPREGNANT
CIR Parental status codes	CIRPRTST
CIR Children living with client	CIRCLDWT
CIR Are any of the client's children (biological, step, foster, adoptive, guardian) or any of the children living with the client receiving early help or are they in contact with children's social care?	CIREHCSC
CIR Does the client have a mental health treatment need?	CIRMTHTN
CIR Is the client currently receiving treatment for their mental health need(s)?	CIRCRTMHN

Public Health England

TREATMENT OUTCOMES PROFILE

CLIENT ID

KEYWORKER

DOB DD / MM / YYYY

SEX MALE ☐ FEMALE ☐

TREATMENT STAGE START ☐ REVIEW ☐ EXIT ☐ POST-TREATMENT ☐

INTERVIEW DATE DD / MM / YYYY

Use 'NA' only if the client does not disclose information or does not answer

1 SUBSTANCE USE

Record the number of using days in each of the past four weeks, and the average amount used on a using day

	WEEK 4	WEEK 3	WEEK 2	WEEK 1	AVERAGE PER DAY	Total for NDTMS return
A. ALCOHOL	0-7	0-7	0-7	0-7	UNITS	0 0-28
B. OPIATES/OPIOIDS (ILLICIT) Includes street heroin and any non-prescribed opioid, such as methadone and buprenorphine	0-7	0-7	0-7	0-7	G	0 0-28
C. CRACK	0-7	0-7	0-7	0-7	G	0 0-28
D. COCAINE	0-7	0-7	0-7	0-7	G	0 0-28
E. AMPHETAMINES	0-7	0-7	0-7	0-7	G	0 0-28
F. CANNABIS	0-7	0-7	0-7	0-7	SPLIFFS	0 0-28
G. OTHER SUBSTANCE. SPECIFY:	0-7	0-7	0-7	0-7	G	0 0-28
H. TOBACCO Includes ready-made and hand-rolled cigarettes, cannabis joints with tobacco, cigars, pipe tobacco, shisha/waterpipes, etc	0-7	0-7	0-7	0-7		0 0-28

2 INJECTING RISK BEHAVIOUR

Record the number of days the client injected non-prescribed drugs during the past four weeks

	WEEK 4	WEEK 3	WEEK 2	WEEK 1	
A. INJECTED	0-7	0-7	0-7	0-7	0 0-28
B. INJECTED WITH A NEEDLE OR SYRINGE USED BY SOMEBODY ELSE	YES ☐	NO ☐			Y or N (Y if either is yes)
C. INJECTED USING A SPOON, WATER OR FILTER USED BY SOMEBODY ELSE	YES ☐	NO ☐			

3 CRIME

Record the number of days of shoplifting, drug selling and other categories committed during the past four weeks

	WEEK 4	WEEK 3	WEEK 2	WEEK 1	
A. SHOPLIFTING	0-7	0-7	0-7	0-7	0 0-28
B. SELLING DRUGS	0-7	0-7	0-7	0-7	0 0-28
C. THEFT FROM OR OF A VEHICLE	YES ☐	NO ☐			Y or N (Y IF EITHER IS YES)
D. OTHER PROPERTY THEFT OR BURGLARY	YES ☐	NO ☐			
E. FRAUD, FORGERY OR HANDLING STOLEN GOODS	YES ☐	NO ☐			
F. COMMITTING ASSAULT OR VIOLENCE	YES ☐	NO ☐			Y or N

4 HEALTH & SOCIAL FUNCTIONING

A. CLIENT'S RATING: PSYCHOLOGICAL HEALTH (Anxiety, depression, problem emotions and feelings)

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

POOR GOOD

0-20

Record days worked, or at college or school in the past four weeks

	WEEK 4	WEEK 3	WEEK 2	WEEK 1	
B. DAYS IN PAID WORK	0-7	0-7	0-7	0-7	0 0-28
C. DAYS IN VOLUNTEERING	0-7	0-7	0-7	0-7	0 0-28
D. DAYS IN UNPAID STRUCTURED WORK PLACEMENT	0-7	0-7	0-7	0-7	0 0-28
E. DAYS ATTENDED COLLEGE OR SCHOOL	0-7	0-7	0-7	0-7	0 0-28

F. CLIENT'S RATING: PHYSICAL HEALTH (Extent of physical symptoms and bothered by illness)

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

POOR GOOD

0-20

Record accommodation status for the past four weeks

G. ACUTE HOUSING PROBLEM	YES ☐	NO ☐	Y or N
H. UNSUITABLE HOUSING housing situation that is likely to have a negative impact on health and wellbeing and / or on the likelihood of achieving recovery	YES ☐	NO ☐	Y or N
I. AT RISK OF EVICTION	YES ☐	NO ☐	Y or N

J. CLIENT'S RATING: OVERALL QUALITY OF LIFE (Able to enjoy life, gets on with family and partner, etc)

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

POOR GOOD

0-20

TREATMENT OUTCOMES PROFILE

ABOUT THE TOP

The Treatment Outcomes Profile (TOP) is the national outcome monitoring tool for substance misuse services. It is a simple set of questions that can aid improvements in clinical practice by enhancing assessment and care plan reviews. It can also help to ensure that each service user's recovery care plan identifies and addresses his or her needs and treatment goals.

Outcome reports are compiled centrally within Public Health England (PHE) via the National Drug Treatment Monitoring System (NDTMS).

Keyworkers should complete the TOP within two weeks either side (+/- two weeks) of the first modality start date at the beginning of each service user's treatment journey. This provides a baseline record of behaviour in the month leading up to starting a new treatment journey. If the treatment start TOP is completed after the first modality start date, it should focus on the 28 days before this date.

It is good practice to review a service user's recovery care plan every 12 weeks, and it is recommended that the TOP is completed at these reviews. However, this may be more or less frequent depending on individual need.

Also complete the TOP at treatment exit. Some services may want to use the TOP to measure post treatment exit outcomes.

HOW TO COMPLETE THE TOP

START BY ENTERING:

- client ID, date of birth and gender
- completion date
- keyworker name
- date of assessment
- treatment stage – treatment start, review, treatment exit, or post-treatment exit.

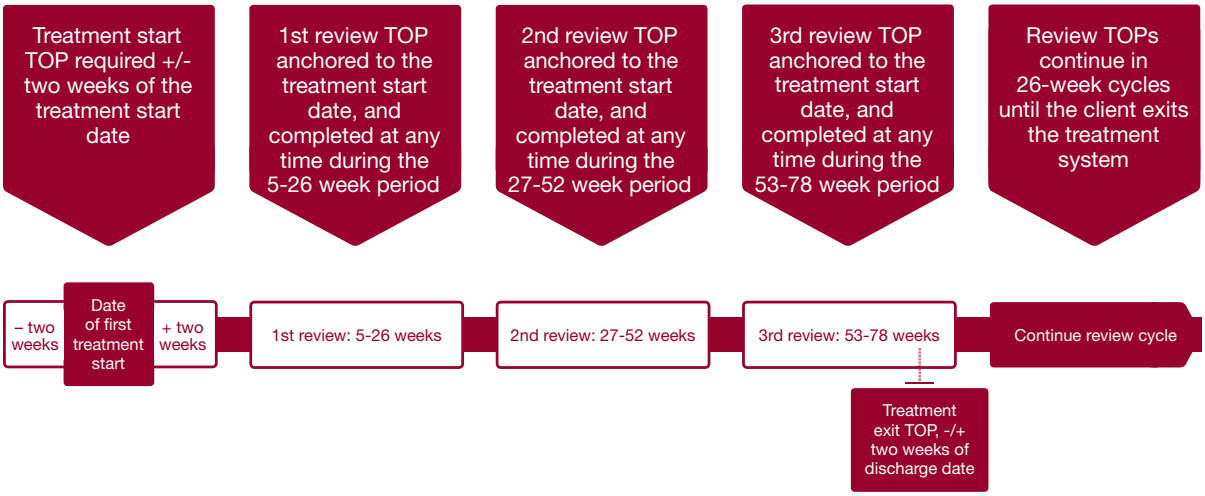
TYPES OF RESPONSES:

- timeline – invite the client to recall the number of days in each of the past four weeks on which they did something, for example, the number of days they used heroin. You then add these to create a total for the past four weeks in the red NDTMS box
- yes and no – a simple tick for yes or no, then a 'Y' or 'N' in the red NDTMS box
- rating scale – a 21-point scale from poor to good. Together with the client, mark the scale in an appropriate place and then write the equivalent score in the red NDTMS box.

A FEW THINGS TO REMEMBER

- the red shaded boxes are the only information that gets sent to PHE
- week 4 is the most recent week; week 1 is the least recent
- the Treatment Start TOP should always capture pre-treatment drug use, so it is important that the recall period is the 28 days before the treatment start date. Not doing this will skew outcomes as there is likely to be a lower baseline.

THE PROTOCOL FOR TOP REPORTING



Alcohol units converter

Drink	%ABV	Units
Pint ordinary strength lager, beer or cider	3.5	2
Pint strong lager, beer or cider	5	3
440ml can ordinary strength lager	3.5	1.5
440ml can strong lager, beer or cider	5	2
440ml can super strength lager or cider	9	4
1 litre bottle ordinary strength cider	5	5
1 litre bottle strong cider	9	9

Drink	%ABV	Units
Glass of wine (175ml)	12	2
Large glass of wine (250ml)	12	3
Bottle of wine (750ml)	12	10
Single measure of spirits (25ml)	40	1
Bottle of spirits (750ml)	40	30
275ml bottle alcopops	5	1.5

THANK YOU FOR USING THE TOP AND CONTRIBUTING TO NDTMS

Portsmouth CITY COUNCIL

Title of meeting:	Cabinet Member for Health, Wellbeing and Social Care
Date of meeting:	3rd October 2019
Subject:	Funding for the Re:Fit project
Report by:	Director of Public Health
Wards affected:	All
Key decision:	No
Full Council decision:	No

1. Purpose of report

1.1 To update the Cabinet member for Health, Wellbeing and Social Care on the forthcoming ceasing of lottery funding for the Re:Fit project and to seek funding to maintain a reduced service.

2. Recommendations

2.1 It is recommended that the Cabinet Member:

a. Approve a funding contribution towards the Pompey in the Community Re:Fit worker post of £29,000 p.a. (total: £58,000) for 2 years from 01 November 2019.

b. Approve that in the first instance, funding for this for this project would be identified from any underspend in the current financial year Public Health Grant. In the following financial years, opportunities to fund this expenditure within the relevant year's budget would be sought. Should any funding shortfall be identified, then the funding from the Public Health reserve can be utilised.

3. Background

3.1 Re-Fit is a partnership between The Society of St James and Pompey in The Community (PitC), working with people who suffer from addiction to drugs or alcohol. They provide daily diversionary leisure and sport activities alongside training, education and employment opportunities, all of which can significantly improve physical & mental health, self-esteem, confidence, social interaction, and motivation.

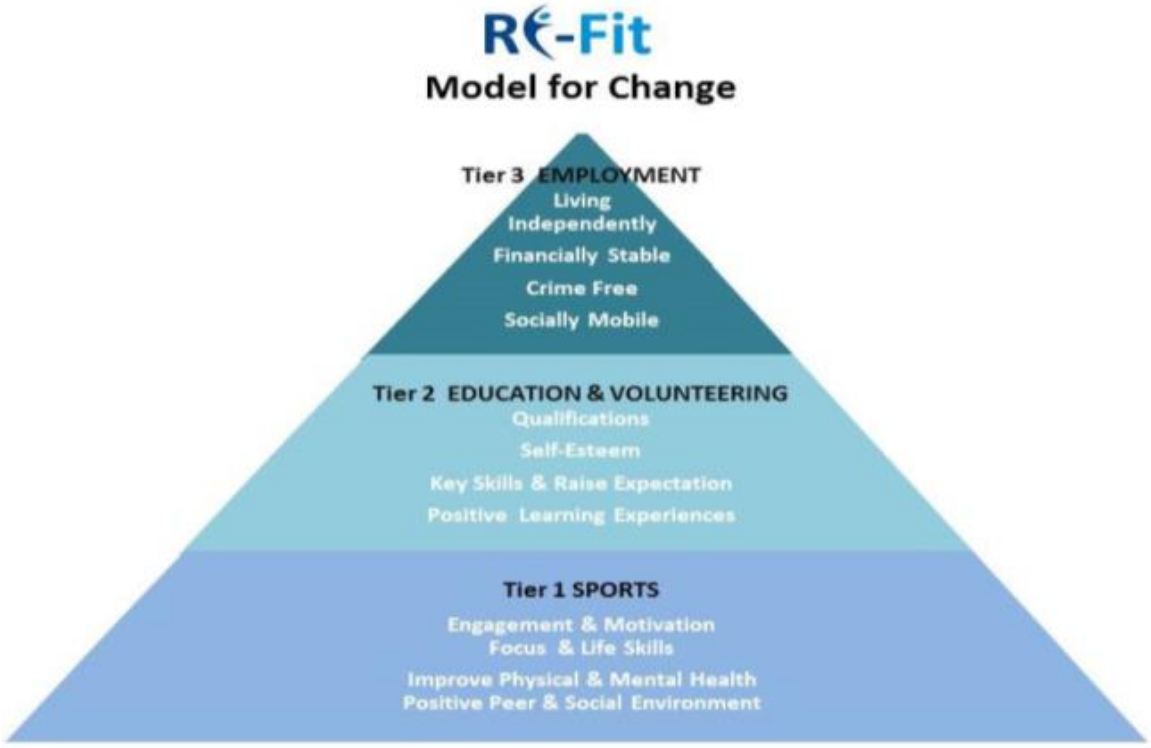
They aim to:

- Promote a healthier way of living.

- Build self-confidence, discipline, improve decision making and develop the ability to better deal with adversity.
- Reduce drug and alcohol use.
- Reduce offending and destructive behaviour.
- Alleviate stress and boredom.
- Increase integration, acceptance and tolerance of others.
- Create positive social, family and peer experiences.
- Provide educational pathways, learn goal setting and increase skill base.
- Provide routes into volunteering, peer mentoring and employment.
- Address loneliness and increase social networks.

3.2 Project Model

Re-Fit use a three-tier model for change approach to facilitate and change the lives of its service users. Each tier allows us to give our service users the best opportunities for change.



3.3 More detail about the impact of the service is provided in Appendix 1 (annual report), which provides a high level of detail and case studies. This is the most recent annual report as subsequently only smaller quarterly reports have been produced. This report demonstrates how important the project is to the substance misuse system. It provides positive activities for people in treatment to move on from addiction. As demonstrated in the report, service users are enabled to undertake voluntary work, qualifications and gain employment.

3.4 **Current and proposed staffing**

There are currently 112.5 hours per week of staffing within Re:Fit. This includes 2 fulltime project staff with additional part time and sessional coaches.

It is proposed that if this additional funding can be secured, the project will continue with 74 hours of staffing. This would be at reduced capacity, but would still provide the most popular activities and access to wider community engagement activities, although significantly reduced from the current comprehensive programme.

4. Funding

4.1 The Re:Fit project has benefited from lottery funding since November 2016, of £109,425 p.a. This provided a significant extension of the project. However this funding is ending in October 2019. The lottery have advised the providers that should some additional match funding be found, they would consider providing some additional funding.

4.2 A £29,000 per annum contribution would continue to fund a full time (37 hours) project co-ordinator from PitC, including on-costs. The balance of the 74 staffing hours would come from a review of staffing hours across the whole substance misuse contract Portsmouth City Council holds with the Society of St. James. Any additional funding from the lottery which may arise would be used to increase the activities and opportunities to nearer the current level of provision.

6. Conclusion

Re:Fit is a valuable project which contributed to supporting people in recovery to live drug and alcohol free lives. The ending of the lottery funding is regrettable. In order to maintain some level of funding, we are seeking approval to provide additional funding to extend the life of the project to tie in with the existing community substance misuse treatment contract.

5. Equality impact assessment

No EIA completed, this is an existing service.

6. Legal implications

If the contribution is approved in accordance with the recommendation it will be necessary to enter into an agreement in writing with PitC to record the terms on which the funding will be provided.

7. Finance comments

7.1 The recommendations contained within this report seek to provide additional funding of £29,000 per annum, for a period of two years to support the continuation the Re:Fit programme. The reason for this request part way through the financial year, is that the lottery funding which currently supports the project, is anticipated to cease in October 2019.

7.2 The project will need to identify future funding sources, in order to replace this temporary two year funding support; if the project is to continue in the longer term.

7.3 If approved, the expected funding requirement for 2019-20 would be £12,083 for the period 01 November to 31 March 2020. In the first instance it is proposed that this would be funded from any underspend in the current financial year Public Health Grant. In the following financial years, opportunities to fund this expenditure within the relevant year's budget would be sought. Should any funding shortfall be identified, then the funding from the Public Health reserve would need to be utilised.

……
Signed by: Director of Public Health

Appendices:

1. Re:Fit Annual Report 2017-18

Background list of documents: Section 100D of the Local Government Act 1972

The following documents disclose facts or matters, which have been relied upon to a material extent by the author in preparing this report:

Title of document	Location

……
Signed by:

Appendices:

Background list of documents: Section 100D of the Local Government Act 1972

The following documents disclose facts or matters, which have been relied upon to a material extent by the author in preparing this report:

Title of document	Location

The recommendation(s) set out above were approved/ approved as amended/ deferred/ rejected by …… on ……

……
Signed by:

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Re-Fit Annual Report

2017-18

Contents

1. INTRODUCTION

This is the end of year report for the Re-Fit project, funded by the Big Lottery. It includes information about the core sports, education and volunteering that Re-Fit provides as well as highlights from the past year such as new or one-off activities.
The achievements of the project are demonstrated by inspirational case studies, excellent service user feedback and the data in the KPI section.

2. PROJECT OVERVIEW

Re-Fit is a partnership between The Society of St James and Pompey in The Community (Portsmouth Football Club's charitable arm). We provide daily diversionary leisure and sport activities alongside training, education and employment opportunities, all of which can significantly improve physical & mental health, self-esteem, confidence, social interaction, and motivation.

We also aim to:

- Promote a healthier way of living.
- Build self-confidence, discipline, improve decision making and develop the ability to better deal with adversity.
- Reduce drug and alcohol use.
- Reduce offending and destructive behaviour.
- Alleviate stress and boredom.
- Increase integration, acceptance and tolerance of others.
- Create positive social, family and peer experiences.
- Provide educational pathways, learn goal setting and increase skill base.
- Provide routes into volunteering, peer mentoring and employment.
- Address loneliness and increase social networks.

The Re-Fit Partnership

The Society of St James

The Society of St James (SSJ) has been successfully delivering high impact, evidence based, person-centred accommodation, substance misuse and mental health services for vulnerable people for over 40 years. On average they provide brief, structured interventions and specialist services to over 3,000 people annually. They are in the unique position of having the requisite knowledge, skills and experience to deliver substance misuse treatment and housing in this new service.

SSJ also has a set of Values which are in place to guide the organisation.

OUR VALUES

SSJ believes that every human being is of worth and worthy of respect. Individuals will be dealt with on the basis of their current needs and situations. SSJ will be prepared to take risks in order to house and support the most vulnerable and socially excluded members of our society.

CORE VALUES

SSJ have three core values which our staff are aligned with in their roles. Our core values are those which staff decisions should be based on and for which staff behaviour are assessed. Our core values are:

The Society of St James has recently been awarded a Gold standard by Investors In People (IIP). Investors in People are the mark of high performance in business and people management.

With a community across 80 countries worldwide, successful accreditation is the sign of a great employer, an outperforming place to work and a clear commitment to sustainable growth.

Our IIP assessor commented on the commitment and passion that staff demonstrates in their work and in their support for the values that are important to us.

To achieve a gold standard all nine indicators must be at a developed and established level, seven of the nine must be at an advanced level.

Pompey in the Community

Pompey in The Community is Portsmouth Football Club's charity.

Pompey in the Community prides itself on the health projects and initiatives that it delivers to help people to make healthy lifestyle choices. They aim to raise awareness and understanding of healthy lifestyles as well as providing opportunities to get active. Portsmouth City has areas of great deprivation, acute health inequalities and a lower life expectancy than its surrounding areas. Much of this is due to high levels of vascular disease, secondary to the lifestyle factors that lead to it, including obesity. Pompey in the Community recognises the important role the club can play in helping people make healthy lifestyle choices and develop into responsible citizens. Their objective is to improve people's life decisions and encourage them to try new thing which will enhance their lives.

OUR PURPOSE

We want to develop the Pompey culture by engaging the people of Portsmouth, enhancing their lives and empowering them for the future.

OUR VALUES

POSITIVE-	Enhancing the lives of everyone in our community.
INNOVATIVE-	Finding new ways to help our community.
TRANSFORMATIVE-	Creating change in our community.
CARING-	Looking after our community.

3. GOVERNANCE, LEADERSHIP & PROJECT MANAGEMENT

Re-Fit has the overarching support structure and governance of The Society of St. James (SSJ) and Pompey in the Community. These are designed to ensure accountability, transparency, responsiveness, rule of law, stability, equity and inclusiveness, and empowerment.

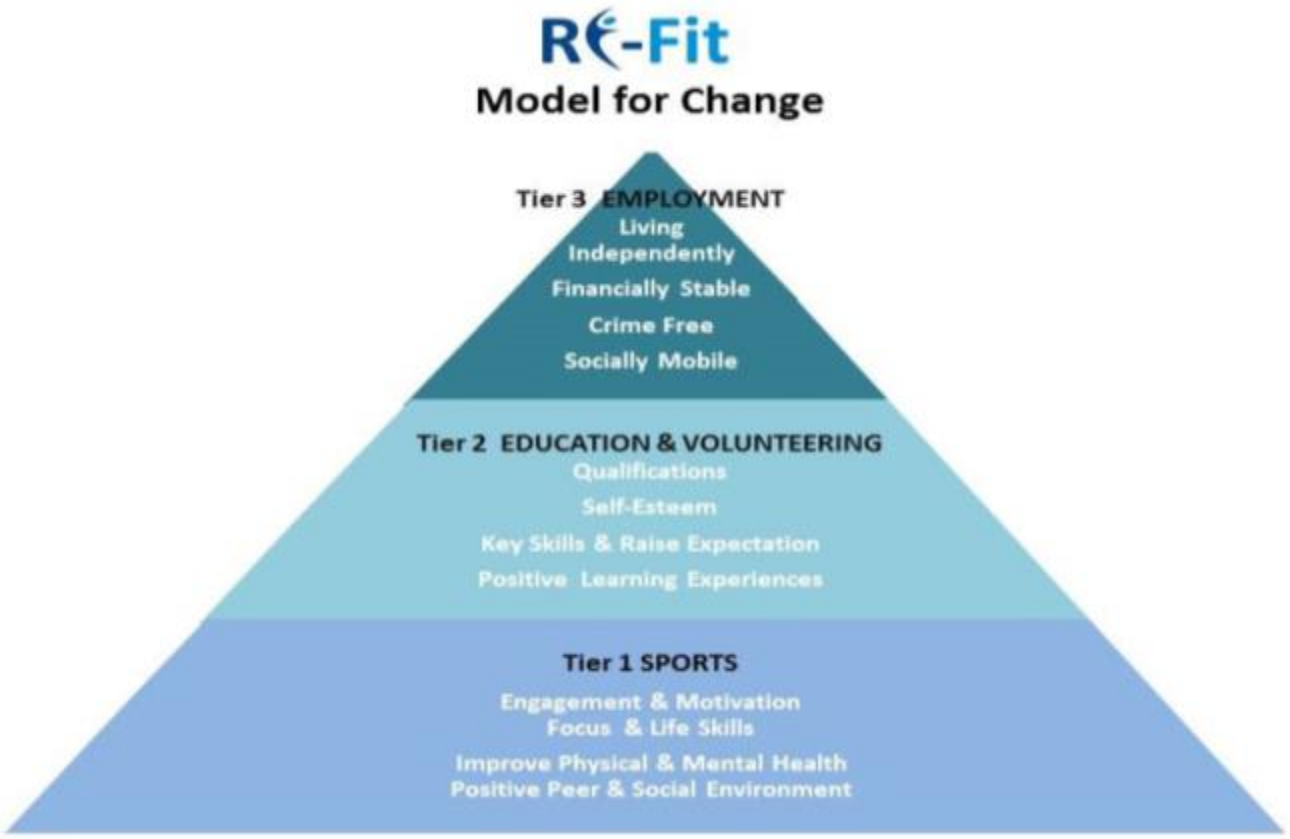
This is achieved by having a SSJ Management Board made up of 14 independent trustees that sit outside of SSJ but help with the charity's decision making and direction.
Whilst ensuring we adhere to our values and governance, trustees have overall control of the charity and are responsible for making sure it's doing what it was set up to do. The trustees are the people who lead the charity and decide how it is run.

Trevor Pickup CEO is the SSJ link to the Management Board but the trustees take a very pro-active interest in the charity and will visit the projects regularly. This keeps them informed of what going on at service level.

As well regular meetings with the CEO and senior management team, the Trustees have an annual Operations Committee. This is a subcommittee of the main Management Board and gives Project Managers an opportunity to show case their project to the trustees who then offer support and suggestions but also scrutinise performance and practices.

Project Model

Re-Fit use a three-tier model for change approach to facilitate and change the lives of its service users. Each tier allows us to give our service users the best opportunities for change.



4. SPORTS ACTIVITIES

The timetable of Sports Activities is shown below along with some photos from sessions run in the last year. In addition to what is on the below flyer we have offered Lawn Bowls, and a number of other sessions mentioned in the highlights.






CASE STUDY

SC - aged 44
I had a good upbringing with a decent and supportive family. I started experimenting with alcohol at the age of 10; this progressed onto the recreational use of solvents, cannabis, MDMA, and LSD.
At the age of 17 I had a motorbike accident which resulted in me breaking my back. I was prescribed opiate based painkillers which gave me the taste and opened the door to 20 years of heroin use and the drug dealing to fund it.

I came to Portsmouth towards the end of 2016 to attend the ARC treatment centre. It was here that I found out about Re-Fit when Jim came in to do a promotional talk.
When I finished treatment at the ARC, I relocated to one of their 'move on houses'. It was here when I went to my first Re-Fit badminton session with another resident. I found that I really enjoyed myself which I hadn't done for years. I was welcomed by the staff and other service users, I felt safe and made to feel valued. I knew then this was the start of the next stage in my recovery.

Re-Fit has helped me build my confidence, self-esteem, social skills, engage with the community, as well as improved my health and wellbeing.
Re-Fit has opened new doors in my life and helped me realise I can be a productive member of society. I have taken on education and training and I have completed my health and social care level 2 and I'm about to start level 3. I have gained my food hygiene qualification; I have also completed SSJ B2V volunteer training and started volunteering with Re-Fit.

My volunteering role gives me a sense of purpose and structure in my life, I also feel I am giving back and I like seeing people flourish from the same opportunities Re-Fit gave to me.

My goals for the future are to build up as many skills and training, and to work my way towards full time employment.

5. RESTART

Restart take service users out on a different activity each week such as archery, kayaking, golf and Laser tag, to provide different experiences and to encourage positive change. We found that service users feel more relaxed and willing to open up during these sessions.







6. SERVICE USER FEEDBACK

There is space on the Re-Fit monitoring form for service users to give feedback on Re-Fit and over the last 12 months there were 226 pieces of feedback. There was no negative feedback.
There are 4 pages of quotes that show the effect that attending Re-Fit is having and it is a great way to show the positivity we see at sessions. Here is a selection:-

- Refit is fantastic.
- Re fit has played an essential part in me getting my life back and feel it's an integral part of the community
- Refit has been amazing and boosted my confidence.
- Feels emotional, it is truly amazing.
- Given me a sense of purpose in my life.
- It's a nice relaxing environment and makes you feel comfortable
- Ideal programme for Portsmouth
- Enjoyed the programme and made some good friends
- Brilliant
- Awesome
- Very sociable
- Good safe place
- 100% helped me over the years
- A good community with good people
- Great project

- Staff are all very friendly and helpful, I love the refit staff and programme
- Brilliant and essential to my recovery and helps my confidence
- Excellent service to the community
- Keeps me busy
- Can't praise it enough, love it!
- Motivational project
- Really grateful for the opportunities given to be given to me. It's literally saved my life.

7. WHAT'S NEW & HIGHLIGHTS IN THE LAST YEAR

LAND & WAVE SURVIVAL SKILLS & COASTEERING

10 National Citizens Service graduates and 6 Re-Fit service users came together to have a 2 part experience. The first was an outdoor experience with Land and Wave who offered us a 50% discount. The group travelled to Dorset for an activity day of Coasteering, Survival Skills and Bush craft.
The second part was with our chef practitioner who taught the group basic food hygiene skills and knife skills before the group set upon their ready steady cook challenge where they were given ingredients to put on a three course meal for a sit down meal for PITC's dementia group. The meal was a tomato and red pepper soup, fish pie or red beetroot falafel, and fruit salad and ice cream desert.

LAND & WAVE PADDLE BOARDING TRIP 28/8/18

"***Didn't we have a lovely time the day we went to Swanage……"***

We boarded the minibus for an early start and headed off to North Beach in Swanage to be met by the Land and Wave team. After our first challenge, getting the wet suits on, we walked down to the beach and were introduced to our paddle boards. It was a perfect late summer day; cloudless sky, warm and, importantly flat sea. We learned the basic skills through a mixture of instruction, encouragement and trial and error. Before long we were all "experts" on our boards, standing up (just about) and paddling around the bay. Then time for games with lots on falling in and smiley faces.
Three hours later it was off with the wet suits and back into the minibus to head for the woods for lunch followed by archery and axe throwing.

On our way home, the bus was quiet. Some of the passengers had time to reflect on the day: the new skills we'd practiced and a better understanding other's abilities and frailties and supporting and encouraging each another. Some just fell asleep exhausted.

WOMEN'S SELF DEFENCE

In July Re-Fit ran a one-off 2 hour self-defence seminar hosted by Sam Graham who is a Krav Maga tutor.

Krav Maga is a military self-defence and fighting system developed for the Israel Defense Forces and Israeli security forces that derived from a combination of techniques sourced from boxing, wrestling, Aikido, judo, and karate, along with realistic fight training.

The seminar covered the below moves and drills:

- Stance
- Movement
- Basic strikes
- Basic covers/blocks
- Clinch 1
- Defence from front lapel/shirt grabs, front choke, rear choke, bear hugs, hair grabs

The tutor delivered the seminar that was sensitive to the fact some of the women attending may have been victims of Domestic Violence.

Due to the success of this one off session we are exploring the possibility of running this as a regular activity. We recognise that some woman will be more comfortable attending women's only groups.

BOXING AWARDS

Previously Re-Fit funded Gareth Tenant to obtain his Boxing trainer qualification so he could progress from a Re-Fit volunteer to paid sessional worker. This year we put him through an additional qualifications - Boxing Teacher Trainer Course. With this qualification Gareth and Re-Fit can now offer, train and certify the Boxing Awards.

Three people have recently completed the Preliminary Boxing Award.
The Preliminary Award teaches stance, guard, torso movement, footwork, straight punches and self-defence. It incorporates technique and partner work, shadow boxing, skipping and boxing drills.

This certificate can be used to support the following:

- GCSC, BTEC, ASDAN, Duke of Edinburgh Award and Princes Trust
- This certificate has a value of one credit towards all

ASDAN awards and qualifications

MOUNTAIN BIKING

Up until very recently the mountain biking was run in conjunction with Saints4Sport because they had the means of transporting the bikes to the venue. Now with thanks to The Big Lottery Fund we have been able to purchase our own bike trailer for 10 bikes, thus gaining our independence.

We teach the participants the following 'Life Skills' - how to ride the trails and rough terrain, change gear and brake correctly, ride in a group safely, adjust seat height and ensure they can fit their helmets securely. In addition we also get the participants to complete the bike safety "M Check". This gets every rider to check the complete bike for any defects by examining the tyres, brakes, wheels, frame, handle bars and forks. We encourage the riders to adopt these checks every time they cycle independently of our group.

CITY CYCLING

Re-Fit recognised that a full day mountain biking may be too much for some, especially those that do not feel very competent on a bike and those that don't have the fitness to cycle for long periods. We decided to run an easier and shorter "city cycle session" Cycling UK funded the Group Leader Cycling training for one of our Volunteers / Peer Mentors, Paul Morrison, so we could offer this as a weekly activity and pay Paul as a sessional worker.

MP VISIT TO RE-FIT BADMINTON

A big thank-you to Stephen Morgan, Labour Member of Parliament for Portsmouth South who joined us at our badminton session and listened to service users concerns. He was not a bad player too!

HOUSE OF COMMONS VISIT

After visiting the Re-Fit badminton session, Stephen Morgan MP invited us to the Palace of Westminster's House of Commons on July 18th 2018. After travelling up on the minibus and arriving at the House of Commons we were met by the official guide who gave us an historic tour of the public areas. Once this tour was completed, we then followed official protocol and wrote a request slip to see Stephen Morgan. Stephen came to meet us and took us on another tour not open to the general public, this included secret corridors. Finally we were shown the viewing gallery which looks down on the MPs in session, who at the time were discussing BREXIT.

STEPHEN MORGAN MP

HOUSE OF COMMONS
LONDON SW1A 0AA

Dear Michael

Thank you so much for your recent visit to the House of Commons and for taking a tour of the home of British democracy.

It was an absolute pleasure to welcome the Re-Fit Group from Pompey in the Community to the Houses of Parliament to show you where I spend much of my working week. I was pleased to have the opportunity to spend time with such an important social group that supports residents in our community.

I really enjoyed showing you the gallery, spending time with you on the terrace and hearing about all the inspiring work you do.

If you have any ideas or suggestions do not hesitate to contact me, my details can be found at www.stephenjmorgan.org. Know that, as your local MP, I am here to support you in any way I can.

Wishing you all the best

Stephen

Stephen Morgan MP

Member of Parliament for Portsmouth South

VISIT TO PORTSMOUTH HISTORIC DOCKYARD

Portsmouth Historic Dockyard is an area of HM Naval Base Portsmouth which is open to the public; it contains several historic buildings and ships. It is managed by the National Museum of the Royal Navy as an umbrella organisation representing five charities: the Portsmouth Naval Base Property Trust, the National Museum of the Royal Navy, Portsmouth, the Mary Rose Trust, the Warrior Preservation Trust Ltd and the HMS Victory Preservation Company. Portsmouth Historic Dockyard Ltd was created to promote and manage the tourism element of the Royal Navy Dockyard, with the relevant trusts maintaining and interpreting their own attractions. It also promotes other nearby navy-related tourist attractions. Through our contacts at Portsmouth Historic Dockyard, Re-Fit has now added a regular culturally historic activity to The Re-start itinerary, via a guided tour of the dockyard.

On the first trip we visited HMS Victory, Lord Nelson's flag ship in the battel of Trafalgar 21st October 1805.

Our second visit was to see the HMS M33, a M29-class monitor of the Royal Navy built in 1915. She saw active service in the Mediterranean during the First World War, including Gallipoli and in Russia during the Allied Intervention in 1919.

RESEARCH STUDY

Re-Fit was asked by a PhD student, Kim McCall, from Kings College, London, to conduct a research study with our service users. The hypothesis below:

How does a physical exercise and sports programme help people who use drugs and alcohol? An evaluation of a physical exercise and sports programme for people in recovery from drug and alcohol dependence.

"As part of my PhD with the Addictions Department at the Institute of Psychology, Psychiatry and Neuroscience (IOPPN) and with the support of Paul Allen and Jim Cook at Re-Fit in Portsmouth, my study aims to find out more about how a programme like Re-Fit helps people who are seeking to reduce or control their use of drugs or alcohol. I hope that my findings will help to improve understanding about the ways in which a sport and physical fitness programme can be used to support drug and alcohol users who are seeking to control or reduce their drug or alcohol use. This will include considering whether taking part in the programme leads to reduced drinking and drug use, as well as other outcomes that may support recovery (such as reduced anxiety)." Kim McCall

The study is being undertaken at the current time.

8. EDUCATION, TRAINING & EMPLOYMENT

This year Re-Fit has expanded its NVQ program and has expanded the number of places that offer work placements. We now facilitate NVQ Level 2 & 3 sessions in Health & Social Care that are run in Partnership with St Vincent College. This is a great opportunity for our service users to gain a valuable vocational qualification. The course is usually 38 weeks long spread over a year. However some students finish ahead of schedule, whilst others take longer. St. Vincent have agreed to extend the learning period to 18mth for SSJ service users only. Many of our services users have historically failed or have been let down by the education system. For most this is the first qualification they have signed up for since leaving school, we want to show them that they can achieve academically, that they are capable and that we believe in them. We find once our service users have qualified they now get "the bug" and go on to do other courses.

The course is free to Re-Fit service users by accessing funding to get people into employment; the course should cost £2,000 per participant for level 2 and £2800 for level 3.
Part of the course involves a **work placement**; the following have been used by this year's NVQ students:

- The Recovery Hub- Drug and Alcohol support services
- Café in The Park- The aim of the café is to provide employment and training opportunities to local people with histories of homelessness and substance misuse and this fits in perfectly with Re-Fit's training and employment program.
- Day Rehab - Structured Day Programme for people with Drug and Alcohol issues.
- Pushing Change (PUSH) – Portsmouth Service User Group
- Night Shelter – Accommodation for Vulnerable adults
- Re-Fit
- Chimes – Dementia group run by Portsmouth In The Community
- Shift – mental health peer group.
- Food Cycle – Organisation that supports people who are hungry and lonely by serving tasty lunches and dinners every single day in towns and cities across the country. Many guests struggle to afford the basics to eat and many will eat alone without company or conversation.

Re-Fit ran 3 NVQ Level 2 & 3 sessions in Health & Social Care
Class 1 - 9 enrolled - 7 completed

Class 2 - 8 enrolled - 7 completed, 1 extended due to close bereavement
Class 3 - 8 enrolled - 7 completed, 1 withdrawn due to personal issues.

We have really focused on this work placement element of the course and it is proving to be very successful. What the work placement does is two-fold, one they get to put in practice what they have learnt academically and two they realise that they can actually do a job and do it well. Many of our service users are not in employment because they simply haven't the self-confidence; they don't believe they can do it. These short placements show they can and due to the positive feedback they get from fellow workers and managers they now know they are capable of finding employment, many that qualify from their course do go on to either volunteer of to find jobs in the caring sector.

Virginia Thompson Course tutor: *During the duration of the NVQ the learners enhance a great deal of life skills as well as gaining the academic qualification. The primary ones being the ability to interact and listen to others in a non-judgemental manner. We often hold open discussion on emotional topics, meaning that learners have to develop diplomacy and debating skills. They require time keeping, punctuality and an excellent attendance record. These are all beautiful transferable skills that they then take into their placements and onwards into the work marketplace. We have often seen coaching and mentoring skills develop in the learners also.*

NVQ Case Studies- *"What a difference a year makes"*

FB age 39

F was homeless and addicted to drugs. She got arrested for shoplifting and went to prison for a month. After her sentence she was rehoused and accessed Re-Fit. She enrolled onto the NVQ 2 in Health and Social Care which she is just completing well ahead of schedule. She has attended all classes and rekindled a love for learning that she used to have when she was at university doing her English degree. F has gained a sense of self belief in herself and her abilities again. She now volunteers in the community group supporting service users with dementia and their families. Over the year she has gone from strength to strength and is a true role model to other women.

SF age 38

At School SF repeatedly felt that he was not good enough and an underachiever, thoughts that he had reinforced by others around him on many occasions. This led to some pretty bad life choices which led to a severe heroin addiction. After accessing rehab he came to Re-Fit who referred him to the NVQ programme as a component of his recovery. It took time but very slowly he has regained confidence and self-esteem. For his tutor and support staff this has been a long journey building up trust and respect, taking time to read and re-read his work reassuring him each step that he is good enough and that he can do this. His tutors were right as he has just achieved his diploma. He is now not only volunteering at Re-Fit with the sports coaching but with other agencies too. As a team we were so proud that he is now, in partnership, setting up an upcycling project with a view to engaging others in recovery. In January he is enrolled on the Level 3 in Health and Social Care, because he now has faith in his own abilities.

JC age 35

JC was always a lively teenager that got into heroin at a very young age. After attempting an armed robbery with his brother, he spiralled out of control, using every day and becoming very unstable. After a detox he began accessing the NVQ program and volunteering in a day rehabilitation centre near his home. He made such an impact that they offered him a paid role and training in drama workshops. He has just completed his Level 3 in Health and Social Care and is now studying a psychology degree with the Open University. He has also more importantly built some vital bridges with his mum and feels has given her something to be proud of.

SD aged 40

Often the NVQ course and Re-Fit achieve non-academic successes. SD has been rather erratic for a number of years and her drinking has always been a mask for huge emotional distress from years of dysfunctional parenting and domestic abuse; patterns that she carried forward into her adult life.

Earlier his year her father died and ordinarily this would be a catalyst to self-destruction. However with support and knowing that the Re-Fit and college staff were there each week she has made positive choices that have empowered her as an individual. She has chosen to access the support, to detach herself from her violent ex-partner, make positive parenting choices for her 8 year old daughter and put herself first. This was initially through aggression to staff, loud outbursts and detaching from the program. We have now reached the stage that she can talk through her emotions, maintain her boundaries and ask for support. Her course will take a little longer than some others, but we have been able to extend her dates and support her at an appropriate pace so that she is in control and will achieve.

RH aged 35

R was homeless for some time and in her words, "I really didn't care, I was dirty, smelly and had bad skin. My only thought was for heroin". Fresh out of day rehab she was offered the chance to volunteer to support others. She is just completing her Level 3 in Health and Social Care and is now employed working full time as a recovery worker using her experience to get others out of addiction. She also now never misses the opportunity to get her nails done and save for her next holiday.

Student testimonials

"I strongly believe this course has given me a reason to remain a clean addict and give back".
"I've gained an insight into myself, helped me remember who I am and has given me confidence."
"I had constant support and understanding; I've gained lots of knowledge and some confidence."
"I'm really glad that I enrolled on the course, I've made lots of friends and I have started volunteering."
"I have gained belief in myself as at the start I thought I wouldn't be able to do this, but I proved I can. I also struggle in a classroom environment but I've proven I can handle this."

Virginia Thompson Course tutor explains -

"The biggest part of what we do is working in partnership. So if a client walks through the door at Re-Fit we can offer them education, sports, a listening ear right down to food parcels to keep them going. Many a time classroom breaks have been filled by the dishing out of sanitary towels, chocolate and food parcels. As you cannot focus on learning when your basic needs are not met"

CELEBRATION

At the end of term, we provide a meal for our NVQ Health and Social Care students provided by PITC's NCS students.

9. RE-FIT CHAMPIONS and VOLUNTEERING

MAYORAL AWARDS

Every year SSJ has an Annual General Meeting (AGM) where the Major or Sheriff presents our volunteers with a certificate to show our thanks for the hard work they have put into their projects.

This is a list of the Re-Fit Volunteers who received recognition.

- **Tony Southam** – has been with us two years. In that time has become a vital part of the team, and has embraced everything that is asked of him.
- **Steve Clarke** – has been with us two years and volunteered for a year, Steve helps out at various sessions encouraging and supporting others.
- **Stuart Flannigan** - been with Re-Fit from the start as a service users, then onto volunteering, and finally sessional worker. He is now in full time employment but still attends sessions on a weekly basis.
- **Paul Morrison** – has been with us two years going from volunteer to paid sessional worker and also runs a project for Pompey in the community helping young people from offending.
- **Gareth Tennant -** has been with us for over two years. Re-Fit put him through his boxing tutor awards and Gareth now delivers our boxing session on a Friday and he is now in full time employment .
- **Mick Crawford** - is 65 has been with us from the start and has only missed a couple of sessions in all those years, he helps on a Friday at the table tennis setting up etc.

RE-FIT CHAMPIONS

Re-Fit champions are service users that have been recognised as people that have helped develop or enhance the project. These certificates are not easily achieved and have to be earnt through dedication and commitment and achieving one or more of the following:

- For showing outstanding commitment towards the Re-Fit Project
- Being a positive role model towards their peers.
- Making significant commitment to their Health & Wellbeing.
- Been a Re-Fit ambassador.
- Supported others at Re-Fit sessions.
- Made significant life changes.
- Have promoted and supported others in engaging with Re-Fit.








Recognising it is a significant milestone in a person recovery journey all champions are presented with a certificate:
Our Re-Fit champions take great pride in receiving these certificates and feel that their work and efforts are recognised. It gives them a sense of belonging and ownership of the project.

Becoming a Re-Fit Champion is the first stage of progression within the project, after becoming a Champion the client then may have aspirations to become a volunteer and one day may move on to paid sessional work.












CASE STUDY

Gareth

My name is Gareth. I was born in Leeds, West Yorkshire in 1981 in an area called Gipton to a single mum. I have one brother, one sister and a half-brother and 2 half-sisters.

When I was 12, I thought I was cool and I tried weed with my mates. It was cool and I smoked it every chance I got, but not in school because I liked school. I completed school with a few GCSEs but didn't go to college because I joined a gang. The gang went around stabbing or shooting people for no reason.

On my 20th birthday, I went out with a few friends and was beaten up with a pool cue. They smashed in the left side of my face damaging my eye socket, cheek and part of my nose. I have three metal plates to hold it together.

In 2003, I moved to Staines Middlesex. I worked doing door to door sales which I didn't like much because I didn't make much money. In 2006, I met a woman and had my first child in 2007. After splitting up with his mum, she said she would never stop me from seeing him but she did. I kept going round to bang on the door demanding to see him and threatening her. The police were called and I got arrested and sent to prison a number of times.

In 2012, I had my first daughter, who was one of a twin but unfortunately her sister died. The same thing happened with this next partner around access but before I was sent to prison I started drinking and using legal highs because I didn't know how to cope with the loss. I couldn't get weed at the time so someone I know introduced me to the legal highs to take the pain away. This made me do some things I wish I never done and I went to prison again and breached orders. Now I am under an order for life to stop me from seeing my daughter because I pushed her mum and kicked the door to get in and she accused me of hitting her which I did not do.

I took legal highs for 4 years. I still took them when I had my youngest daughter who was born in 2014. I moved to Portsmouth with her mum who was hoping that I would change. I kept going back to Guildford to see if I could see my eldest daughter but I did end up having another daughter who is 4 months older than my youngest and I couldn't handle getting arrested all the time. I decided to turn my life around and stick to what I needed to do and go to my appointments so that I could get into the day rehab.

In 2015, I started the day rehab and engaged in Re-Fit's boxing to get my anger out in some other way. In 2016, I met Pip and got married. I completed rehab and stayed out of trouble. I got to see my youngest daughter again and I have two beautiful step children that have taught me how to be a man and a dad. My wife has stood beside me all the way through my recovery; she is my best friend and helped me get over the death of my nan.

Since 2017, I have worked for SSJ facilitating Re-Fit boxing and I also work full-time at a homeless night shelter. I am not on benefits anymore and I have a house. I got my life back and I am happy. It is because of the day rehab, myself, Re-Fit, my wife, my step-children and my daughter that I am here today in a good place and I never intend to go back there again.

10. WOMEN, SUBSTANCE MISUSE AND RE-FIT

Our demographic data shows that 26% of Re-Fit attendees are female. To decide whether this shows a lower rate of take up than of males, it is necessary to understand the demographics of the clients who are being referred in to Re-Fit.

Re-Fit supports people affected by complex issues, such as drug and alcohol misuse, mental health, homelessness and criminality. We receive nearly half of our referrals from Substance misuse services with Criminal Justice (National Probation Service and Community Rehabilitation Company) and Homelessness Services the next largest referrers. If we look at the local or national gender ratios in these services we can see that:

The Portsmouth Drug & Alcohol Service has a slightly higher percentage of females at 30%. If we look at Criminal justice, the percentage of women compared to men going through the Criminal Courts is 27%. Of the individuals counted or estimated to be sleeping rough in 2017 in the England, 14% were women.
So the fact that a quarter of Re-Fit's attendees are female is actually what we would expect. It is important to remember many women in substance misuse treatment have court orders or licence agreements that stipulate they must attend substance misuse services, whereas attendance at RE-FIT is purely voluntary. Added to that there are sports that Re-Fit provide which do attract predominantly males such as Football and Boxing , due to this we are now looking to address this by implementing women only sessions.

SUBSTANCE MISUSE

Historically, men have a higher reported incidence of substance abuse and dependence, but women are rapidly closing that gap. Young women and middle-aged women now have an almost equal percentage of drug and alcohol abuse and dependence concerns as do men. However, the percentage of women in treatment is a lot lower; there are many reported reasons for this including:

- Women feel more fear and shame which stops them asking for help.
- Women tend to be the main child carers so often cannot attend treatment
- Many women have the belief that if they admit to their issues their children will be taken away from them Social Services.
- Women are particularly affected by relationships, the status of their relationships, and the effects of substance abuse by a partner. In fact, women who abuse substances are likely to have a partner who is also a substance abuser. Some women think of shared drug use as a means of communicating and/or connecting with their partners. Drug use rituals – such as sharing needles – are often initiated by males. These put women at risk of contracting HIV/AIDS and hepatitis through needle-sharing practices and by having unprotected sex with males who inject drugs. 26% percentage of British women have reported being victims of domestic violence, the actual figure would be much higher as most incidents are unreported. Often partners that do this have a controlling nature and will not allow women to attend appointments without them.
- Women are often forced by their partners to commit crime; this often leads to incarceration and leads to the "revolving door syndrome" where women are constantly in and out of prison, meaning they cannot attend treatment services even if they wanted too.

Why have we introduced a female only session?

- A safe place where they can talk to people about their issues.
- To meet other women going through similar problems,
- To learn to protect themselves.
- To encourage women to access substance misuse treatment services.
- For staff to be able to protect vulnerable adults.
- Women who have a substance use disorder often have a history of trauma, including interpersonal and childhood sexual abuse. This often leaves them very wary of males.

11. RE-FIT KPI'S

Re-Fit is two-thirds of way through the funding so the KPI data shown below consists of the 3 year contract target, this year's figures and the cumulative total from the last 2 years to see whether we are on track to meet that target.

There have been 338 unique service users attending Re-Fit this year and over the year 471 monitoring completed. The number of individuals monitored was 175.

		Contract target (3years)	Year 2 Nov 2017-Oct 2018	Cumulative total Year 1 & 2
KPI				
Outcome 1	**Vulnerable adults will develop and enhance essential life skills**	400	171	249
	Vulnerable adults will complete formal awards/qualifications	200	35	71
	Vulnerable adults will be signposted to the B2V programme	50	40	65
Outcome 2	**Vulnerable adults will report increased feelings of happiness**	400	126	327
	Vulnerable adults will report increased confidence/self-esteem	400	123	320
Outcome 3	**Vulnerable adults will become more physically active**	600	308	570
	Vulnerable adults will report decreased usage of drugs/alcohol	150	21	64
	Vulnerable adults will report maintaining abstinence.	n/a	125	285
Outcome 4	**Vulnerable adults will complete practical work experience/ voluntary hours**	80	25	51
	Vulnerable adults will report reduced feelings of loneliness and increased belonging to their community	400	119	294
	Vulnerable adults will become Re-Fit Champions	50	20	37

Substance Misuse KPI

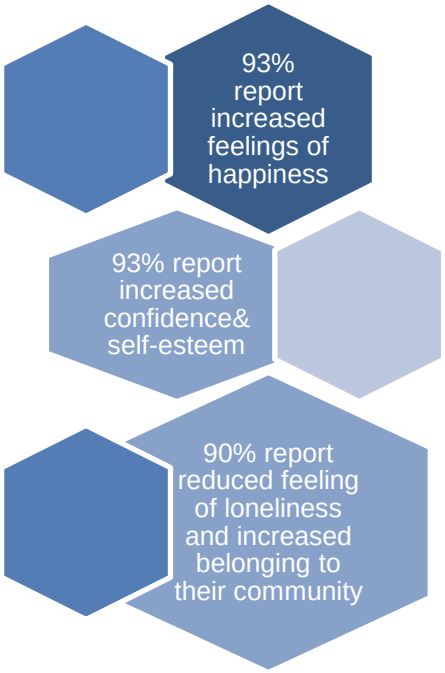
Outcome 3.2 reports on the number of vulnerable adults who report decreased usage of drugs/alcohol.

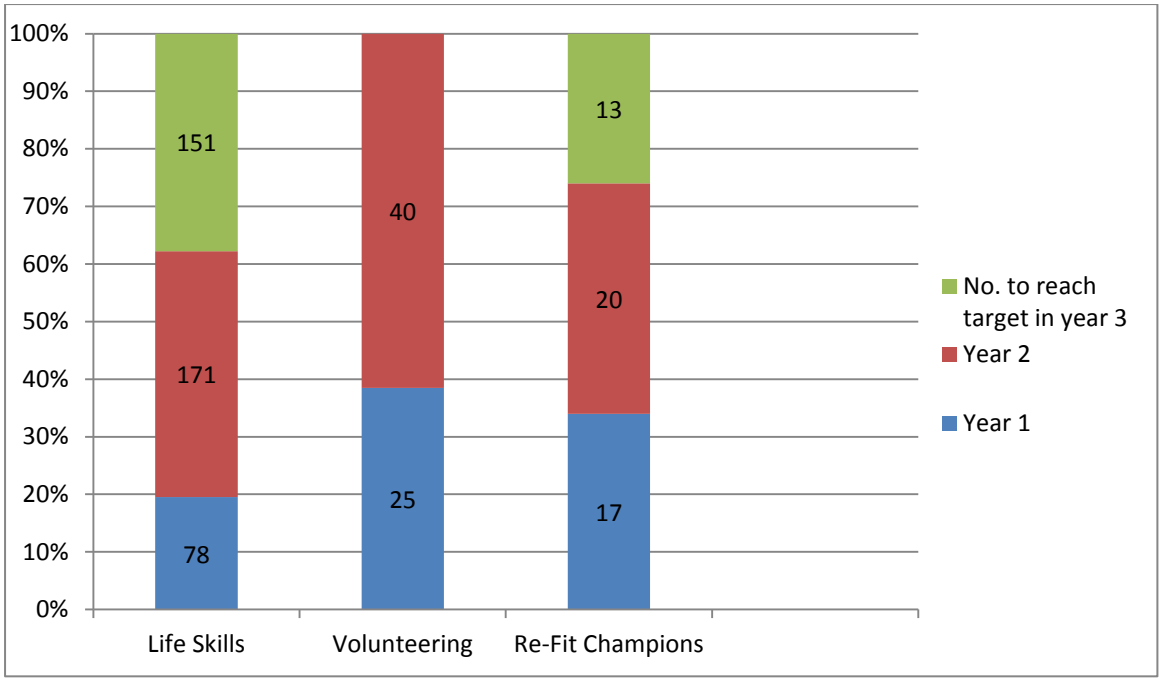
As in the previous report the number of those reporting decreased use is lower than the target but the KPI fails to count all those who have previously reduced their drug use and who are maintaining abstinence. We have added those numbers in outcome 3.3 to show that the actual figure of those with decreased use or no problematic drug use is far higher and already over double the target of 150.

WHEN ASKED ABOUT THEIR PROBLEMATIC SUBSTANCE USE SINCE STARTING REFIT
• 71% had remained abstinent • 12% had decreased their use • 7% had stayed the same • 10% did not have a substance use problem

So as in the last report none of the monitored service users reported an increase in substance use in the last year.

The positive effect that engaging in Re-Fit helps to achieve is seen by the percentages below. If we look at the service users who were monitored and answered the relevant question these are the results.





The graph above shows three of the outcomes with yearly totals as percentages of the 3 year target. This highlights where Re-Fit has improved on last year's figures and is on track to reach the target or in the case of signposting to volunteering, has already surpassed the 3 year target.

12. PREVIOUS FUTURE PLANS – UP DATE

REFERRAL INFORMATION

There were 360 referrals from 19 different organisations and these can be grouped into the following:

ORGANISATION	% of referrals 2017-18
Substance Misuse Services	45%
Self-referrals	27%
Criminal Justice partners	16%
Supported housing/homelessness services	9%
Employment Services	2%
Mental Health Services	1%

The more interesting statistics relate to the numbers that have actually engaged with Re-Fit following referral. If we exclude the self-referrals then only 49 people that were referred by a partner organisation engaged in the year which is only 14% of the total referrals received. Most of the information collected by this process is duplicated on the monitoring from when a service user actually attends. The collection of referral data is not used for monitoring as it is clearly not representative of those who attend so we plan to simplify the referral form to ask for contact details and serious risks that could affect the running of a session.

This low level of referrals that result in engagement is not particularly surprising. Organisations working with adults with complex needs will often signpost and refer to projects such as Re-Fit which they identify as being a positive step forward for their clients

when the individual themselves may not feel ready for. Also service users may agree to be referred as they may feel that attending Re-Fit would be a good goal to have yet they may still be living such a chaotic life that it proves to be out of their reach.

13. FUTURE PLANS

- We plan to simplify the referral form to make it less time consuming for those referring in as well as reducing the amount of personal data we collect for individuals who may never attend our project. We plan to concentrate on monitoring every new client who attends Re-Fit so that the monitoring data is completely representative of all those who attend. Weekly team meetings can identify new clients who if not already monitored can be prioritised.

- Regular ongoing monitoring will keep happening and we will try to ensure that frequent attendees do not get over-monitored whilst others are missed.
  This will involve reviewing the list of attendees against the recent monitoring forms so that facilitators can be given a monthly list of those who need monitoring in the following 4 weeks.

- We are in talks with Greggs about running work placements in Portsmouth.
- We are starting weekly Women only self-defence sessions.
- We will conduct a Stakeholder and Service user consultation to continue the development of the project in the future.

14. EQUALITY MONITORING

2.1 Who has benefited from your project?*

For each category give the percentage of people who have benefited from your project during this reporting period. You should only give details of the direct beneficiaries (the people who use the project), rather than any indirect beneficiaries (for example, their family).

The total for each table should always be 100 per cent.

Ethnic background	Percentage %
White	
English/Scottish/Welsh/Northern Irish/UK	88%
Irish	0%
Gypsy or Irish Traveller	0.8%
Any other white background	5%
Mixed / Multiple ethnic groups	
Mixed ethnic background	3%
Asian / Asian UK	
Indian	0.8%
Pakistani	0%
Bangladeshi	0%
Chinese	0%
Any other Asian background	0.8%
Black/African/Caribbean/Black UK	
African	0.8%
Caribbean	0%
Any other Black/African/Caribbean	0.8%
Other ethnic group	
Arab	0%
Any other	0%
Total	**100%**

Gender	Percentage %
Male	74%
Female	26%
Total	100%

Age	Percentage %
0 - 24 years	10%
25 - 64 years	90%
65 + years	0%
Total	100%

Disability	Percentage %
Disabled	7%
Not disabled	83%
Total	

Religion or belief	Percentage %
No religion	63%
Christian	35%
Buddhist	1%
Hindu	0%
Jewish	0%
Muslim	1%
Sikh	0%
Other religion	0%
Total	100%

Sexual orientation	Percentage %
Heterosexual	92%
Lesbians, gay men or bisexual people	8%
Total	100%

Only complete the following table if we asked for this information in your application form. If you are unsure whether to complete this table contact your funding officer:

Detailed age breakdown	Percentage %
0 - 4 years	0%
5 - 9 years	0%
10 - 14 years	0%
15 - 19 years	1%
20 - 24 years	9%
25 - 34 years	21%
35 - 44 years	38%
45 - 54 years	23%
55 - 64 years	7%
65 - 74 years	1%
75 - 84 years	0%
85 + years	0%
Total	100%

2.2 How have you arrived at these percentages?*

Explain what your percentages are based on, for example, data you routinely collect, surveys or monitoring forms.

These figures are based on the monitoring forms which ask for all the demographic information.

2.3 How well did you reach everyone who could benefit from your project?*

Describe what you've done to make sure everyone who could benefit from your project knew about it and was able to get involved. If you've not been as effective as you'd have liked, explain what you'll do differently in the future.

Firstly, We have a Re-Fit mailing list for all our referrers and other wrap around support services. We use this to disseminate and promote our activities.

Re-Fit staff also promote by attend different services team meetings to discussion our criteria, activities and referral processes.

We also try to offer a range of activities to appeal to a broader audience.

It should also be noted, that our demographics will mirror the wrap-around services that refer into us.

15. FINANCES

Budget Sheet

Revenue costs	Agreed Budget Year 2	ACTUAL Spend Year 2 (6 months)	Variance
Salaries, NI and Pensions	£77,452	**£79,488**	-2,036
Recruitment	£0	**£0**	0.00
General running expenses	£21,458	**£20,904**	£554
Training	£500	**£0**	£500
Travel	£750	**£729**	£21
Consultancy & advice (including evaluation)			0.00
			£0
Underspend from year 1 (trailer)	£3,736	**£2,775**	£961
Total revenue costs	£103,896	**£103,896**	£0

Overheads			
Staff	£7,576	**£7,576**	£0
Accommodation			£0
Utilities			£0
Other - please detail here			£0
Other - please detail here			£0
Total overheads	£7,576	**£7,576**	£0

Capital costs			
Refurbishment			£0
Professional and legal fees			£0
Office equipment			£0
Vehicles			£0
Other - please detail here			£0
Other - please detail here			£0
Total capital costs	£0	**£0**	£0
Total project costs	**£111,472**	**£111,472**	£0

16. RE-FIT TEAM

Dean Latona (BA Hons) – Manager

Dean has 9 years' experience of managing within the substance misuse sector. He is the former service manager of Southampton Drugs Intervention Program and is currently employed as the Psychosocial Treatment Manager within Southampton's Drug and Alcohol Recovery service. Prior to this he managed within the Homelessness sector. Dean co-founded Re-Fit's sister project Saints4Sport back in 2010. Dean manages the project from The Society of St James side.

Ashley Christopher (BSc Hons) - Team Leader

Ashley combines his love of sport with his in-depth knowledge of addiction behaviour to lead the Re-Fit team. Ashley has a BSc Hons in Therapeutic Intervention for Addictions. He has worked in a substance misuse services since 2002 from key-worker through to service manager. Ashley has brought much of his experience from Substance misuse services into the Re-Fit project in the way of processes and procedures, such as Risk Registers and Safeguarding. Ashley is a keen open-water swimmer, swimming in the sea all year round and regularly encouraging new swimmers to venture into open-water. The photo above shows him swimming the English Channel in August 2017.

James Cook- Re-Fit Sports Coordinator

Jim started as a Re-Fit volunteer and comes from an ex service user background, who came to Portsmouth from London to access treatment. Once in Recovery Jim quickly realised the importance of keeping active and busy, and so set about building a team to enter the Central Point Homeless football league. He then became part of a group that helped set up 'Street Revolution' Football in Portsmouth. What is testament to the contributions Jim has made, is him receiving the Local Meridian Award and being nominated for the Pride of Britain award. Again, Jim is much liked by our client group and is an inspiration for those in and out of recovery.

Paul Allen - Re-Fit Sports Coordinator

Paul has worked with Pompey in the Community for the past 15 years and is a UEFA B licensed coach who has coached at academy level and for the Hampshire women's and girls' Centre of excellence. Paul is also a qualified in food and nutrition, he is a health and fitness trainer and boxing tutor. He is responsible for setting up men's health groups, dementia groups and walking football for the over 50s. He has worked in various treatment centres in Portsmouth delivering health and wellbeing linked to physical activity on behalf of Pompey in the Community. Paul started working on the Re-fit pilot project from the very start and has been a fundamental part of the success and growth of Re-Fit, again much liked and respected by our client group.

Clare Freemantle (BA Hons) - Administrator/Employment Officer

Clare Freemantle is an English degree graduate with experience in working within a substance misuse clinical service, Re-Fit, Saints4Sport and a Psychosocial treatment team. During this time Clare has facilitated and supported different psychosocial groups, including Creative Writing, Fishing, Golf and Health & Social NVQ's. Alongside this Clare is also running the European Social Funded Employment Project. In Clare's spare time she writes comedy and has done a bit of stand up, these skills make her very approachable and much liked by our client group.

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