



# 10-year strategic plan for the drug and alcohol treatment and recovery workforce (2024–2034)

July 2024



## Version Control Table

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1.1	10-07-2024	NHSE	<ul style="list-style-type: none"> <li>• <i>Clarification that DANOS competencies will remain in the National Occupational Standards (NOS)</i></li> <li>• <i>Clarification of the consultant and practitioner psychologist numbers from the National Workforce Census</i></li> <li>• <i>Inclusion of additional acknowledgments into Appendix 6</i></li> </ul>

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# Foreword by Secretary of State for Health and Social Care

In 2019, the then Home Secretary appointed Professor Dame Carol Black to undertake an independent review on drugs.

As the then Minister for Crime, Safeguarding and Vulnerability, I shaped the review's commission to ensure that it would give the Government the tools we needed to crack down on the supply of drugs, drive down demand, and tackle the range of harms they inflict on individuals, our public services, and our society.

Dame Carol's review was a comprehensive and accomplished piece of research and a bold step forward in combatting drug dependence and the plethora of harms it causes. After it was published, Government committed to building on her work, tackling the threat drugs pose head-on, and ensuring that victims of this nefarious illegal industry receive the support they deserve.

In 2021, we published an ambitious and wide-ranging 10-year Drugs Strategy to cut crime and save lives. Improving and expanding treatment and recovery services is central to this mission, and we cannot do this without a resilient, well-trained, and properly supported workforce. That is why the Drugs Strategy committed to rebuilding the professional workforce and developing a comprehensive drug and alcohol treatment and recovery workforce strategy.

As Secretary of State for Health and Social Care, I am delighted to be delivering that commitment through this Drug and Alcohol Treatment and Recovery Workforce Strategic Plan. This vital plan will grow, strengthen, and support our workforce, and be a cornerstone from which the government and our partners can build a world-class treatment and recovery system by 2031.

It will deliver better training and development opportunities for frontline staff and bring more new and experienced professionals into the workforce. So that services are stronger, staff are better supported, and we can help more people transform their lives from harm to hope.

**The Rt Hon Victoria Atkins MP**

**Secretary of State for Health and Social Care**

## Foreword by the Parliamentary Under Secretary of State

This government's 10-year drug strategy, backed by almost £900 million of additional funding, is already helping to transform drug and alcohol treatment and recovery services up and down the country.

We know that drug and alcohol dependence harms lives, families and communities, as well as driving nearly half of all burglaries, robberies and other acquisitive crime. We also know that people accessing treatment often have severe and complex needs. However, with the right support people can and do recover. That is why this government has put growing and nurturing the workforce front and centre of its commitment to deliver a world-class drug and alcohol treatment and recovery system.

The Department of Health and Social Care has partnered with NHS England to deliver a national drug and alcohol treatment and recovery workforce transformation programme. Central to the programme is this first of its kind strategic plan, which will guide and underpin national and local workforce transformation activity over the next decade.

We are extremely proud of this specialist part of the health workforce and the resilience it has shown, despite consistent pressures. I am especially delighted at the progress already made to realise the drug strategy expansion targets. In 2022/23, local authorities and service providers recruited more than 1,250 drug and alcohol workers and 170 medical, mental health and other regulated professionals.

We must keep this momentum going and focus our efforts on sustainably growing, training and retaining a high-quality workforce, and this strategic plan will help employers to do just that.

I would like to show my utmost appreciation to NHS England and wider sector partners for their dedication to workforce transformation. With this plan in hand and this evident determination, the drug and alcohol treatment and recovery sector will soon be an exemplar of a specialist, multidisciplinary workforce with the capacity and capability to meet the needs of those it serves, now and for the future.

**The Rt Hon Andrea Leadsom MP**

**Parliamentary Under Secretary of State (Minister for Public Health, Start for Life and Primary Care)**

## Executive Summary

Dame Carol Black's independent review of drugs<sup>1</sup> called for the drug and alcohol treatment and recovery workforce to be rebuilt to deliver better outcomes for the people it serves.

In response, the government committed to developing a comprehensive workforce strategy and invested an additional £532 million between 2022 and 2025 to improve the capacity and quality of drug and alcohol treatment. This additional funding is supporting the expansion of the workforce by the end of 2024/25 with:

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

In the first year of the additional Supplemental Substance Misuse Treatment and Recovery Grant (SSMTR) funding, local authorities (LAs) planned to meet or exceed drug strategy recruitment targets for 7 of the 10 roles. The sector successfully recruited 1,700 additional staff including 170 medical, mental health and other regulated professionals and 1,250 drug and alcohol workers. The 2022/23 drug strategy recruitment targets for nurses, social workers and pharmacists were achieved. By September 2023/24, over 2,400 staff had been recruited using SSMTR funding. However, in years 2 and 3 of SSMTR funding, LAs reduced their ambition for most regulated roles, meaning recruitment of 5 of these regulated role types is unlikely to meet drug strategy targets. This indicates that LAs have responded to the ambition to recruit more regulated professionals, but the skills shortages have limited their ability to meet targets and moderated their ambition in later years.

The Office for Health Improvement and Disparities (OHID) and NHS England have already delivered the two comprehensive national drug and alcohol treatment and recovery workforce censuses and formed cross-sector groups of psychologists and psychiatrists to develop action plans focused on expanding these professions in the sector through recruitment, education and training.

The publication of this strategic plan and the forthcoming capability framework will underpin the work of the 10-year workforce transformation programme. In addition, the [NHS Long Term Workforce Plan](#) commits to joint work between [NHS England](#) and the [Department of Health and Social Care \(DHSC\)](#) to develop the drug and alcohol treatment and recovery workforce over the course of the drug strategy.

These firm foundations for workforce transformation provide a real opportunity to develop a sustainable, multidisciplinary drug and alcohol treatment and recovery workforce, equipped

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<sup>1</sup> Department of Health and Social Care (2020) 'Independent review of drugs by Professor Dame Carol Black'. Available at: [www.gov.uk/government/collections/independent-review-of-drugs-by-professor-dame-carol-black](http://www.gov.uk/government/collections/independent-review-of-drugs-by-professor-dame-carol-black)  
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with the skills to reduce the harm of problematic drug and alcohol use and help more people to initiate and sustain recovery.

To adopt this approach, all parts of the system need to play their part. This includes: government; national professional bodies and regulators; commissioners; service providers, including treatment and lived experience recovery organisations; employers; training and education providers; and regional support teams.

This strategic plan for the drug and alcohol treatment and recovery workforce outlines our commitments for and the actions required by all in the next year underpinned by a £257m investment. It sets out the path in the next 3 years, 5 years and 10 years to achieve this vision by 2034. It has been developed by the OHID and NHS England through extensive sector engagement.

The plan has 3 parts:

1. **Context:** outlining the context of the plan and how it works with other workforce programme products, such as the capability framework and multidisciplinary workforce calculator
2. **Strategic actions:** providing actions with guidance to help improve the entire workforce and each of the sector's core roles
3. **Priority action plan:** an action plan focused on the priority actions for the next year, next 3 years, next 5 years and next 10 years

Each part is structured around 3 interconnected priorities. These are:

1. **Reform**
2. **Recruit**
3. **Train, develop and retain**

The key elements of the plan are to:

- provide clarity on the roles required to deliver effective drug and alcohol treatment and recovery services through the development and implementation of the capability framework
- develop training programmes in line with the capability framework and standardise and accredit training for drug and alcohol workers
- increase the professional mix in the sector, attracting and retaining more medics, nurses, psychologists, social workers and pharmacists
- significantly improve the quality and coverage of clinical supervision and enhance clinical governance systems



- develop the pipeline for regulated professionals entering the system

The publication of this strategic plan and the forthcoming capability framework are both important steps towards this. These will provide the foundation for better and more consistent training, career progression and longer-term workforce planning.

The key actions within the 3 overarching workforce priority actions are outlined below.

### 1. Reform

Effective clinical supervision supports both professional development and evidence-based treatment and recovery. Regulated professionals have a central role to play in leading clinical governance and supervision structures within organisations. With 800 medical and mental health professionals joining the sector by 2025, this will strengthen and enhance clinical governance structures and promote a culture that prioritises workforce wellbeing and career development. This will lead to improved caseload management and improved practice and establish a firm foundation for future workforce development.

By March 2025:

- commissioners will have workforce planning underpinned by the standardised expectations set out in the forthcoming capability framework and the tailored outputs of the workforce calculator tool
- OHID and NHS England will clarify and promote standards for both high-quality clinical governance and clinical supervision
- employers will have employee wellbeing initiatives in place that meet requirements

By March 2027:

- with more regulated professionals in place leading clinical governance and supervision structures, service providers will have clinical supervision that meets requirements. Clinical supervision will ensure that the frontline workforce is supported to develop their knowledge, skills and competence and to provide high quality care. It will also support the recruitment and retention of all frontline staff especially regulated professions.
- employers and service providers will have training for all staff in line with this strategic plan and the capability framework

By March 2029:

- with regulated professional numbers maintained and evidence-based practice embedding across the sector, service providers will have clinical governance structures, led by a regulated professional, that fully meets requirements. This will support recruitment and retention generally and especially of regulated professions.

## 2. Recruit

Local authorities and delivery partners must recruit multidisciplinary teams (MDTs) in line with the drug strategy expansion targets, using the workforce calculator to inform MDT workforce planning and in line with the capability framework. OHID and NHS England are leading national initiatives to support improved recruitment with a focus on attracting regulated professionals into the sector, notably, psychologists and psychiatrists.

By March 2025:

- employers will recruit regulated and currently unregulated roles in line with drug strategy expansion targets, the capability framework and workforce calculator. This includes regulated roles such as medics, nurses, psychologists, social workers and pharmacists. The expansion of regulated professions will help to strengthen clinical governance structures and clinical supervision provision.

By March 2027:

- employers will continue to recruit roles in line with drug strategy ambitions, the capability framework and workforce calculator.

## 3. Train, develop and retain

By formalising the training and skills required of currently unregulated roles such as drug and alcohol workers, peer support workers (PSWs) and commissioning roles, these roles will be better equipped to deliver and commission effective interventions. More training placements and posts for regulated professionals will help attract them into the sector and ensure there is capacity to train the next generation of specialists. Building sustainable pipelines of regulated professionals into the sector is crucial, especially for psychology and psychiatry. OHID supported by NHS England will lead national initiatives to improve these pipelines.

By March 2025:

- NHS England will work to secure additional addiction psychiatry training posts to expand the bank of posts currently available
- OHID will explore with the Royal College of Psychiatrists (RcPsych) development of a pathway for consultants to train and demonstrate equivalence to become addiction specialists (credentialing)
- OHID and NHS England will have developed drug and alcohol worker, children and young people's drug and alcohol worker (CYP D&A worker) and PSW curriculums

By March 2027:

- OHID and NHS England will have supported the accreditation of training for drug and alcohol workers, CYP D&A workers and PSWs



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- service providers will have expanded training placements for regulated roles
- commissioners and service providers will have access to apprenticeship routes into regulated roles

By March 2029:

- employers and service providers will have the first cohorts of drug and alcohol workers, CYP D&A workers and PSWs completing accredited training

This plan marks a step change in the development of the workforce, supporting the delivery of world-class, evidence-based drug and alcohol treatment and recovery systems of care by 2034.

# Part 1: Context

## Introduction

This 10-year strategic workforce plan will support the transformation of the drug and alcohol treatment and recovery workforce over the next decade (2024–2034). It lays out the context for this and the actions required for workforce transformation.

Dame Carol Black's [independent review of drugs](#)<sup>1</sup> called for radical reform of the drug and alcohol treatment workforce, leadership, funding and commissioning, so that services can be rebuilt and transformed to meet the needs of the people they serve. The review identifies a shortage of funding as the primary reason for a loss of capacity and expertise in the sector<sup>1</sup>. Historical changes and reduced funding have been linked to workforce challenges resulting in a high number of posts that do not require professional registration with a regulatory body. This resulted in a workforce that was not fit for purpose as it was overburdened, undertrained, under supported and tasked with providing care, treatment and recovery support to people who often have numerous interconnected health and social care needs. For example, people under the care of drug and alcohol treatment and recovery services have commonly experienced significant trauma and have high rates of multiple co-occurring mental and physical health conditions<sup>2</sup>.

It should be applauded that despite funding and resources being squeezed, the sector has worked extremely hard to provide valuable care, treatment and recovery support to people who use(d) drugs and/or alcohol.

The government's 10-year drug strategy, [From harm to hope: A 10-year drugs plan to cut crime and lives](#)<sup>3</sup>, committed that:

“Within a decade, we will have a world-class drug and alcohol treatment and recovery system across England, delivered via a highly trained and motivated workforce offering a full range of evidence-based interventions.”

To achieve this, the government committed to a range of actions to support workforce transformation, including:

- work with HEE (Health Education England, now part of NHS England) to implement a comprehensive strategy to expand the workforce through effective recruitment and retention

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<sup>2</sup> Public Health England (2017) 'Better care for people with co-occurring mental health, and alcohol and drug use conditions. Available at: [www.gov.uk/government/publications/people-with-co-occurring-conditions-commission-and-provide-services](http://www.gov.uk/government/publications/people-with-co-occurring-conditions-commission-and-provide-services)

<sup>3</sup> Department of Health and Social Care (2022) 'From harm to hope: A 10-year drugs plan to cut crime and save lives'. Available at: [www.gov.uk/government/publications/from-harm-to-hope-a-ten-year-drugs-plan-to-cut-crime-and-save-lives](http://www.gov.uk/government/publications/from-harm-to-hope-a-ten-year-drugs-plan-to-cut-crime-and-save-lives)

- work with HEE (now part of NHS England) to define and improve the training and skills of all sections of the drug and alcohol treatment workforce, including regulated health professionals, drug and alcohol workers and PSWs
- work with the royal colleges and groups of professionals, peer workers, service providers and service users to create a Centre for Addiction for everyone working within substance misuse services
- develop guidance and relevant standards to support a reduction in caseload sizes to enable staff to deliver high-quality interventions and pursue career and professional development
- make funding available (by the end of 2024/25) for:
  - 800 more medical, mental health and other professionals
  - 950 additional drug and alcohol and criminal justice workers
  - adequate commissioning and co-ordinator capacity in every local authority

Analysis of workforce recruitment numbers by OHID indicates the sector has already made great strides in rebuilding the workforce. This includes, in year 1 of the additional SSMTR funding, recruiting over 1,700 additional staff including:

- over 170 medical, mental health and other regulated professionals, meeting the 2022/23 drug strategy recruitment targets for nurses, social workers and pharmacists
- over 1,250 drug and alcohol workers

By September 2023/24, over 2,400 staff had been recruited using SSMTR funding. Around 1,500 additional staff were also recruited with the Rough Sleeping Drug and Alcohol Treatment (RSDATG), Housing Support Grant (HSG), and Individual Placement and Support (IPS) funding by the end of 23/24.

In year 1 of the SSMTR grant, LAs planned to meet or exceed drug strategy recruitment targets for 7 of the 10 role types. This included 2 of the 3 unregulated roles (drug and alcohol workers and commissioners), and 5 of the 7 regulated roles (addiction psychiatrists, consultant psychologists, nurses, pharmacists and social workers). They succeeded in meeting targets for drug and alcohol workers and nurses, pharmacists and social workers.

In years 2 and 3, LAs reduced their ambition for most regulated roles, meaning recruitment of 5 of these role types (addiction psychiatrists, psychologists – practitioner and consultant, GPs and pharmacists) is unlikely to meet 2024/25 drug strategy targets. LAs have maintained their ambition to meet or exceed the drug strategy expansion targets for both nurses and social workers and were on track to do so as of September 2023. This indicates that LAs have responded to the ambition to recruit more regulated professionals, but the skills shortages have limited their ability to meet targets and moderated their ambition in later

years. Recruitment of regulated role types, especially psychologists and psychiatrists, requires concerted collective effort over the next decade.

Data, from the drug and alcohol workforce census<sup>4</sup>, for the whole drug and alcohol treatment and recovery workforce indicates that there were roughly 3 frontline roles to every 1 clerical, managerial, data and commissioning role in the treatment delivery and commissioning workforce as of 30<sup>th</sup> June 2023. Data also indicates that for every 1 regulated professional or pre-registration trainee in the frontline workforce there were 4 to 5 people in unregulated role types.

The changes within the drug and alcohol sector are happening alongside wider redesign and workforce transformation in other areas of health and social care. The [NHS Long Term Workforce Plan](#) commits to training, retaining and reforming the NHS workforce and includes plans that will impact the drug and alcohol sector and workforce both directly and indirectly. It also specifically commits to joint work between NHS England and the Department of Health and Social Care (DHSC) to develop the drug and alcohol treatment and recovery workforce over the course of the drug strategy.

### About this plan

This strategic plan has been commissioned by the [Office for Health Improvement and Disparities](#) (OHID) and provided by NHS England to support and underpin the national drug and alcohol treatment and recovery workforce transformation programme.

It has been developed through wide cross-sector engagement, with representation from: national bodies; drug and alcohol treatment service providers; lived experience recovery organisations (LEROs); frontline staff; commissioners; and people with lived experience of using drug and alcohol treatment and recovery services, their families, carers and affected others who support them. This included: steering groups; focus groups with people with lived experience; focus groups with staff; one-to-one conversations; and a workforce survey. The engagement activity completed to inform the development of this plan, including acknowledgements, is outlined in [Appendix 6](#).

This plan has been developed to be aligned with:

- [national clinical guidelines for drug and alcohol misuse and dependence](#)
- [forthcoming national clinical guidelines for alcohol treatment](#)
- [the National Institute for Health and Care Excellence \(NICE\) guidance](#)

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<sup>4</sup> [The National Drug and Alcohol Treatment and Recovery Services Workforce Census Report: England workforce data \(December 2023\)](#). An NHS Benchmarking Network ([www.nhsbenchmarking.nhs.uk](http://www.nhsbenchmarking.nhs.uk)) project commissioned by NHS England, December 2023  
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- **NHS Long Term Workforce Plan**

This plan is intended to be used by all those with a role in drug and alcohol workforce development including:

- strategic policymakers
- royal colleges
- professional and service regulators
- **integrated care systems (ICSs) and integrated care boards (ICBs)**
- local authority (LA) commissioners
- education and training commissioners
- LEROs
- clinical, professional and operational leads
- service and team managers
- team leaders, senior practitioners and supervisors
- frontline staff

This strategic plan is divided into 3 parts.

**Part 1** outlines the context for the plan. This includes its scope and how to use it alongside other workforce-specific and related resources.

**Part 2** provides details of the implementation and actions required by each part of the sector to improve the whole workforce and each core role in the sector. It is divided into 2 main sections. The first section covers the whole workforce and applies across all role types within the sector. The second section covers core roles in the sector with a focus on those with drug strategy expansion targets.

The specific roles covered are:

- nurses and nursing associates
- **social workers**
- medical workforce
- **pharmacists** and pharmacy technicians

- psychological professions
- drug and alcohol workers
- children and young people's drug and alcohol workers (CYP D&A workers)
- peer support workers (PSWs)
- volunteers (all unpaid roles)
- commissioners

**Part 3** provides a high-level action plan for the next year, 3 years, 5 years and 10 years. It identifies who is responsible for each action.

The appendices include:

- best practice resources on international recruitment ([Appendix 1](#)), clinical supervision ([Appendix 2](#)), return to practice ([Appendix 3](#)) and workforce planning ([Appendix 4](#))
- a glossary of key definitions ([Appendix 5](#))
- an outline of how this plan was developed, including acknowledgements ([Appendix 6](#))

### Scope

This strategic plan applies to the settings outlined below:

- LA-commissioned adult community drug and alcohol treatment and recovery; children and young people's drug and alcohol treatment; residential rehabilitation; and inpatient detoxification service providers, including NHS and voluntary sector providers and some LA-delivered service provision
- services funded by LAs through the local drug and alcohol treatment budget and those funded by the public health grant, Supplemental Substance Misuse Treatment and Recovery Grant (SSMTRG), Rough Sleeping Drug and Alcohol Treatment Grant (RSDATG), Individual Placement and Support (IPS) and any other drug and alcohol treatment and recovery-related direct grants from OHID to LAs. This includes general practitioners (GPs) who are commissioned by an LA to treat people dependent on drugs and alcohol as part of a shared care arrangement with a specialist drug and alcohol treatment service, or as part of a LA-commissioned primary care-led or other specialist treatment service
- LEROs, which are organisations led by people with lived experience of recovery that deliver a range of harm reduction interventions, peer support and recovery support, and help people to access and engage in treatment and other support services



- LA drug and alcohol-specific commissioning teams in public health

The settings below are out of the scope of this strategic plan:

- non-specialist workers who screen and refer into drug and alcohol specialist settings
- pharmacists in retail community pharmacies and hospital pharmacies (only pharmacists directly employed by treatment services are within scope)
- GPs treating people dependent on drugs and alcohol but not commissioned to do so by an LA either as part of a shared care arrangement with a specialist drug and alcohol treatment service or as part of an LA-commissioned primary care-led or other specialist treatment service
- NHS England-commissioned substance misuse teams in secure settings
- NHS-funded alcohol care teams (ACTs)

While some services and healthcare providers are outside of the scope of this plan, it is recognised that there is a need for stronger links between the wider health and social care system and the drug and alcohol treatment and recovery sector. Collaboration across all system partners at both local and national levels will ensure greater cohesion and enable the operational effectiveness of this strategic plan. When this document refers to drug and alcohol treatment and recovery services, service providers, workforce or sector, it refers to the LA-commissioned community, inpatient and residential treatment and recovery services, workforce and sector. When this strategic plan refers to LEROs, it refers to all LERO provision, regardless of whether it is or is not commissioned by an LA.

### How to use this plan

This plan is not to be used in isolation. It should be used alongside:

- national clinical guidance, including [Drug misuse and dependence: UK guidelines on clinical management](#), the forthcoming alcohol treatment guidelines and NICE guidance
- best practice guidance, including the [Drug and alcohol commissioning quality standard \(CQS\)](#)
- wider workforce planning resources such as the [NHS Long Term Workforce Plan](#) and the tools outlined in [Appendix 4](#)

Two key workforce programme products will be published in Summer 2024. These are outlined below.

The forthcoming **capability framework** will underpin the national drug and alcohol treatment and recovery workforce transformation programme. This framework has been developed following Dame Carol Black's independent review of drugs<sup>1</sup> which found that the Drug and Alcohol National Occupational Standards (DANOS) no longer reflect the current needs of the sector<sup>1</sup>. The new capability framework will therefore provide guidance on the knowledge and skills required for core roles in the sector. The DANOS competencies will remain in the National Occupational Standards (NOS).. It is due to be published in Summer 2024. It will include role-specific profiles and job capability statements for drug and alcohol workers, nurses, psychologists, PSWs, CYP D&A workers, senior drug and alcohol workers, social workers, pharmacists, commissioners, adult focused family workers and child focused family workers. Role profiles are also included for counsellors, medical workforce and leadership and management. The capability framework must be used by LAs and service providers to:

- design and commission a multidisciplinary workforce able to deliver evidence-based treatment and recovery interventions
- plan training and skills development for specific roles that link to whole workforce training and development
- have consistent job descriptions, job titles and contracts for roles across the sector
- enable sector-wide consistency on the capabilities and expectations of roles
- aid the assessment of the skills gap in the workforce
- support future service planning and design

An **MDT workforce calculator** will be available in Summer 2024. This has been developed by NHS England and OHID to support LA drug and alcohol commissioners and service providers to understand the current and future adult drug and alcohol workforce needs, numbers and skill mix required to meet local treatment population needs. This tool is based on clinical consensus (reached via a clinical consensus group) and existing clinical guidelines. The calculator will support commissioners and service providers to build MDTs capable of delivering evidence-based community treatment and will allow for additional workforce uplift to meet the complexities of some of the treatment population. The calculator will not include target-based or specialist roles, inpatient or residential treatment settings. The calculator will work at local treatment system or LA level. It will not always necessarily apply in full at an individual service level, depending on where an individual service sits in the care pathway of a local treatment system and what it is commissioned to deliver as part of the system.

Other workforce programme activity is outlined below.

The **national drug and alcohol treatment and recovery workforce census**. NHS England has commissioned the NHS Benchmarking Network (NHSBN) to undertake a census of the

drug and alcohol treatment and recovery workforce employed by services in the scope of this programme. Subsequently, two censuses have been completed, and their findings have been made publicly available. Those findings have influenced recruitment, retention and workforce development within this strategy. NHSBN brought together representatives from those service types in scope to help shape this unique primary data collection. These annual censuses provide an analysis of the workforce and assist NHS England and OHID in building a comprehensive national workforce profile. This enables collaborative working between key strategic partners to inform education and workforce planning and investments. The first census report is currently accessible on the [HEE \(now known as NHS England\) website](#). The second census report is available on the [NHSBN website](#). The forthcoming report for 2024 will be available in Winter 2024/25.

An **annual workforce delivery plan** underpins NHS England's components of the workforce transformation programme. This includes:

- plans to expand the development of training placements within drug and alcohol treatment and recovery services, including but not limited to regulated professionals
- identifying opportunities to upskill and develop the existing workforce to ensure that it continues to thrive and grow
- exploring opportunities for the introduction of innovative roles recently developed for mental health services into drug and alcohol treatment and recovery services where appropriate
- working with OHID to identify sustainable and innovative recruitment and retention strategies that can be integrated into annual planning cycles

The **establishment of role-specific expert engagement networks** is underway. Role-specific cross-sector groups for psychology and psychiatry leads are already playing a key role in contributing to the development of workforce transformation programme deliverables for these professions.

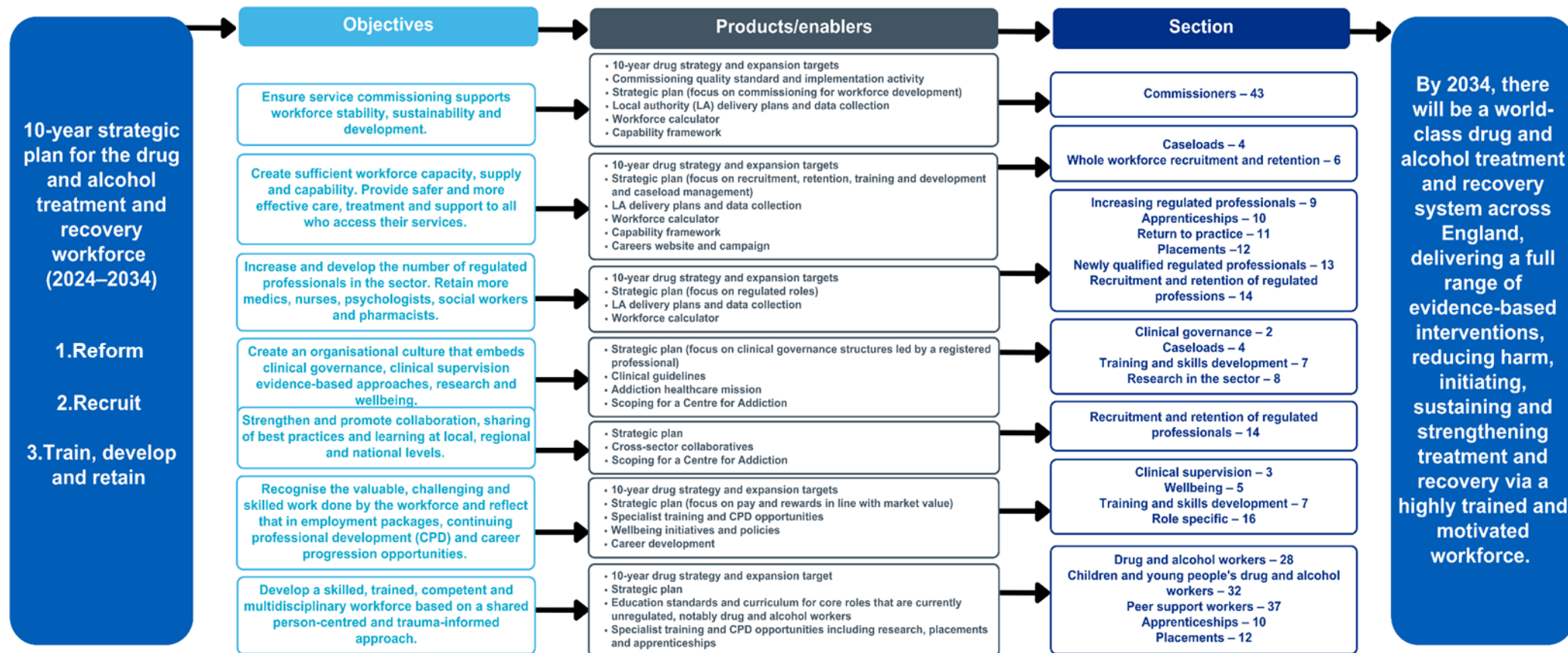
A new **Centre for Addiction** for everyone working within drug and alcohol treatment and recovery services is planned. It is proposed that this centre will enable the development and delivery of specialist training and continuing professional development opportunities for the sector and the sharing of best practices, as well as providing leadership on workforce development at a national level. Scoping to inform the remit of and best way to establish this centre is planned for 2024/25.

Other relevant activity related to workforce that is underway as part of other drug strategy programmes is outlined below.

A national **drug and alcohol commissioning quality standard (CQS)** has been published by OHID. Further resources and ongoing support are supporting the implementation of this standard.

A **shared mental health workforce action plan**. This is focused on the mental health workforce, not the drug and alcohol treatment and recovery workforce but will benefit workers in the sector. When consulting with stakeholders to inform the development of this plan, we heard how people who use(d) drugs and/or alcohol often do not attend hospitals or health and social care appointments due to experiences of being judged or negative attitudes from health and social care staff. This arguably contributes to the health inequalities seen among this population. Improved multi-agency working is clearly needed for people who use(d) drugs and/or alcohol, with a move away from the notion that they and their needs can and should be met by only one part of the health and care system. DHSC and NHS England are currently reviewing the mental health workforce training needs as part of the drug strategy commitment to develop a shared action plan to address gaps in provision for people with co-occurring needs relating to mental health, drugs and alcohol.

# 10-year strategic plan for the drug and alcohol treatment and recovery workforce



**Figure 1: Drug and alcohol programme transformation enablers**

Figure 1 shows how the workforce programme and other workforce-related products and enablers will support the achievement of the workforce programme’s strategic objectives. It also indicates which actions in this plan are linked with each objective. The ‘section’ column serves as a navigational tool for Part 2, mapping out the sections and their themes while also cross-referencing section numbers.

## Steps of workforce transformation

### Key workforce priorities

This plan identifies 3 interconnected workforce priorities. These are:

1. Reform
2. Recruit
3. Train, develop and retain

### Reform

It is important that during this period of change there is a focus on organisational structure and processes through clinical governance and building capacity for leadership that supports both new staff joining the sector and the current workforce managing this significant transformation. Clinical governance, caseload management, training, clinical and management supervision and mentoring all need to be accounted for within workforce planning to enable time to be used in a meaningful and sustainable way.

Recruiting regulated professionals as a priority will enable clinical leadership to be in place, with governance structures being strengthened alongside robust clinical supervision, management supervision, caseload management and wellbeing processes, before unregulated roles or newly regulated supervisees join the sector. The new MDT workforce calculator tool will support LA drug and alcohol commissioners, as well as treatment and recovery service providers, to better understand the current and future workforce requirements and the skill mix necessary to meet local treatment population needs. The calculator will be published in Summer 2024.

Clinical supervision crucially enhances care provision by supporting and encouraging professional development with the aim of improving care, treatment and support for people accessing services<sup>5</sup>. As outlined in the national clinical guidelines on drugs, and as echoed in the clinical guidelines for alcohol treatment:

“A key role of senior clinicians is to oversee the balanced implementation of a range of psychosocial interventions within overall programme design and the needs of people in treatment. **Clinical supervision is the predominant method by which the quality of psychosocial interventions is assured.**”

The supervision a practitioner receives should monitor how they put the skills and competencies gained in training into practice, including core skills in development of

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<sup>5</sup> Tomlinson, J. 'Using clinical supervision to improve the quality and safety of patient care: A response to Berwick and Francis', BMC Medical Education 2015: volume 15, issue 103. Available at: <https://doi.org/ten.1186/s12909-015-0324-3>

therapeutic alliance, motivational work and any more specific techniques or interventions used. Effective supervision requires the supervisor to have competencies in both the intervention being supervised and the process of supervision itself.

Services providing psychosocial interventions therefore need staff of sufficient seniority and competence to provide effective supervision and to monitor the overall quality of treatment delivered. All clinical services should build in adequate time to both deliver and receive supervision in the routine work plan of all staff.”

Increasing the number of regulated professionals in drug and alcohol treatment and recovery services who can offer clinical leadership will also support services in better navigating and interfacing with external services, such as other health or social care, and challenging clinical decisions to ensure holistic care for people from multiple agencies when required.

At a national level, cross-sector collaboratives should continue to be formed and sustained to share best practices and to help to create national networks of those working in the sector, moving away from silo working. There is considerable existing collaboration across providers and LAs. This includes, for example: [Collective Voice](#), [NHS Addictions Provider Alliance](#), [College of Lived Experience Recovery Organisations](#), and the [English Substance Use Commissioners’ Group](#). This already collaborative approach provides a firm foundation for future collective action.

At a local level, ICSs are in a strong position to support local collaborations, with multiple organisations formally coming together for co-commissioning opportunities and joint working. Collaborative arrangements<sup>6</sup> could see providers coming together for greater efficiency, enabling integration of quality research, increased sustainability by making better use of the available workforce, recruiting regulated professions, providing stability for career development and improving quality of care by standardising clinical, non-clinical and commissioning practice.

### Recruit

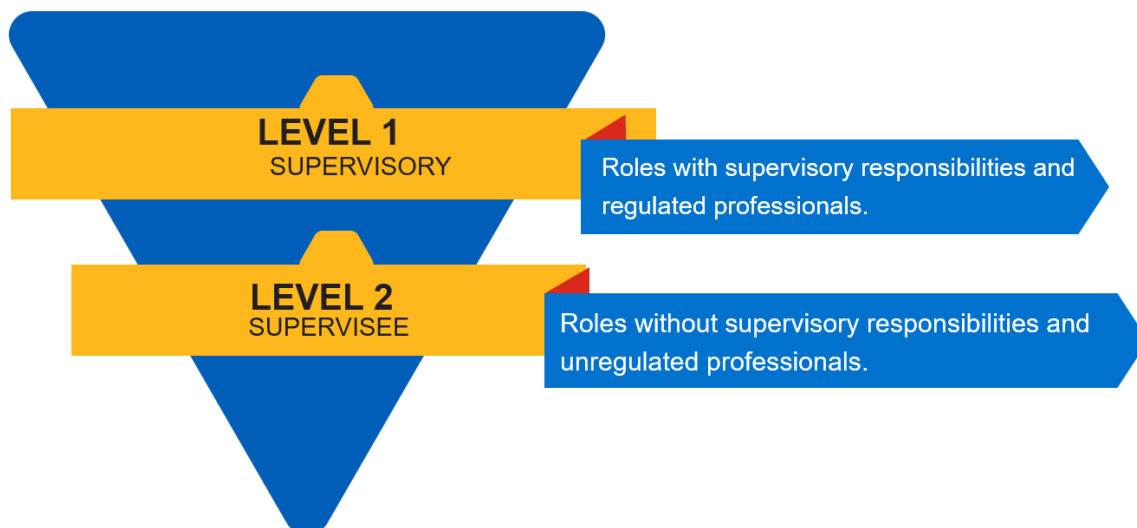
Recent drug strategy investment has seen a recent expansion in the number of unregulated roles in the sector and additional management capacity has been brought in to support this expansion. It is now important to focus recruitment efforts on expanding the number of clinical supervisors and regulated professionals in the sector. As outlined in Figure 2, this strategic plan recommends that:

- posts with supervisory responsibilities and posts for regulated professionals should be prioritised in the next phase of recruitment

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<sup>6</sup> Wickens, C (2022) ‘Provider collaboratives: explaining their role in system working’, The King’s Fund. Available at: [www.kingsfund.org.uk/publications/provider-collaboratives](http://www.kingsfund.org.uk/publications/provider-collaboratives)  
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- roles without supervisory responsibilities and those that are currently unregulated are then further expanded with supervisors already in place



**Figure 2: Recruitment model**

The interconnected and diverse needs of people in drug and alcohol treatment require a proportionate number of regulated professionals to deliver clinical leadership, specialist interventions and treatment, and uphold clinical governance structures.

When planning for the expansion of the workforce, commissioners and service providers need to remain mindful of the additional responsibilities and impact on workload that the steps in this action plan bring.

### **Train, develop and retain**

The sector must foster a learning, development and research culture, prioritising the expansion of strong links with universities and higher education institutions (HEIs) and offering training and education placements. This will make the sector an attractive, dynamic and vibrant place to work, with a wide range of roles offering clear career development opportunities and a sustainable career in a sector offering evidence-based care. Having a focus on pre-registration student placements and apprenticeships linked with universities and training providers will help to develop a pipeline of new graduates joining the sector. Those in the sector who are already successfully improving placement uptake have done so by strengthening links to education providers.

A strong professional identity plays a pivotal role in this journey. Fostering shared values, norms, skills and behaviours within a group or sector results in them ‘thinking, acting and feeling’ in a shared way. A professional identity enables people to attach meaning to their work as well as to develop a sense of self and a perception of belonging. A strong professional identity has positive consequences for individuals and their colleagues and has



been linked to an increase in autonomy and resilience, enhanced wellbeing and the ability to mitigate burnout and ethical decision-making in difficult situations. It also drives better care.

The expansion of psychological professions into the sector is already being supported through the introduction of the [mental health and wellbeing practitioner \(MHWP\) role](#), with 18 trainees beginning their training in 2022/23. The scoping of clinical psychologist and nursing placements is also underway by NHS England. This scoping exercise will identify opportunities to expand and create new place-based training opportunities in the drug and alcohol treatment and recovery sector. There is the potential for services to have 42 additional places, bringing the total to 70 clinical psychology training places in the sector subject to services' ability to provide appropriate supervision for the trainees. NHS England will continue to work with DHSC to look to secure additional psychiatry placements for 2024–2025.

Providers and commissioners should also recognise their responsibility in enabling and facilitating research in the sector. This will not only provide important insights into evidence-based treatment and recovery interventions but will also create additional professional development opportunities for employees.

Having an approach to recruitment led by supervisory and regulated posts will also improve staff retention rates by ensuring that people are well trained and supported in their roles. In particular, this approach will support improved retention of the regulated workforce by ensuring that there are clear structures, guidance and processes around not only regulated roles, but all roles within the MDT.

The key actions within each of these priorities are outlined in the priority action plan in [Part 3](#).

Figure 3 provides a roadmap breaking down the key activities by who is responsible for them. The roadmap gives an overview of the direction of travel, illustrating the major steps required to achieve the desired vision.

10-year strategic plan for the drug and alcohol treatment and recovery workforce

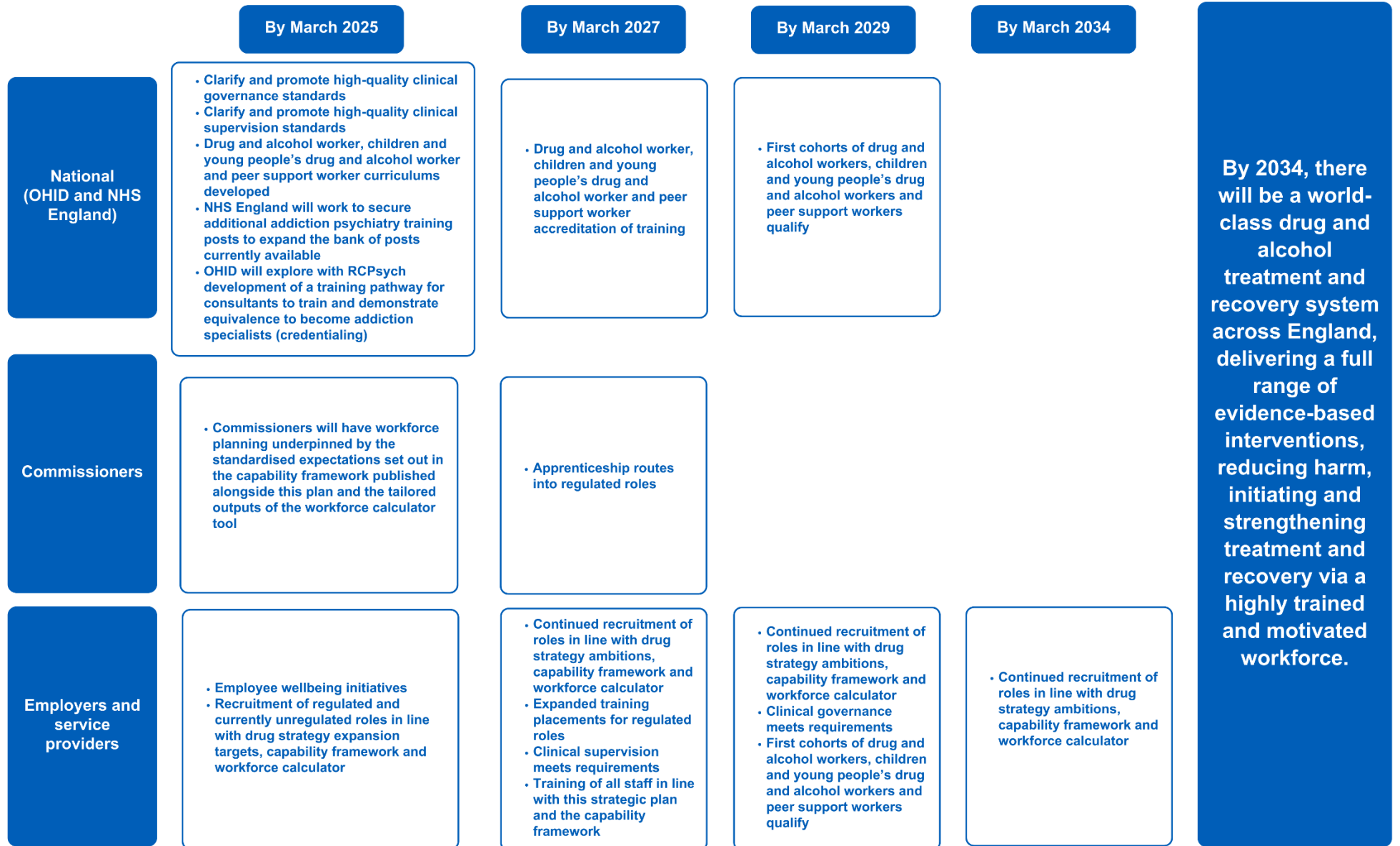
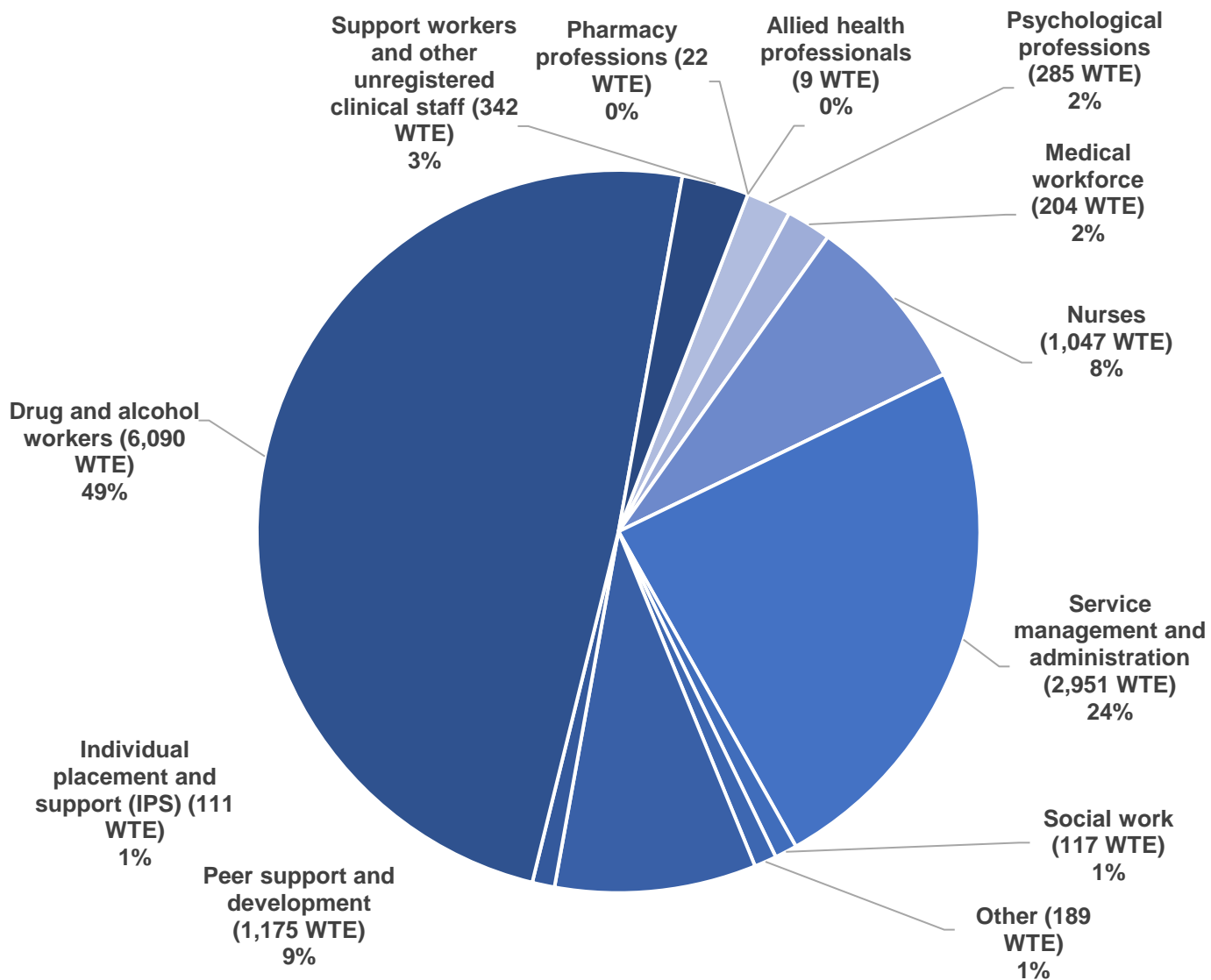


Figure 3: 10-year workforce development roadmap

## National workforce census findings

The [second national workforce census](#)<sup>4</sup> for drug and alcohol treatment and recovery services provides valuable insights to further understanding the current and developing workforce. This second census took a snapshot of the workforce as of 30th June 2023 compared to the baseline position established on 30th June 2022. The findings of subsequent censuses will continue to track trends as drug strategy funding is rolled out.



**Figure 4: Composition of the treatment and recovery workforce delivery (treatment and LERO)**  
(WTE: whole time equivalent)

Whilst there is data for consecutive years, it is not possible to make direct comparisons of the changes in whole time equivalent (WTE) between the two years due to the variation in participation of the number, scope and size of the organisations in each area that have returned data in each year. Therefore, because of the limitations of not being able to make direct comparisons, this data should not be used to infer that the workforce size overall or by types / professions has increased or decreased by any given amount.

The main findings of the second census were:

- The voluntary sector accounted for almost three quarters (74%) of the delivery and commissioning workforce followed by the NHS (13%), lived experience recovery organisations (4%), independent/private providers (3%), LA-delivered treatment (3%) and LA commissioning staff (3%). The voluntary sector accounts for 80% of the treatment provider workforce followed by the NHS (14%), independent (3%) and LA-delivered (3%).
- Drug and alcohol workers made up half (50%) of the treatment provider workforce.
- The treatment provider workforce included the following proportions of regulated professionals: nurses (9%); psychological professions (2%); and small numbers of pharmacists, social workers and medical workforce (including psychiatrists and GPs).
- The percentage of unpaid/volunteer staff within the workforce decreased from 12% in 2022 to 7% in 2023.
- The turnover rate reported for all delivery staff in the treatment provider and LERO workforce of 25% was higher than the 19% reported in 2022. The turnover rate for commissioning staff had increased from 11% in 2022 to 22% in 2023.
- The commissioning workforce reported a vacancy rate of 12% in 2023, a decrease from 14% in 2022.
- Figure 5 demonstrates that the LA-delivered treatment profile is very different to other parts of the treatment provider workforce, with 74% of staff on more than £26,700 (band 5 or more) and only 9% of staff earning less than £26,700 (band 4 and below) (2022 18%). This compared to 44% of staff earning less than £26,700 in the voluntary sector, 33% in the NHS and 44% in the independent sector.

## 10-year strategic plan for the drug and alcohol treatment and recovery workforce

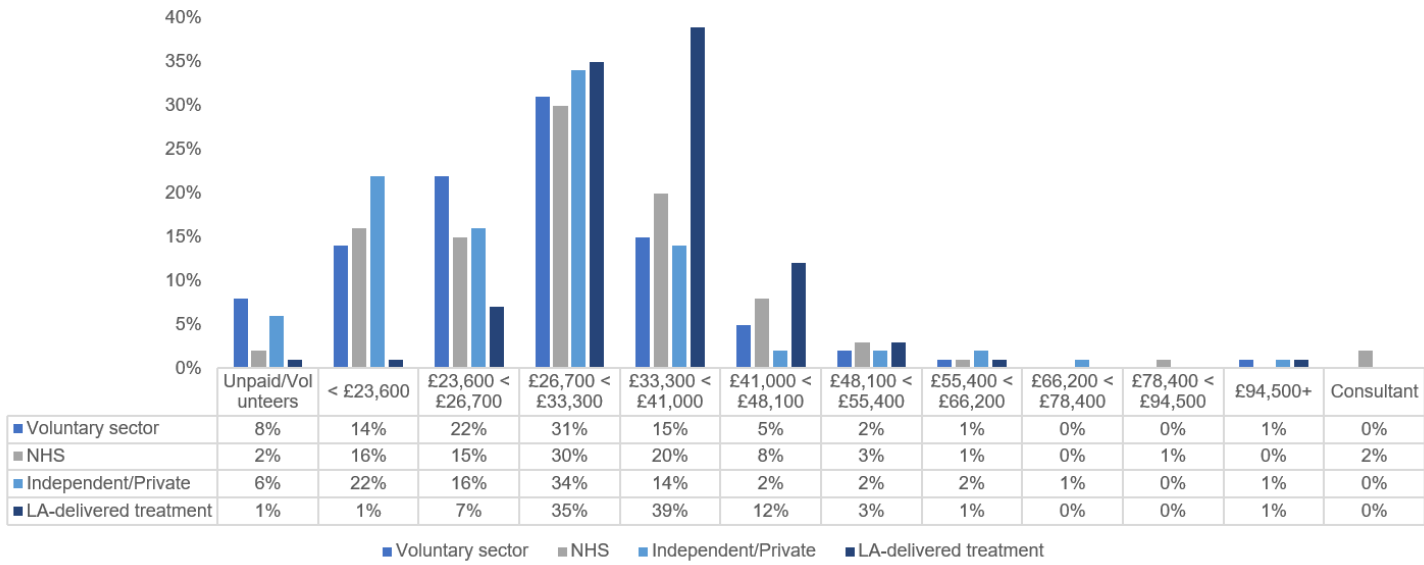


Figure 5: Treatment provider workforce by salary and sector

## Current workforce challenges

Our cross-sector stakeholder engagement to inform the development of this plan (outlined in [Appendix 6](#)) identified the following workforce related challenges. It is worth noting that these challenges and the actions to overcome them have degrees of constant interaction meaning it is not always possible to clearly differentiate them.

### Reform

Stakeholders clearly signalled the need to reform the sector at large and the workforce specifically. They reported that:

- the way services have historically been commissioned, with short re-tendering cycles, has had negative implications for the workforce
- clinical governance structures and processes were often inconsistent across the sector, with a lack of clarity around what clinical governance is, how it should be structured and how processes should be led
- a lack of clarity about what clinical supervision should involve, who should receive it and why and how it differs from managerial supervision

Working with people with diverse needs and regular exposure to [vicarious trauma](#) can have a significant impact on the [wellbeing](#) of employees. [The courage of compassion](#) report by The King's Fund found that stress, absenteeism and turnover in the nursing professions have reached alarmingly high levels, exacerbated by excessive workload and burnout. Stakeholders in the drug and alcohol sector reported that service providers are inconsistent with the level of clinical supervision and wellbeing support offered and that wellbeing is not always prioritised. Without appropriate clinical supervision and wellbeing support, this can lead to high levels of burnout, turnover and a reduction in the quality of care delivered.

### Recruit

Recruitment is presenting challenges across the health and care sectors. There are currently national workforce shortages<sup>7</sup> in regulated professions throughout the NHS and health and social care sectors<sup>8</sup>. This includes:

- since April 2021, social workers, nurses (all areas) and psychologists have been on the [Skilled Worker visa: shortage occupations list](#) to encourage international recruitment into these health and social care roles

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<sup>7</sup> Waitzan, F (2022) 'Staff shortages in the NHS and social care sectors', House of Lords Library. Available at: <https://lordslibrary.parliament.uk/staff-shortages-in-the-nhs-and-social-care-sectors>

<sup>8</sup> Care Quality Commission (2022) 'The state of health care and adult social care in England 2021/22'. Available at: [www.cqc.org.uk/publication/state-care-202122](http://www.cqc.org.uk/publication/state-care-202122)

- as of December 2023, there were just under 111,000 vacancies across the NHS workforce (a 7.6% vacancy rate) and just under 35,000 nursing vacancies in the NHS (an 8.4% vacancy rate)

In June 2023, the [NHS Long Term Workforce Plan](#) was published to address a number of national workforce challenges within NHS healthcare, including recruitment.

Stakeholders consulted to inform this drug and alcohol specific workforce plan spoke of factors that attract people to work in the sector. These included:

- the interesting and rewarding nature of the work
- a commitment to social justice
- exposure to the sector during training and education

The factors impeding recruitment were many, complex and inter-related. These included:

- high caseloads
- low morale
- a lack of clarity and satisfaction in job roles
- limited training and development opportunities
- little career progression opportunities within the sector (beyond moving into management)
- uncompetitive pay and reward packages

The current workforce shortages impact on the workforce supply chain as a lack of supervisors to provide placement opportunities limits the number of pre-registration students and trainees in the sector. This then further impacts on the number of newly regulated staff with an understanding of the sector and an interest in working in it.

The factors currently limiting the expansion of training placements include:

- a lack of availability of mentors and supervisors
- a lack of knowledge of the placements' ability to meet learning outcomes
- workforce supply issues
- challenges in the way services are set up
- pressures from clinical demand

In 2020, HEE London and the [RcPsych](#) published a report entitled [Training in addiction psychiatry: current status and future prospects](#). The report found that the number of training posts for addiction psychiatrists had declined significantly since 2017 and that the way training posts are funded is a perceived barrier. It suggested that changing this funding model could help to increase the number of these specialist training posts.

A scoping exercise completed by NHS England in 2023 of the trainee clinical psychologist placements in the sector showed that 13 of the 26 education providers did not currently provide any trainee clinical psychologist placements in drug and alcohol treatment settings. For the providers that do provide placements to trainee clinical psychologists, these were often their 'elective' placements, meaning that the uptake of placement opportunities relied on trainees with a pre-existing interest in working in the sector.

Despite the effects and potential harm from problem drug and alcohol use being seen across health and social care services, direct experience and placements working in drug and alcohol treatment and recovery services are not perceived as a fundamental experience for health and social care learners generally. This lack of exposure to the sector negatively affects recruitment.

Some stakeholders reported concerns around recruitment practices, identifying that services often see lived experience as more important than specific capabilities, qualities, skills or learned experience. Not all service leads spoken to in developing this plan recognised the value of a diverse, experienced and skilled team with a complementary skillset that includes both lived and learned experiences as the most effective in delivering treatment and recovery support.

Pay, pensions and contract conditions were reported as a contributing factor for recruitment and retention issues. Some voluntary sector organisations were reportedly offering contracts with lower pay compared to similar roles within the NHS on [NHS Agenda for Change \(Face\)](#), uncompetitive pension packages and/or annual pay increments that compared unfavourably with NHS benefits.

Stakeholders reported that just as individuals who use(d) drugs and/or alcohol are greatly stigmatised, so too are the services they use and the workforce working with the services. This was seen to be impacting negatively on recruitment. For example, some services told us that they actively avoid using words such as 'drug' or 'alcohol' in their job titles or job adverts, stating that when they do, they received fewer applicants.

### **Train, develop and retain**

Stakeholders consulted reported multiple challenges to training for staff. These included:

- limited funding for development and learning activities beyond basic mandatory and statutory training



- service delivery pressures restricting the time available to release frontline staff to attend training – this pressure was particularly felt by drug and alcohol workers, which can leave them feeling disempowered and lacking in confidence to deliver the frontline care and treatment required

Workers across different role types reported lacking time to conduct detailed holistic assessments, build meaningful therapeutic relationships and deliver evidence-based interventions. Regulated roles in the sector, which could provide high-quality assessment, care, treatment and recovery support, reported that they often had to prioritise urgent care and operational management responsibilities over providing clinical care and oversight.

Staff consulted reported:

- frustration
- reduced job satisfaction
- a lack of clarity and consistency across roles within the sector
- a lack of clear career progression

Retention was widely reported as an issue affecting workforce sustainability and service quality. Drug and alcohol workers with years of experience in the sector reported leaving services because they did not have opportunities for career or pay progression. The main career progression opportunity for frontline unregulated workers was moving into management. This was often not a preferred option for those who have entered the sector because of their passion and interest in working directly with people who use(d) drugs and/or alcohol. Stakeholders reported that regulated professionals, especially those working in the voluntary sector, were more likely to seek employment elsewhere in the sector or in different services due to pay, employment and contract conditions, career progression, and training and skills development opportunities. This has a negative impact on the quality of care, support and treatment provided and potentially contributes to high turnover rates.

## Part 2: Strategic actions

### Whole workforce strategic actions

The strategic actions written in **bold** below state the required steps needed by the whole sector to ensure the strategic development of the workforce.

#### 1. Implementation

- 1.1. **OHID will continue to provide targeted support to local partnerships and will work with regulatory bodies over time to support the phased implementation of this strategic plan and other related resources such as the commissioning quality standard.** This activity will be mindful of the factors that may inhibit partnerships from fully implementing the guidance, including workforce shortages and the rollout of national workforce programme resources.
- 1.2. **OHID will scope the remit of and best way to establish a Centre for Addiction.**

#### 2. Clinical governance

Clinical governance is a way of describing the process and structure that an organisation uses to assess, monitor and demonstrate the quality and effectiveness of the treatment they provide. It also allows organisations to demonstrate that they are continuously seeking to improve their services with a culture of learning and evidence-based practice. This supports service providers to demonstrate their accountability to commissioners and wider stakeholders. Organisations are responsible for creating a culture that supports clinical governance within the sector and can use [Guidance on good governance and collaboration](#) and [Clinical governance in drug treatment: a good practice guide for providers and commissioners](#) to assist with this. Effective clinical governance structures led by a regulated professional can enable the continuous improvement of service delivery and provide assurance on the consistency, delivery and quality of the clinical and psychosocial interventions being delivered.

Through a governance framework, organisations are accountable for providing assurance and consistency around:

- risk and incident management
- clinical supervision
- clinical effectiveness and quality assurance of evidence-based safe practice
- quality improvement

- complaints management
- safeguarding
- information governance
- education and training
- leadership and culture, including freedom to speak up

- 2.1. **Service providers should have high-quality clinical governance systems in place led by regulated professionals.** These should focus on the assurance and measurement of safe, effective, evidence-based and high-quality service provision.
- 2.2. **Service providers should have systematic processes in place to measure and support this system-based thinking and assess the effectiveness of their services** using tools such as clinical audits, service evaluations and monitoring experience and satisfaction ratings completed by staff and people who use(d) drugs and/or alcohol. These measurements should comprise both qualitative and quantitative data, including lived experience, quality improvement, risk management and other metrics.
- 2.3. **Service providers should actively support reporting and learning from incidents and ensure clinical leads provide feedback to support learning from incidents.** This should include developing, monitoring and maintaining action plans focused on quality improvement.
- 2.4. **Commissioners and service providers should ensure contracts for services, job planning, and workforce planning recognise and enable the time for clinical governance, continuing professional development (CPD) and clinical supervision to be fulfilled.**
- 2.5. **Employers should have clear professional leadership structures** within their organisation. This structure is required for effective clinical governance and strategic aspiration.

### 3. Clinical supervision

Clinical supervision is an essential component of the training and development of clinicians and ensuring that treatment and recovery is being delivered in an evidence based, effective, ethical and professional manner. The definition of the terms clinical and clinical supervision can be found in the glossary in [Appendix 5](#).

- 3.1. **Commissioners should enable service providers to use quality-assured external provision of clinical supervision where there is a temporary shortage or lack of appropriately trained supervisors.**

- 3.2. **Service providers and commissioners must ensure that every member of the workforce delivering treatment and recovery interventions (including psychosocial interventions), regardless of their level of skill and experience, has access to high-quality regular clinical supervision.** All roles need supervision, but the frequency and content will depend on the role, skill level and competence of the individual. Clinical supervision must involve elements of reflective practice and follow a specific evidence-based model. Examples of acceptable models are listed in [Appendix 2](#) of this strategic plan. For full-time regulated roles, clinical supervision should be once per month (calculated pro-rata for part-time staff) for a session of at least 60 minutes, facilitated by a regulated professional.
- 3.3. **Service providers must ensure that clinical supervisors are appropriately trained to carry out high-quality supervision and should receive regular clinical supervision themselves<sup>9</sup>.** Clinical supervisors will require training to be able to deliver clinical supervision effectively and in line with a supervision model.
- 3.4. **Service providers should deploy the skills of regulated professionals to provide high-quality clinical supervision.** Given the urgent need for the provision of clinical supervision to the workforce, services should factor clinical supervisor responsibilities into their workforce planning to enable the appropriate capacity to provide supervision and allow for flexibility with how they use the skills of regulated professionals.
- 3.5. **Service providers must ensure that all regulated professionals are provided with regular high-quality clinical supervision in line with their registration requirements.** To enhance the benefits of supervision, it should be arranged to be consistently provided by the same supervisor, and ideally by someone with the same professional registration or background. For those in specialist clinical roles, separate specialist clinical supervision sessions may be beneficial (and/or essential in line with registration/regulatory requirements) in addition to routine clinical supervision, especially where their routine clinical supervisor does not have a background in their specialism.
- 3.6. **Service providers must ensure that managers and team leaders are appropriately trained to carry out high-quality management supervision and that they receive regular management supervision themselves.**
- 3.7. **Service providers should emphasise the importance of clinical supervision to commissioners and ensure that there is a cultural shift within services to clinical supervision being highly valued and prioritised as an essential integrated part of all roles and services.** The time for both receiving and delivering

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<sup>9</sup> Office for Health Improvement & Disparities (2022) 'Commissioning quality standard: alcohol and drug treatment and recovery guidance'. Available at: [www.gov.uk/government/publications/commissioning-quality-standard-alcohol-and-drug-services/commissioning-quality-standard-alcohol-and-drug-treatment-and-recovery-guidance](http://www.gov.uk/government/publications/commissioning-quality-standard-alcohol-and-drug-services/commissioning-quality-standard-alcohol-and-drug-treatment-and-recovery-guidance)

clinical supervision should be protected to ensure it is established and maintained within services delivering treatment, including psychosocial interventions. Clinical supervision should be treated as an essential aspect of treatment service provision, not as an optional add-on or benefit. It is vital that service providers factor time for receiving and delivering clinical supervision into their workforce planning and workforce capacity.

- 3.8. **Commissioners should commission in a way that enables and promotes clinical supervision for all staff.**

## 4. Caseloads

Effective caseload management is also a core component for ensuring that workload is appropriate, protecting wellbeing and reducing burnout. Both the quantity and complexity of caseloads should be considered. In line with Dame Carol Black's independent review of drugs **good practice suggests a caseload of 40 or less, depending on the complexity of need.**

“High caseloads reduce the quality of care provided and the effectiveness of treatment. Focus should be on providing high-quality personalised care, rather than paperwork.”**Error! Bookmark not defined. Error! Bookmark not defined.**

Stakeholders have stated that, depending on the setting, caseloads can be significantly higher than 40. A change in culture to one of greater openness and trust is needed to enable the workforce to communicate with their managers about workload capacity and reach desired caseload level. This change in culture, combined with caseload management tools and clinical governance, would support providers and commissioners to plan caseloads and wider service provision over the next decade to achieve this recommended caseload capacity.

- 4.1. **Caseload management and workforce planning should allow additional capacity where there are complexities,** including but not limited to:
- safeguarding and child protection (including early help, child in need, child protection and looked after children)
  - physical and mental health needs
  - no fixed abode
  - referred via the criminal justice system
- 4.2. **Commissioners must support service providers by commissioning for workforce development to enable caseloads to be regularly reviewed and active caseload management to be prioritised to support retention.**

- 4.3. **Service providers and commissioners should consider their locality and service design when managing caseloads.** For example, rural or urban, outreach or in-reach services.
- 4.4. **Service providers must be mindful that caseloads need to be lower for outreach models of working** (both adult and children and young people (CYP)). Caseloads also need to be lower for CYP drug and alcohol (D&A) workers due to the complexity of the work and the need to work collaboratively with several wider CYP services, often including safeguarding services and often with parents. The frequency of contact is often more for CYP D&A workers and greater flexibility is required to meet the needs of CYP than for adults engaged with drug and alcohol services.

## 5. Wellbeing

Whilst there is a significant correlation between the wellbeing of the workforce, recruitment and retention, it is also important to recognise that staff wellbeing needs to be considered as its own element of workforce development. It has a direct impact on the quality of service provided when combined with burnout and compassion fatigue<sup>10</sup>. Some stakeholders have expressed concerns that workplace wellbeing is overlooked. Stakeholders spoke of a lack of clear processes and policies to help and guide those who have concerns about their wellbeing at work.

- 5.1. **Employers must prioritise employee wellbeing.** Service providers should understand staff wellbeing as a systemic issue generated from overall staff experience. Workforce wellbeing is a continual process and service providers need the ability to reshape intervention to respond to changing circumstances. There should be visible support from leaders, especially clinical leadership and a long-term commitment to creating a culture that prioritises the wellbeing of the workforce. Evidence-based guidelines should be used, such as [Organisational interventions to support staff wellbeing, National Institute for Health and Care Excellence \(NICE\) guideline NG212 mental wellbeing at work](#) and the [World Health Organization's guidelines on mental health at work](#) and [Wellbeing | Local Government Association](#).
- 5.2. **Employers should be aware of the direct links between wellbeing and retention and be actively working to improve the wellbeing of their workforce.** The below resources are available to support this:
- NHS England has a guide for managers and leaders to support with [looking after your team's health and wellbeing](#).
  - NHS Professionals has developed a [toolkit](#) to support wellbeing, including resources to support members of the lesbian, gay, bisexual, trans and queer

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<sup>10</sup> Thapa DK and others. 'Burnout, compassion fatigue, and resilience among healthcare professionals' *Nursing and Health Sciences* 2021: volume 23, issue 3, pages 565–569. doi:10.1111/nhs.12843

(LGBTQ) community and men's and women's mental health within the workplace.

- The Leadership Academy has developed a **self-assessment tool** to help assess staff emotional and mental wellbeing, which also offers relevant information, advice and support based on staff member's responses.
- The **Online resilience toolkit**, **Emotional resilience toolkit** and **Your wellbeing and resilience toolkit** can support employers with practical guides and tools for resilience and wellbeing whilst reducing the potential anxiety and stress associated with working in a frontline role.

- 5.3. **Service providers should explore the benefits of having wellbeing champions** within the workplace to provide support and guidance for the mental health and wellbeing needs of the service.
- 5.4. **Employers should have wellbeing conversations with the workforce to create personalised wellbeing plans.** These plans should be reviewed annually. **Toolkits** are available to support employers and line managers with wellbeing conversations.
- 5.5. **Employers must ensure they have accessible policies and procedures to support the workforce with their own wellbeing.** These should include, but are not limited to:
  - staff wellbeing
  - **freedom to speak up**
  - lone working
  - equality, diversity and inclusion
  - domestic abuse policy (which should have a section on employees affected by domestic abuse)
- 5.6. **Employers should explore workforce wellbeing initiatives** and ensure they are accessible to the whole workforce.
- 5.7. **Employers must create and promote a positive workplace culture** where the whole workforce is treated with compassion and respect.
- 5.8. **Employers should consider team building for their workforce.** Developing and strengthening the working relationships within a team will not only strengthen the multidisciplinary team's (MDT's) capacity for effective communication, but also foster a culture of creativity, teamwork, mutual respect among colleagues and a shared

commitment to common objectives. This all has a positive impact on the care that is being delivered and the retention of the workforce<sup>11</sup>.

- 5.9. **Employers should encourage a positive work–life balance** with agreed working hours and flexibility, which allows time management. [Guidance on Flexible working in social care](#) by the Local Government Association is available.
- 5.10. **Employers must ensure that they regularly carry out the Health and Safety Executive’s stress risk assessment to prevent and minimise workplace stress.**

## 6. Recruitment and retention

Recruitment and retention practices are currently inconsistent across the sector. To support the expansion of the sector-wide workforce, consistency in recruitment and retention needs to be combined with creating attractive workplaces that support wellbeing and development. Employers should also review the aligned training and development statements (found in the whole workforce section and each role-specific section of part 2 of this plan) to ensure their recruitment and retention packages are attractive to potential candidates and improve the retention rates of the current workforce.

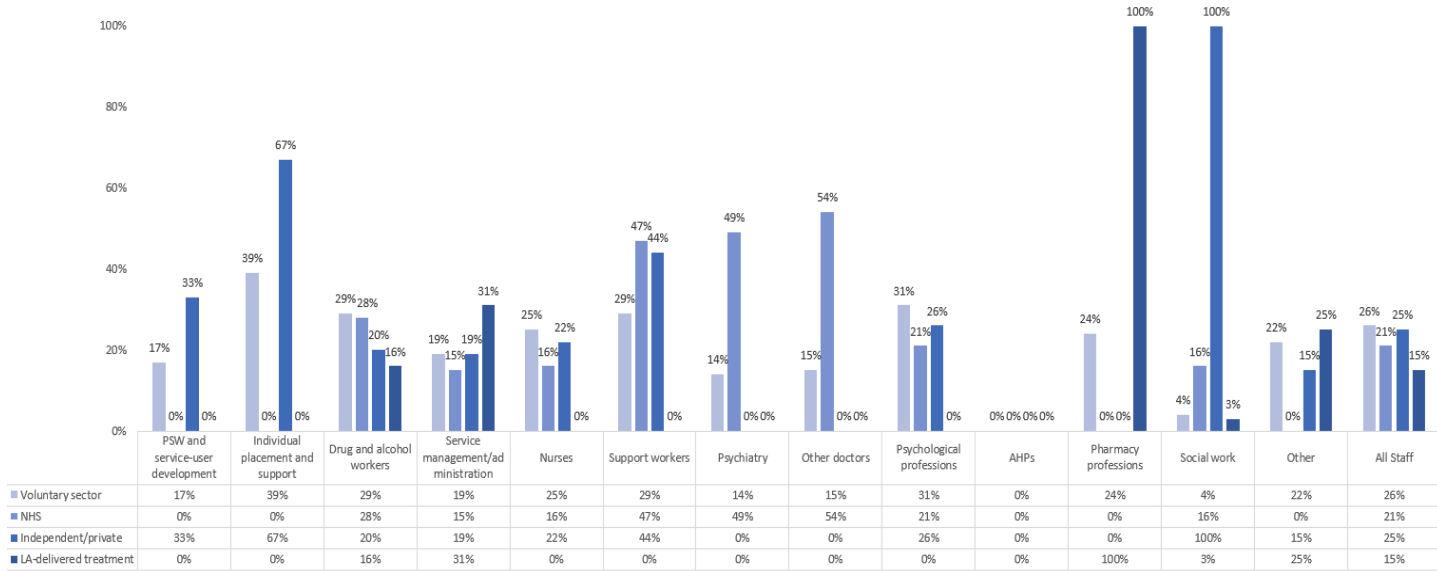
Throughout this strategic plan, there is significant crossover between retention and learning and skills development statements, as having a satisfying and rewarding career will aid retention in the sector.

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<sup>11</sup> Babiker A, El Hussein M, Al Nemri A, Al Frayh A, Al Juryyan N, Faki MO, Assiri A, Al Saadi M, Shaikh F, Al Zamil F. 'Health care professional development: Working as a team to improve patient care' Sudanese Journal of Paediatrics 2014: volume 14, issue 2, pages 9–16. PMID: 27493399; PMCID: PMC4949805



**Turnover rate by staff group and sector**



**Figure 6: Turnover rate by treatment provider staff group and sector<sup>4</sup>**

Figure 6 shows a turnover rate for the treatment provider workforce of up to 26% in the voluntary sector. To create sustainable workforce transformation, it is important that employers prioritise retention, and not just recruitment. It should be noted that these turnover rates categorised by job role groups are based on small numbers in some cases.

Sustainable growth of the drug and alcohol treatment and recovery workforce will help ease pressures on other parts of healthcare, especially mental health services. Untreated alcohol and drug dependence puts pressure across the healthcare system including on primary care, ambulance services, A&E, hospital admissions and acute and community mental health services. In terms of mental health specifically, previous research identified that 44% of people accessing community mental health services in England have reported drug use or harmful alcohol use in the last year<sup>12</sup>. Over two-thirds of people starting drug and alcohol treatment in England in 2022/23 said they had a mental health need (71%)<sup>13</sup>.

**6.1. Commissioners and service providers should work together to explore collaborative commissioning and shared posts funded by multiple organisations.** Stakeholders have spoken positively about posts that have been collaboratively commissioned and the new opportunities these have presented for workforce development. Stakeholders shared examples of shared posts, including joint mental health and drug and alcohol posts on a 'co-occurring conditions' pathway

<sup>12</sup> Weaver T, Madden P, Charles V, Stimson G, Renton A, Tyrer P, Barnes T, Bench C, Middleton H, Wright N, Paterson S, Shanahan W, Seivewright N, Ford C; Comorbidity of Substance Misuse and Mental Illness Collaborative study team. Comorbidity of substance misuse and mental illness in community mental health and substance misuse services. Br J Psychiatry. 2003 Oct; 183:304-13. doi: 10.1192/bjp.183.4.304. PMID: 14519608. <https://pubmed.ncbi.nlm.nih.gov/14519608/>

<sup>13</sup> Office for Health Improvement and Disparities. Substance misuse treatment for adults: statistics 2022 to 2023. <https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2022-to-2023>  
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or drug and alcohol workers within the ambulance service. These posts attracted applicants from different professional backgrounds and provided new opportunities for different ways of working.

- 6.2. **Commissioners must commission in a way which allows for workforce development** by ensuring that workforce planning facilitates training and career development.
- 6.3. **Employers should explore new ways of improving their current retention rates**, with managers and leaders equipped to have regular conversations with team members to discuss ways to support them to stay.
- 6.4. **Employers should recognise the importance of workforce stability and permanent contracts** when recruiting to support sustainable workforce development, retention and transformation.
- 6.5. **OHID will undertake scoping to see if a drug and alcohol workforce jobs, volunteering and training campaign across the sector can be progressed.** OHID has identified the need for a drug and alcohol workforce jobs, volunteering, and training campaign to showcase opportunities across the sector. This project could promote working in the sector as told by people with lived experience and those currently working and volunteering in the sector. It could support attracting people from a variety of backgrounds to work in the sector, including regulated professionals, international candidates, those considering a return to practice and those seeking a career change.
- 6.6. **Service providers and commissioners must actively tackle stigma.** This should include making links with their local community, social and healthcare providers, running local or national campaigns and offering information to local training providers about what they do. Helping other health and social care services see the importance of engaging in issues experienced by people using drugs and alcohol can help break down the stigma of working with these individuals. It can also increase the wider awareness of the fulfilling roles and opportunities available within the drug and alcohol sector.
- 6.7. **Service providers and commissioners must use the capability framework and MDT workforce calculator to direct and inform workforce planning and skill mix within services.**
- 6.8. **Employers must ensure they use the capability framework to clearly define roles, job descriptions and job titles.**
- 6.9. **Employers must ensure that they use the capability framework when recruiting roles to ensure an appropriate range of skills, experience, and training from candidates.** This will result in a workforce with a range of backgrounds whose

combined lived and learned experience will bring useful insights and actively challenge stigma about dependence, recovery and inclusion.

- 6.10. **Employers should maximise recruitment opportunities by exploring a ‘grow your own’ workforce approach** by offering training and developmental roles to those who do not meet the capabilities of their role currently, but could with additional training and skills development, and those who have transferable skills suitable for the sector.
- 6.11. **Services must be led by clinical leads, team leaders and service managers who are skilled, trained and able to promote a culture of compassionate leadership.** They should be able to support people exposed to vicarious trauma, including PSWs and volunteers who may have their own ongoing needs and require different management considerations. **Compassionate leadership** is vital to the delivery of effective services, providing strategic direction and fostering a positive work culture. Scoping of the potential routes to improve management and leadership training in the sector needs to be done by service providers.
- 6.12. **Employers must ensure their recruitment processes are culturally sensitive and accessible** for people with disabilities and neurodiversity to ensure a diverse and representative workforce is recruited. Barriers to recruitment should be removed wherever possible and reasonable adjustments to the recruitment processes made as required.
- 6.13. **Service providers should explore mentoring and coaching opportunities to enhance their retention offer** with personalised career development pathways for the current workforce.
- 6.14. **Employers must recruit a diverse workforce** to deliver inclusive and accessible services and reflect the national and local populations they serve. They should consider undertaking targeted engagement of groups underrepresented in workforce gap analyses.
- 6.15. **Employers should collaborate to share examples of good recruitment and retention practices and support new innovative approaches.** These may include making links with LA skills, employment and education services, linking with volunteering programmes and considering traineeships for people with lived experience looking to move into drug and alcohol worker, PSW and other roles.
- 6.16. **Service providers and employers should consider attending colleges, universities, higher education institutions (HEIs) and community job/careers fairs** and engaging people who may be interested in exploring an opportunity to develop new skills or work in a new sector.
- 6.17. **Employers should consider the potential benefits of undertaking collaborative local, regional or national recruitment campaigns to maximise the workforce**

**skill mix in their services and the drug and alcohol sector at large.** There may be benefits for multiple service providers in working together to maximise the reach of a recruitment campaign and the range of opportunities that can be offered to candidates.

- 6.18. **Employers must ensure that job adverts and job titles align with job responsibilities and the capability framework.** This will ensure clarity and transparency regarding the nature and expectations of the role. The capability framework will provide guidance on the core capabilities of key roles in the sector and is to be used when recruiting including when developing job descriptions and role titles.
- 6.19. **Employers should be creative and proactive in their recruitment approach.** Some providers have been offering on-the-day interviews to people attending careers fairs or recruitment events to break down some of the barriers that the application process can present.
- 6.20. **Employers should respond to applications promptly.** Failure to respond to applications in a timely manner may have a detrimental impact on the wellbeing of the applicant.
- 6.21. **Employers should commit to paying wages in line with market value and offering competitive total reward packages.** Everyone working in the sector should be rewarded fairly for their role to ensure the sector has the necessary skilled and experienced workforce. Those in lower-paid, direct entry positions can, with the right training and support, transfer relatively easily into other jobs in the economy with better pay, greater flexibility and more benefits. The total reward package, which goes beyond just pay, needs to be attractive and competitive. Service providers should consider their total reward package for recruitment and retention beyond salary, including pensions, leave allowances, flexible working, wellbeing culture and enabling a work–life balance.
- 6.22. **Service providers should support flexible working** to allow staff to remain in their roles and allow returning staff with experience and knowledge to return to the sector in the future. Allowing flexibility and a work–life balance in employment enables higher rates of retention.
- 6.23. **Service providers should encourage conversations around flexibility in career planning with the workforce.** Autonomy and flexibility around career planning are of growing importance to the workforce and facilitate a valued and healthy professional experience in addition to supporting long-term workforce retention.
- 6.24. **Service providers should have continuous feedback mechanisms in place to encourage staff communication** and ensure that they have a listening approach that best engages staff and ensures that feedback is acted on.

- 6.25. Commissioners and service providers should ensure that they are represented on the local enterprise partnership (LEP) or equivalent.
- 6.26. Commissioners and employers should look to support the growth of the workforce using NHS England's **Allied health professions' support workforce – grow your own workforce strategies guidance**.
- 6.27. OHID regional teams will be leading on workforce target conversations and plans around workforce expansion targets with their **integrated care system (ICS)**.
- 6.28. Service providers and LAs should ensure that they have strong links with their **ICS and work closely together on integrated workforce planning**. The introduction of ICSs provides a unique opportunity for NHS systems and LAs to work together to provide integrated care. Workforce planning and training for drug and alcohol treatment and recovery will benefit from improved joint working between ICSs and LAs. This can include integrated workforce planning, for example, through opportunities for joint teams, joint training and shared commissioning of new posts.
- 6.29. OHID, in collaboration with **National Institute for Health and Care Research (NIHR)**, will commission an evaluation of the workforce programme, which includes an assessment of factors influencing employees' perceptions and experiences of working within the sector.
- 6.30. Employers should collect high-quality workforce data to inform an annual **census of the drug and alcohol treatment and recovery workforce**. This should include quantitative and qualitative data and consider the multi-faceted workforce itself, as well as outcomes for those accessing services. The findings from the **first** and **second** national drug and alcohol treatment and recovery workforce census have enabled NHS England and OHID to work collaboratively with key strategic partners to inform education and workforce planning and investments for now and in the future. The census findings will also help service providers to compare service-level findings and LAs to compare LA-level findings to national findings.
- 6.31. Employers should use the **international retention toolkit**, which contains actions employers can take to ensure internationally recruited staff will want to stay, thrive and build lasting careers.
- 6.32. Service providers should familiarise themselves with the **World Health Organization (WHO) Code of Practice on ethical international recruitment and the resources in Appendix 1**. A revised Code of Practice was released in August 2023. There is a **quick guide** to help NHS service providers and candidates understand what the WHO Code of Practice means for them.

## 7. Training and skills development

Addressing the training and skills development needs of the whole workforce not only has a positive impact on service delivery, but also positively overlaps with recruitment and retention by creating a progressive, evidence-based and rewarding sector to work in.

This strategic plan addresses specific roles which were covered in the first phase of the development of our comprehensive capability framework. A subsequent update of this plan will include more detail on the additional roles which were covered in the second phase of development of the capability framework. This update will ensure the strategic plan covers the entirety of the capability framework in the same level of detail.

- 7.1. **NHS England and OHID will lead on the development of workforce implementation guides, reviews, plans and audits to support this strategic plan.**
- 7.2. **NHS England will lead on the scoping and gap analysis of relevant undergraduate and postgraduate training at a national level.**
- 7.3. **OHID, NHS England and cross-sector partners will support the strengthening of existing and the development of new **provider collaboratives**** to share best practices and grow national professional networks and to support a culture that moves away from silo working. This way of working is part of a fundamental shift in the way the health and social care system is organised, moving from an emphasis on organisational autonomy and competition to collaboration and partnership working.
- 7.4. **Commissioners should commission for the development of the workforce through training to fulfil the required roles and capabilities.**
- 7.5. **Employers should liaise with organisations that are supporting career development in research within health and social care, including NIHR and UK Research and Innovation (UKRI)**, to maximise the critical role they play in developing career opportunities within research. This will encourage service providers to develop and support careers focusing on clinical research within the sector.
- 7.6. **Service providers must use the capability framework to ensure that their workforce is skilled, trained and able to fulfil the capabilities required of their role.**
- 7.7. **Employers should ensure new members of the workforce have an induction package** that supports them in their new role. This ideally should include training, shadowing and mentoring.

- 7.8. **Service providers must make sure all training and skills development is fully accessible to the workforce.** It should accommodate various learning types, diverse neurotypes and different levels of formal education.
- 7.9. **Service providers must enable access to regular continuing professional development (CPD)** and support the workforce with staying up to date on current practice and changes in the sector. This should include service providers and commissioners working together to ensure that budgets for CPD are reflected in workforce development. All roles within the drug and alcohol workforce require appropriate ongoing training and CPD, with learning activities tailored to their expertise and role responsibilities being offered. This will enable the whole workforce to engage in suitable CPD and skill development to enhance their confidence, competence and abilities within their role. Service providers need to invest in the skills and development of all their employees and ensure that workforce management allows for protected time for ongoing CPD to be prioritised.
- 7.10. **Service providers should take a clear and consistent approach to workforce development,** including annual workforce planning and training needs analysis. Workforce planning guidance can be found in [Appendix 4](#).
- 7.11. **Service providers should support individual leadership development within career conversations** that allow the workforce to develop whilst supporting the sector to build a sustainable workforce with skilled and trained leadership roles.
- 7.12. **Service providers should ensure that all training in clinical interventions (including pharmacological and psychosocial) is evidence based and in line with NICE and national clinical guidelines.**
- 7.13. **Service providers should ensure that all frontline staff, regardless of role or seniority, have received training,** including but not limited to the following:
- **delivering trauma-informed care** that enables them to understand what a trauma-informed approach is, ways that trauma may present in people who use(d) drugs and/or alcohol and why it is necessary to have a trauma-informed approach within the drug and alcohol treatment and recovery sector
  - **signs and symptoms of problematic alcohol and drug use, including recognising signs of dependence and withdrawal**
  - **common mental health problems, including signs, symptoms and risks enabling detection of early warning signs, to provide basic strategies for supporting someone in a crisis and non-crisis situation and to advise on how to access more mental health help**
  - **evidence-based pharmacological interventions** used in drug and alcohol treatment and recovery services

- **evidence-based psychosocial interventions** used in drug and alcohol treatment and recovery services
- **common physical health problems** associated with drug and alcohol use, including signs of withdrawal and intoxication, breathing issues, ulcers, blood-borne viruses, other common health complications, de-escalation and conflict management
- **risk assessment and risk management**
- **evidence-based harm reduction** to enable them to share information, advice and interventions with people who use(d) drugs and/or alcohol, their families, affected others and professionals
- **inclusive service delivery including cultural competence**
- **working with people who have a learning disability and people who are neurodiverse**
- **recognising domestic violence**, both in terms of victimisation and perpetration, and how to enquire sensitively as part of everyday assessment and review skills
- **Mental Capacity Act 2005, Mental Health Act 1983, The Children Act 1989, the Human Rights Act 1998 and other legislation as relevant**
- **safeguarding adults and children**, including how to recognise, respond to and escalate concerns
- **initiating and maintaining engagement** using active listening skills, co-production techniques and maintaining boundaries

The above training is in addition to all statutory and mandatory training requirements. In cases where there are no specific training and development statements, such as for PSWs, then refer to the list above and [Skills for Health – Core Skills Training Framework®](#).

## 8. Research in the sector

As part of the government's wider programme for drug and alcohol treatment and recovery services, the [Office for Life Sciences](#) (OLS) is delivering an Addiction Healthcare Mission. This mission aims to enhance the UK-wide research environment and incentivise the development of innovative and effective new treatments, technologies and approaches to support recovery, as well as reduce the harm and deaths that dependence can cause. The [government](#) has committed to accelerating the development of new technologies to prevent deaths from overdoses across the UK. Funding will also help grow research capacity and



capability across the UK to better understand problematic drug and alcohol use and the most effective ways to treat it.

Research is critical to improving treatment and recovery care outcomes by bringing breakthroughs in innovation into the clinic and providing evidence to inform practice. Leading or involvement in research by healthcare professionals focused on improving treatment outcomes for people with drug/alcohol problems can also increase job satisfaction. A well-resourced, properly trained and highly motivated drug and alcohol treatment and recovery workforce will be integral to driving forward an enhanced research-aware and active sector. Training and participation in research opportunities contribute to an attractive, motivating and fulfilling career option for the drug and alcohol treatment and recovery workforce while also enabling the sector to become world leaders on new and upcoming approaches and treatment. It is integral that research opportunities are shared with people who use(d) drugs and alcohol as active participation is a key factor in the quality of research. For the workforce to be able to share and support ongoing participation, they need to have an up-to-date understanding of the opportunities available.

- 8.1. **OHID will work closely with OLS to ensure that there is a focus on building the workforce's skills in research.**
- 8.2. **Service providers and commissioners should value research in the sector** and support the workforce to maximise their research skills and opportunities to take part in research-focused activities.
- 8.3. **Service providers should support developmental opportunities in academia and research, where possible**, that offer additional career pathways and further progression within evidence-based treatment and recovery for the future sector.
- 8.4. **Service providers and commissioners should ensure that they remain up to date on new and current research**, which can be supported by linking with NIHR, Medical Research Council (MRC) – UKRI and local research teams where possible or establishing their own/collaborative research teams.
- 8.5. **Service providers should ensure that opportunities for research participation are understood by the workforce and actively involve people who use(d) drugs and alcohol.**

### Regulated workforce strategic actions

For the purpose of this strategic plan, 'the regulated workforce' refers to roles that require an essential level of training and/or qualification for registration with a professional body to be able to fulfil the role. This section includes [Nursing & Midwifery Council \(NMC\)](#) registered nurses (all nursing fields including non-medical prescribers (NMPs)) and registered nursing associates, regulated practitioner psychologists, [British Association for Counselling and](#)

Psychotherapy (BACP) accredited counsellors, pharmacists including NMPs, medical workforce and [Social Work England](#) registered social workers. In addition, some professionals are required by employers to be registered with a recognised [Professional Standards Authority](#) accredited register (for example, counsellors, psychotherapists and cognitive behavioural therapy (CBT) therapists).

## 9. Increasing the number of regulated professionals

Regulated professionals have an essential role in leading, supporting and upholding the clinical governance, clinical supervision and clinical leadership elements of this strategic plan. They also provide vital clinical leadership to the wider workforce, care co-ordination and can make and sustain links with wider health and care services including mental and physical health.

Increasing the number of practice placements, [preceptorships](#) and programmes for those who are newly qualified would help to raise the profile of services, break down stigma around working with people who use(d) drugs and/or alcohol and make the sector a more attractive place to work.

- 9.1. **Service providers should work with universities to increase the number of clinical and practice placements and the amount of research happening in the sector.** Increasing the number of regulated professionals in the sector provides greater opportunities for further research and evidence-based treatment and recovery development while also creating a pathway for career development within the sector.

## 10. Apprenticeship routes into regulated roles

Apprenticeships are work-based training programmes that are designed to help service providers train people for specific job roles. Apprenticeships within the drug and alcohol treatment and recovery sector could be used to support increasing the number of regulated professionals in the sector in roles such as nursing, medicine, social work or psychology by enabling current members of the unregulated workforce to gain a professional registration<sup>14</sup>. Apprenticeships are a way in which employers can either develop their existing workforce and 'grow their own' or recruit people externally into apprenticeship roles. Both routes help employers to expand and further develop their workforce. Within health and social care, the apprenticeship route to a professional role can be very appealing as the student remains employed and paid while studying. [Apprenticeships bring a number of benefits](#) to the sector and can offer valuable work experience whilst gaining a qualification.

There are considerations for organisations as they need to pay the salary costs for the apprentice during training and ensure the apprentice is released for their study time. Service

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<sup>14</sup> NHS England (2023) NHS Long Term Workforce Plan. Available at: [www.england.nhs.uk/publication/nhs-long-term-workforce-plan](http://www.england.nhs.uk/publication/nhs-long-term-workforce-plan)

providers potentially also need to plan to backfill the post to continue to meet the service requirements for the period of study and placement.

The [NHS Long Term Workforce Plan](#) commits to collaboration between NHS England, DHSC and the Department for Education (DfE) to streamline apprenticeship levy fund transfer in ICSs. This will enhance transparency of NHS apprenticeship funding usage for national and local decision-makers. NHS England will develop an apprenticeship funding approach that better supports service providers with the cost of employing an apprentice. The [NHS Long Term Workforce Plan](#) also commits to supporting ICSs to develop local apprenticeship strategies that maximise benefits from changes to funding approaches and to focus on workforce shortfalls and the deployment of roles that enhance outcomes. This system-level apprenticeship oversight and plan will better support organisations to grow and recruit their own future workforce and enable ICSs to collaborate on their approaches to using apprenticeships with education providers both nationally and locally.

Using apprenticeships to support this strategic plan can enhance the training and development opportunities for meeting the regulated workforce expansion targets.

Sector-wide workforce planning and joined-up thinking between organisations can help to identify shared skill gaps that could be met by apprenticeships. Organisations can work across an ICS to [maximise the use of the apprentice levy](#), with large organisations supporting smaller organisations for the benefit of increasing the number of regulated professionals in the wider sector as a whole. This could support skills development in other parts of the health system and have a positive impact on service delivery in both the funding and receiving organisations. While the levy cannot be used to joint-fund apprenticeship training, the option exists to designate a lead organisation within an ICS. This organisation would employ apprentices to deliver work benefiting the whole region. This approach could enable wider sector workforce development, while also strengthening relationships and encouraging collaborative working.

- 10.1. **Commissioners and service providers should be having whole workforce planning conversations within their ICS** to maximise the use of the apprenticeship levy so that it can be shared across organisations. This will enable smaller providers to also explore apprenticeship options for their workforce.
- 10.2. **Service providers should maximise their local funding and apprenticeship levy options by linking with the regional Talent for care relationship managers** to consider apprenticeships suitable for their workforce and the possibility of joint apprenticeships where there are shared roles across different healthcare settings. This could include roles to address co-occurring mental health and drug and alcohol use conditions working across in drug and alcohol and mental health services.
- 10.3. **Service providers should ensure that they have the organisational infrastructure in place to support apprentices and make the apprentice route an attractive and achievable option.** To support service providers in meeting the

expectations of a trained, skilled and effective treatment and recovery workforce, there are a number of apprenticeship options available for the unregulated workforce. For those staff in supervisory roles that are not regulated professionals, service providers should consider [apprenticeships for team leaders and supervisors](#) that support developing team members, planning and monitoring workloads, resolving problems and building relationships internally and externally.

- 10.4. **Service providers should ensure that apprentices have access to trained placement mentors from the same professional background available in the workplace for guidance, support and maximising learning opportunities.** They should also support regulated professionals in offering placements and taking on roles as supervisors, practice educators and mentors for pre-registration students, enhancing potential workforce development and making the apprenticeship route attractive and supportive for new and existing workforce.

## 11. Return to practice

Welcoming returning regulated professionals is a great way to bring experience, skills and training back to the sector. Return to practice initiatives have seen thousands of people commence training to return to practice in nursing and other professions.

- 11.1. **Service providers should keep the door open to those who leave and encourage them to return if they choose to by supporting return to practice initiatives.** [Appendix 3](#) includes more information on return to practice.
- 11.2. **Service providers should improve flexible working opportunities for prospective retirees** to support them for longer in their roles and make it easier for those who have already left to return by creating more options to come back in flexible, contracted roles or as part of the temporary workforce.
- 11.3. **Service providers should consider offering return to practice posts and contracts to support regulated professionals wanting to re-enter practice and work in the drug and alcohol treatment and recovery sector.** As part of the return to practice process, there are clinical placements or supervised practice hours that can then be completed in the drug and alcohol sector. This will enable return to practice professionals to be supported with their return and into their new roles as a regulated professional in the sector.

## 12. Placements for pre-registration professionals

Stakeholders and scoping have identified several challenges around placements for pre-regulated professionals. The significance of placements lies in their potential to directly enhance awareness about the sector's work and the spectrum of available roles, thereby having a positive impact on recruitment of newly qualified professionals.

- 12.1. **OHID and NHS England will explore developing placement implementation guides for regulated professions.**
- 12.2. **Commissioners and service providers should work with their ICSs to support developments in education, training and placements.** The [NHS Long Term Workforce Plan](#) anticipates that as ICSs become more involved in education and training planning, there will be an opportunity to develop more multi-profession, system-based rotational clinical placements.
- 12.3. **Service providers should make significant efforts to offer student placement opportunities to pre-registration professionals.**
- 12.4. **Service providers should seek advice from their local training course providers and regional NHS England team on increasing placements and attracting pre-registration learners.**
- 12.5. **Service providers should look to increase the number of supervising and practice educator roles in each regulated profession.** Where supervision capacity is low, with careful governance and clear supervision agreements, the use of hub and spoke placements may offer a temporary solution. This placement model offers learners the opportunity to attend a short placement away from their main (hub) placement, while being supported and supervised by their mentor at their hub placement<sup>15</sup>. This model has been shown to offer several benefits, including an enhanced understanding of pathways between services, a richer learning experience, and increased awareness of career choices.
- 12.6. **Service providers should make efforts to form and maintain strong links and placements with local universities and education providers,** including offering information and advice about working in the sector to pre-registration students and having links with tutor roles, such as regulated professionals lecturing on the course. This provides additional career development options for those already in the sector, whilst also enabling the sector to have visibility to students. Senior regulated professionals can enhance training by leading teaching sessions or information sharing during placements, aiming to boost sector exposure. Creating a role for regulated professionals as clinical academics can offer career development to those interested in teaching. While short-term challenges may arise, the long-term advantages of sector visibility and teaching are worth considering, potentially improving recruitment, retention and awareness of career paths for new professionals. Partnerships with universities for practice education placements could yield more interested and qualified professionals, benefiting both institutions and the sector.

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<sup>15</sup> White KH and King E. 'Hub and spoke model for nursing student placements in the UK'. *Nursing Children & Young People* 2015: volume 27, issue 2, pages 24–9. Available at: <https://journals.rcni.com/nursing-children-and-young-people/hub-and-spoke-model-for-nursing-student-placements-in-the-uk-ncyp.27.2.24.e547>

### 13. Newly qualified regulated professionals

Integrating newly qualified regulated professionals into their new team and place of work is important to help professionals translate their knowledge into everyday practice, grow in confidence and understand how to apply their skills to the sector.

**Preceptorship** and programmes for those who are newly qualified programmes enable a period of structured transition to guide and support all newly qualified practitioners from students to autonomous professionals to develop their practice further. During this time, they should be supported by an experienced practitioner of the same regulated profession to develop their confidence as an independent professional and to refine their skills, values and behaviours. Experiencing support and learning from best practice in dedicated time gives a foundation for lifelong learning and allows practitioners to provide effective person-centred care confidently.

The **NHS People Plan** and the **NHS Long Term Workforce Plan** outline the need for action to support newly qualified regulated professionals and state that investment in preceptorship leads to improved retention.

There are benefits for employers and employees in enabling preceptorships (for nurses) or assessed and supported years in employment (ASYE) (for social workers) including:

- offering the structured support needed to transition their knowledge into everyday practice successfully
- providing a lifelong journey of reflection and the ability to self-identify CPD needs
- increasing staff confidence, sense of belonging and feeling valued by their employer
- attracting and retaining skilled regulated professionals
- enhancing person-centred care and experience
- improving recruitment and retention
- reducing sickness absence and staff turnover
- increasing staff satisfaction and morale

**13.1. Employers should have a preceptorship or programme for newly qualified staff in place that meets the standards and guidance set out in the national preceptorship framework or the national ASYE framework.** For newly qualified social workers, Skills for Care set out requirements of the ASYE programme, which is funded by the DfE.

For newly qualified nurses, as recommended by [NHS England](#), a preceptorship programme should include:

- an organisational preceptorship policy and a designated lead for preceptorship
- defined roles for preceptor, preceptee and preceptorship lead
- a structured preceptorship programme that has been agreed by the executive nurse
- protected time for preceptorship activities, including a minimum initial supernumerary programme
- compliance with [Health Education England Standards \(2015\)](#), the [Nursing & Midwifery Council \(NMC\) Principles of Preceptorship \(2020\)](#) and the [National Preceptorship Framework \(2022\)](#)
- alignment with the organisational appraisal framework

13.2. **Employers should support all newly qualified regulated professionals to complete the [preceptorship](#) programme or [ASYE](#) programme.**

13.3. **Employers should consider applying for the [National preceptorship interim quality mark award for nurses](#).** This will demonstrate their support of future pre-registration and newly regulated nurses and communicate that their organisation is offering a quality preceptorship package for nurses entering the sector. [The National Preceptorship Interim Quality Mark](#) is the national standard for organisations offering a preceptorship programme to newly regulated nurses and was created in October 2022 when NHS England introduced the [new National Preceptorship Framework for Nursing](#).

## 14. Recruitment and retention for regulated professionals

The focus on recruitment and retention of regulated professional is needed not just for the initial growth of the workforce in the short term, but also to ensure that roles are filled with people who hold the necessary capabilities, knowledge and skills and to create a stable and suitable workforce that thrives over the next decade.

14.1. **Employers should recognise the wide range of specialist skills offered by different regulated professionals and be aware of this when evaluating skill gaps for recruitment and deployment purposes.** Regulated professionals offer significant value to drug and alcohol treatment and recovery services, given the multi-faceted needs of the people accessing them. The forthcoming capability framework must be used when looking at capabilities and skill gaps within services.

- 14.2. **Employers should ensure that regulated professionals have ample time and capacity built into job planning for the more rewarding parts of their role,** including therapeutic work with people in treatment. This will allow staff to make use of and maintain their wide range of skills, CPD and research and thereby ensure that jobs are rewarding and provide satisfaction to the workforce.
- 14.3. **Employers should support regulated professionals to progress through clearly defined, flexible organisational career pathways.** The specialist nature of drug and alcohol treatment and recovery services has the potential to provide regulated professionals with ample career progression opportunities. Opportunities may include clinical leadership, service development, senior management, specialised treatments, academia or research.
- 14.4. **Service providers should support regulated professionals to join networks to share best practices, reduce professional isolation and to work in collaboration.**
- 14.5. **Service providers should enable senior regulated professionals to offer support, mentoring, advice and guidance to junior workforce, including unregulated workforce, who wish to progress in their career.**

## 15. Training and skills development of regulated professionals

- 15.1. **Service providers should support regulated professionals by allowing their release to access skills development and training opportunities.** This will help to ensure that staff are competent and confident to deliver specialist evidence-based care and treatment to people accessing drug and alcohol treatment and recovery services. Professional development should be in line with service need and career development, allowing individuals to adopt a portfolio of skills that affords them the opportunity to provide holistic care and treatment, as well as to improve service provision overall.
- 15.2. **Service providers should ensure that regulated professionals have access to sufficient CPD opportunities** in line with the standards set by their registering or regulatory body.



## Role-specific strategic actions

Below are the strategic actions required for specific regulated roles.

### Nurses

**Nursing & Midwifery Council (NMC) registered nurses (all areas, including nursing associates), and those who also have a recordable qualification on the register as non-medical nurse prescribers (NMPs).**

Nurses currently make up around 9%<sup>4</sup> of the drug and alcohol treatment and recovery workforce, the largest clinical role group after drug and alcohol workers. Nurses play an essential role in the care and treatment of people who use(d) drugs and/or alcohol as their training encompasses both physical and mental health and places it in the context of community health. This makes them particularly suited to the drug and alcohol treatment and recovery sector.

The diverse mental and physical healthcare needs of the treatment population require specialist nursing input and, as such, the sector has the potential for ample career development opportunities. Despite this, stakeholders reported problems with recruiting and retaining nurses within drug and alcohol treatment and recovery services.

Stakeholders also shared that where newly qualified nurses are being employed in the drug and alcohol treatment and recovery sector, there is often an assumption that they will have the relevant skills and knowledge to work in these settings. However, nursing education can contain either minimal coverage of alcohol and drug use or, in some cases, no coverage at all. Nurses also reported issues with job satisfaction. Many have trained as independent NMPs, meaning they have completed additional training and recorded their qualification with the NMC as an independent prescriber (IP). This means they can prescribe medicine within their sphere of competency. This includes medicines and products listed in the British National Formulary (BNF), unlicensed medicines and most controlled drugs. This is an essential role within drug and alcohol treatment and recovery services, with a significant level of clinical responsibility. However, many nurse NMPs reported that they are unable to fully utilise their core nursing skills, such as physical and mental health assessment and psychosocial intervention, with people in treatment. This has led to a feeling of being deskilled, undervalued and unable to utilise their full range of nursing skills.

**The role of nurses in alcohol and drug treatment services** can be used to support recruitment. It sets out:

- the roles of nurses working in alcohol and drug treatment, including the contribution they can make to health and social care outcomes
- the added value nurses can bring to alcohol and drug treatment

- the competencies and skills that should be expected of nurses working in alcohol and drug treatment
- what is required to develop and maintain these competencies
- the forthcoming capability framework includes an up-to-date outline of the capabilities required by nurses working in the drug and alcohol treatment and recovery sector.

### 16. Recruitment and retention of nurses

Figure 6 shows a turnover rate for nurses of up to 25% in the voluntary sector. To create sustainable workforce transformation, employers need to prioritise retention and not just recruitment. In addition to the role-specific retention statement below, employers should also refer to [whole workforce recruitment and retention section](#).

- 16.1. **Employers should consider ways to maximise retention of their nursing workforce**, including using a [nursing retention toolkit for line managers and employers](#).
- 16.2. **Employers should ensure they are up to date and aware of current recruitment and retention practices for nurses**, including but not limited to:
  - [NHS England Retention hub](#) – An overview of the different programmes available and links to resources, including a [specific nursing and midwifery retention self-assessment tool](#) and supporting [toolkit](#), case studies and regional resources.
  - [Nursing and midwifery retention Future NHS workspace](#) – A series of masterclasses on various key topics within retention, including legacy mentoring, pension, menopause, flexible working, preceptorship and excellence in care. There are also details of People Promise Exemplar sites, key contacts of retention leads and retention managers for each region, and other related resources.
  - [NHS England Mental health nursing](#) – Resources to engage and support the mental health nursing workforce, such as the mental health nurse's handbook and mental health nurses' careers page.
  - [Mental Health Nurses' Forum](#) – A communication resource and network for mental health nurses. It facilitates mutual support and interaction, providing a space where mental health nurses can learn more about each other, their profession and what they contribute to care.

## 17. Training and skills development of nurses

- 17.1. **NHS England will complete scoping on the potential need for commissioned specialist postgraduate training for nurses in the drug and alcohol treatment and recovery sector.** HEIs should be supported by NHS England to articulate academic and experiential opportunities within the sector, and any learning that can then be shared nationally.
- 17.2. **Service providers should look at their placement offer for pre- and post-registered nurses who may be interested in working in the sector.** Offering placements to post-registered nurses can provide nurses with an opportunity to learn more about working in the sector and develop potential speciality/career change opportunities for nurses.
- 17.3. **Service providers must refer to the individual registration of nurses as well as their individual experience, skills and additional training when looking at their development.** Nurses should be working within their sphere of competence in their roles. It is especially important to note that while nursing associates will contribute to most aspects of care, including delivery and monitoring, nurses will take the lead on assessment, planning, evaluation and leadership. Those using this strategic plan must also adhere to the principles set out in the NMC code that require 'the professional commitment to work within one's competence' and the specific standards of proficiency for nursing associates.
- 17.4. **Service providers should ensure that nurses are trained to:**
- **undertake comprehensive, person-centred assessments** of people's drug and alcohol use and their psychological, social, physical and mental health needs and strengths
  - **plan, deliver and evaluate care and treatment for physical and mental health conditions collaboratively** using a range of evidence-based approaches
  - **undertake comprehensive risk assessments** to inform risk management in line with [NICE guidelines](#)
  - **complete a wide range of observation assessments that may include interpretation of test results**, including but not limited to blood pressure, pulse, respiration/O<sub>2</sub> saturation, breathalyser readings, electro cardiograms (ECG), fibro-scanning, urinalysis and blood tests
  - **use psychosocial interventions to influence and maintain behavioural change in relation to current lifestyle choices** through general physical and psychological health and wellbeing

- **assess the appropriateness and risk of community-based versus inpatient-based detoxification and treatment**
- **use validated withdrawal management assessment tools**, including but not limited to the Clinical Institute Withdrawal Assessment for Alcohol – Revised (CIWA-AR), Clinical Opiate Withdrawal Scale (COWS) and Subjective Opiate Withdrawal Scale (SOWS)
- **provide early identification, screening, care planning/referrals and treatment for drug and alcohol-related physical illnesses** such as alcohol-related liver disease, alcohol-related brain injury and alcohol-related dementia
- **provide clinical interventions, advice and guidance on health promotion and risk management**, including vaccines, blood borne virus screening and treatment, liver screening, smoking cessation, safer sex, physical health care, mental health care, wellbeing and lifestyle
- **provide physical healthcare, including wound dressings and abscess care.**

## Social workers

Social workers currently make up a small part of the treatment workforce (1%)<sup>4</sup>. Stakeholders reported that there could be confusion in services around the role of social workers and how it differs from the role of drug and alcohol workers. This was linked to the lack of a clear definition of the role of drug and alcohol workers. Some stakeholders felt that the responsibilities specific to the role of social workers could be further explored and used better within services. The forthcoming capability framework aims to bring clarity by defining the roles of both drug and alcohol workers and social workers working in drug and alcohol treatment and recovery settings.

Stakeholders reported that where newly qualified social workers are being employed in the drug and alcohol treatment and recovery sector, there is often an assumption that they will have the relevant skills and knowledge to work in the sector. However, social work education often contains either minimal coverage of alcohol and drug use, dependence and recovery or, in some cases stakeholders reported, no coverage at all. As with other regulated professionals, social workers have many transferable skills that can support drug and alcohol treatment and recovery outcomes. Social workers can offer reflective practice, training, mentoring and professional leadership. Social workers bring highly suitable skills and knowledge to the sector, for example: frontline experience of health and social care services; applying health and social care legislation in practice; expertise in mental health settings; and experience and expertise in using therapeutic models.

Social workers also have a key role in safeguarding, complex decision making, practice improvement and systems navigation. They bring together pathways into other services and provide knowledge of other areas of health and social care, enhancing an integrated care approach. Experienced social workers can form an integral part of operational leadership, supporting clinical governance structures, offering strategic oversight and enabling practice improvement.

To have confident and competent social workers within the workforce, appropriate training and development need to be offered. A clinical governance infrastructure is crucial so that social workers can access meaningful and regular clinical and managerial supervision, reflective practice and training.

## 18. Recruitment and retention of social workers

To create sustainable workforce transformation, employers need to prioritise retention and not just recruitment of social workers. In addition to the role-specific retention statement below, employers should also refer to [whole workforce recruitment and retention section](#).

- 18.1. **Service providers can use [Alcohol and other drug use: the roles and capabilities of social workers](#) and must use the forthcoming capability framework (Summer 2024) to set out the roles and capabilities required of**

social workers within drug and alcohol treatment and recovery settings.

## 19. Training and development of social workers

- 19.1. **NHS England will lead on the scoping of specialist postgraduate training for social workers in the drug and alcohol treatment and recovery sector.**
- 19.2. **Service providers must use the capability framework (expected Summer 2024) in addition to the [training list \(see 7.13.\)](#) under the whole workforce section when looking at training and development for social workers.**
- 19.3. **Service providers should support newly qualified social workers to complete their [ASYE](#), ensuring a suitable governance framework is in place with access to regular social work-led supervision, training and reflective practice.**
- 19.4. **Service providers should support social work apprentices and students with suitable social work-led support, supervision, practice educators, work-based assessors and mentoring.**
- 19.5. **Service providers should consider innovative ways to ensure robust leadership of social worker roles, ensuring a suitable infrastructure is in place utilising senior social worker roles.** Providers may consider using a hub model of leadership, if necessary, where senior social worker roles oversee social worker roles across several services.
- 19.6. **Service providers must promote a culture of skills development and training for social workers, enabling access to protected CPD time.** This will ensure that social workers are provided with the training and professional development required to maintain their knowledge, skills and registration with [Social Work England](#).
- 19.7. **Service providers should ensure social workers have the training and working knowledge required to maintain their legal literacy relevant to the drug and treatment and recovery alcohol sector, including but not limited to:**
  - [Mental Capacity Act \(2005\)](#)
  - [Mental Health Act \(1983\)](#)
  - [Care Act \(2014\)](#)
  - [Children Act \(1989\)](#)

## 20. Career development opportunities for social workers

- 20.1. **Employers should promote a culture of career development with opportunities for senior and advanced social workers in the sector.** Social workers should be supported with their professional development, including opportunities to undertake postgraduate research and contribute to service development and continuous improvement.

## Medical workforce

The medical workforce, comprising psychiatrists, GPs and specialty doctors, makes up less than 2% of the current drug and alcohol treatment and recovery workforce. This includes 167 psychiatry roles including trainees, and just 38 GPs including trainees. [Addiction psychiatrists](#) who have completed additional training and development to be able to specialise in this subspecialty make up 0.5% of the workforce<sup>4</sup>.

Stakeholders reported that the medical workforce is an essential element of the drug and alcohol treatment and recovery sector, yet is often overlooked and lacking in numbers. The medical workforce offers expertise in the assessment and treatment of people with complex physical, mental and social needs. Having the medical staff in an MDT can significantly improve the health and wellbeing outcomes for the population of people who use(d) drugs and/or alcohol. It is therefore vital to have the medical workforce as part of MDTs and treatment pathways.

There are currently insufficient numbers of GPs involved in drug and alcohol treatment to give an accurate description of their recruitment and retention, development and career progression. The Royal College of General Practitioners (RCGP) reports that there is a current [chronic shortage of GPs in the UK](#). GPs can offer necessary skills and knowledge of medicines and physical health to the drug and alcohol treatment and recovery sector, including but not limited to: treating common medical conditions; making referrals for people under their care to hospitals and other medical services for urgent and specialist treatment; medication prescribing; guidance/supervision for other prescribers; and expert policy development. Their competence should be assessed and developed using the [Public Health England \(PHE\)](#), [RcPsych](#) and [RCGP](#) guidance.

[A lack of training posts](#) has a direct negative impact on the size of the medical workforce working in drug and alcohol treatment and recovery services. Those involved in psychiatry within the sector point to reduced workforce professionalism due to changes in commissioning as the main reason for the current shortage of psychiatrists in the field. Stigma and misconceptions about problem drug and alcohol use and dependence were also often cited as contributing reasons to psychiatrists being put off working in the sector.

Some stakeholders explained that the challenges people experience interfacing between drug and alcohol treatment and recovery and mental health services may have been compounded in services where psychiatrists are less present. This has left staff who may have a limited understanding of how to navigate mental health services, including drug and alcohol workers, with responsibility for professionally challenging other services.

In addition to strong clinical leadership, the medical workforce provides a vital element to a workforce that enables specialised care and treatment for a population who are highly likely to experience co-occurring mental and physical health problems.

This strategic plan recognises the national shortage of medical professionals. It is important to note that there is no quick fix for the lack of medical workforce presence in the drug and



alcohol treatment and recovery sector. The training of a medical workforce takes many years, meaning vast improvements in recruitment are unlikely to occur soon or within the scope of this strategic plan. It is vital that while following the strategic statements below, providers and commissioners also consider the need to fill skill gaps.

## 21. Recruitment and retention of the medical workforce

To create sustainable workforce transformation, employers need to prioritise retention and not just recruitment. In addition to the role-specific retention statement below, also refer to the [whole workforce recruitment and retention section](#).

- 21.1. **OHID and NHS England commit to working with stakeholders such as RcPsych and the Society for the Study of Addiction to promote psychiatry within the drug and alcohol treatment and recovery sector through recruitment campaigns.**
- 21.2. **OHID will explore an addiction psychiatry specific campaign with RcPsych to encourage trainee psychiatrists to opt for addiction posts**
- 21.3. **NHS England will work to secure additional addiction psychiatry training posts in 2024/25 to expand the bank of posts currently available.**
- 21.4. **Service providers should work with HEIs, commissioners and existing psychiatrists to enable more placement opportunities for trainees by maximising the current supervisor and mentoring opportunities to support placements.**
- 21.5. **Employers must ensure that they remain up to date with the changes relevant to the recruitment of the medical workforce.**
  - The [Certificate of Eligibility for Specialist Registration \(CESR\)](#) is an alternative to traditional specialty and gives the ability to work as a consultant.
  - The [Certificate of Eligibility for GP Registration \(CEGPR\)](#) is an alternative to traditional specialty and gives the ability to work as a GP.
  - NHS England has committed in the [NHS Long Term Workforce Plan](#) to work with the General Medical Council (GMC) and NHS service providers to support doctors to develop their skills and progress through their careers.
- 21.6. **Service providers and commissioners should ensure that they are clear on the role and competencies of doctors and must use the capability framework (expected Summer 2024) when looking at capabilities within the medical workforce.** The medical workforce comes from a variety of training and professional backgrounds (including psychiatry and general practice) and have a range of different qualifications and specialist competencies. To satisfy regulatory

requirements from the [Care Quality Commission \(CQC\)](#) and the GMC to ensure the best outcomes and to manage risk, competencies need to match roles.

- 21.7. **Employers must use the forthcoming capability framework when designing medical job descriptions, service planning, planning training and for development and recruitment.** The capability framework (expected Summer 2024) will provide additional role profiles for the medical workforce.
- 21.8. **Service providers should remain up to date with changes within medical training that may directly impact on the recruitment and retention of the medical workforce.** The [NHS Long Term Workforce Plan](#) commits NHS England to working with the [GMC](#) and medical schools to explore options for a shortened medical degree programme that would be available for some existing healthcare professions, such as pharmacists and paramedics. The Medical Support Worker programme provides a stepping stone for permanent UK residents who hold a non-UK primary medical qualification, but are non-practising, to gain clinical experience while they work towards GMC registration. In the past two years, NHS England has supported around 1,000 medical support workers to attain a full licence to practise, allowing them to seek employment as a doctor. NHS England has committed in the [NHS Long Term Workforce Plan](#) to promote and develop this programme in the short to medium term as a sustainable cost-effective option for supporting the medical workforce.
- 21.9. **Employers should recognise the importance of having the medical workforce embedded in the MDT.** A diverse MDT provides additional clinical knowledge and skills and enhances the general wellbeing and integrated care of people who use(d) drugs and/or alcohol. Having the medical workforce as part of the MDT has a positive impact on treatment and recovery experiences and outcomes, promotes good practice in other healthcare professionals, provides clinical leadership and enables specialist clinical expertise.

## 22. Training and skills development of the medical workforce

- 22.1. **NHS England will work with the Heads of School in the regions, in partnership with RcPsych, to support and create training posts for additional psychiatry trainees to enable the necessary skills and development needed to advance into this subspecialty.**
- 22.2. **Employers must use the capability framework (expected Summer 2024) in addition to the [training list \(see 7.13.\)](#) under [whole workforce](#) when looking at training and development for the medical workforce.**
- 22.3. **Service providers and commissioners should ensure that they are clear on the [different role of addiction specialist doctors in recovery-oriented treatment systems](#).** Addiction psychiatrists have a distinct training qualification and specialist

levels of competence to work to support treatment and recovery outcomes. To satisfy requirements from the Care Quality Commission (CQC) and the GMC, service providers and commissioners should ensure doctors' competencies match their roles.

- 22.4. **NHS England will need to ensure adequate growth in foundation year placements and expansion of specialty training in future years, commensurate with the growth in undergraduate medical training.**
- 22.5. **Service providers should encourage the medical workforce to participate in educational activities** to raise awareness and capability through training, information and provision of up-to-date evidence-based guidance and advice, as well as enabling them to contribute to medical audit or research to further develop the wider sector.
- 22.6. **Service providers must promote a culture of skill development** for the medical workforce within the drug and alcohol treatment and recovery sector.

### **23. Career development opportunities for the medical workforce**

- 23.1. **Service providers should enable the medical workforce to attend national and international specialist conferences and lead research activities**, in line with recommendations from Dame Carol Black's independent review of drugs **Error! Bookmark not defined.** Given its specialist nature, the sector offers the potential for ample career development opportunities, which should be maximised.
- 23.2. **OHID will explore with RcPsych development of a training pathway for consultants to train and demonstrate equivalence to become addiction specialists (credentialing)**
- 23.3. **NHS England will develop a career pathway for GPs who wish to further develop within the drug and alcohol treatment and recovery sector.** Doctors wishing to develop into a **speciality doctor** role will need clear supervision and development pathways.
- 23.4. **Service providers must promote a culture of career development for GPs within the drug and alcohol treatment and recovery sector.** A **GP support pack** can help GPs and employers when thinking about career progression.

## Pharmacists

Stakeholders reported that pharmacists and pharmacy technicians are an essential element of the drug and alcohol treatment and recovery workforce, yet are overlooked and lacking in numbers. There are just 22 specialist pharmacy professionals currently working in the sector<sup>4</sup>.

Pharmacists offer necessary skills and expert knowledge of medicines and health to the drug and alcohol treatment and recovery sector, including but not limited to: medication dispensing; expertise in handling and storing controlled drugs; prescribing and guidance/supervision for other prescribers; and expert policy development.

Pharmacists also have expertise in offering direct healthcare advice to a population of people with significantly poorer health outcomes compared with the general population. This is particularly important as many stakeholders reported that people who use(d) drugs and/or alcohol are unlikely to attend their GP when they are in poor health and are at an increased risk of complications from poor physical health.

Pharmacists' unique expertise and knowledge make them essential members of the MDT, with the ability to significantly improve the health and wellbeing outcomes for the population of people who use(d) drugs and/or alcohol.

## 24. Recruitment and retention of pharmacy professionals

In addition to the role-specific retention statement below, employers should also refer to the [whole workforce recruitment and retention section](#).

- 24.1. **Service providers should consider the many benefits of employing pharmacy professionals and the longer-term potential for return on investment.** Greater numbers of pharmacists and pharmacy technicians embedded in services will have a positive impact on outcomes, promote good practice in other healthcare professionals and provide specialist clinical expertise. Having pharmacists embedded in the MDT will provide additional clinical knowledge and skills, while also enabling other professionals, such as nurses or psychiatrists, additional capacity to provide clinical supervision or specialist therapeutic interventions.
- 24.2. **Service providers who do not employ pharmacy professionals as part of their workforce should consider seeking sessional input or ad hoc expertise and advice from a pharmacist to enhance the MDT approach in their service.** Making links with local pharmacists with wider expertise and experience can support this.

## 25. Training and skills development of pharmacy professionals

- 25.1. **Service providers must use the forthcoming capability framework (expected Summer 2024) in addition to the [training list \(see 7.13.\)](#) under the [whole workforce section](#) when looking at training and development for pharmacy professionals.**

### Psychological professions

Psychological professions bring critical skills, knowledge and experience to MDTs in the drug and alcohol treatment and recovery sector. This section encompasses psychological professions, including but not limited to; assistant psychologists; mental health and wellbeing practitioners; cognitive behavioural therapy (CBT) therapists; clinical associates in psychology (CAPs); counsellors; psychotherapists; and psychological professions trainees. It is recognised that psychological professions include a wide range of roles, some of which are well-developed roles in other parts of mental health services or new roles supported by NHS England. When there are new roles particularly relevant to drug and alcohol treatment and recovery services, these should be considered in workforce planning. The forthcoming capability framework will specify the capabilities and role profile for practitioner psychologists. An addiction counselling competence framework will also be published by the British Association for Counselling and Psychotherapy in Summer 2024.

**Practitioner psychologists** (including clinical, counselling and forensic psychologists) are regulated by the HCPC. Assistant psychologists are unregistered. All other psychological professions relevant to the drug and alcohol treatment and recovery sector will be registered on a recognised accredited register. Some psychological professions are accredited and on voluntary registers. For the purpose of this document, they are considered registered and the statements for regulated professionals apply.

The expertise of psychological professions is not only integral to working with diverse mental health presentations, including the consequences of trauma that are often seen in drug and alcohol treatment and recovery services, but also in delivering psychological therapies in accordance with relevant evidence-based therapeutic models and NICE guidelines. Many clinical psychologists engaged when developing this plan reported significant issues with recruitment into drug and alcohol treatment and recovery services. They highlighted several barriers, including a lack of placement opportunities/uptake and minimal coverage of alcohol and drug use treatment and recovery in training curricula.

National workforce data suggests that there were 22 WTE consultant psychologists working in the drug and alcohol treatment sector and 33 WTE practitioner psychologists in the drug and alcohol treatment sector in 2023. This compares to 16 WTE consultant psychologist and 23 WTE practitioner psychologists in 2022<sup>4</sup>. The census also indicates that around 100 WTE counsellors, as well as some psychotherapists, counselling trainees and a small cohort of Mental health and wellbeing practitioners, are working in the sector. **Psychological professions** are a diverse group whose work is informed by the different disciplines of

psychology and psychological therapy. Each role brings different training, skills and experience. The strengths of these roles need to be considered for inclusion in MDTs to help meet the psychological needs of people accessing treatment and recovery services. Stakeholders reported that many psychological professionals are put off working in the sector because many of the non-NHS providers do not match the employee salaries and benefits offered by the NHS.

## 26. Recruitment and retention of psychological professions

To create sustainable workforce transformation, it is important that retention is prioritised by employers. In addition to the role-specific retention statement below, employers should also refer to the [whole workforce recruitment and retention section](#).

- 26.1. **Employers should explore ways of retaining their current psychological workforce through the [psychological professions workforce plan](#).**
- 26.2. **Service providers should make links with their local universities and HEIs to raise awareness around the diversity of trauma-focused work in the drug and alcohol treatment and recovery sector for both undergraduate and postgraduate psychology students.** Psychologists spoken with found that highlighting the opportunity to work with people with trauma, rather than simply describing the work as 'drug and alcohol' work, has resulted in increased interest in careers in this sector and can enhance the experience of psychologists, which is especially helpful when they look at the criteria for postgraduate training programmes. Additionally, supporting psychologists to teach on local courses is another way of promoting the sector and increasing awareness of the potential roles and career development available to future psychologists.
- 26.3. **Service providers should support their psychologists in offering training placements to doctoral programme trainees (clinical and counselling) to enhance the future recruitment of psychologists to the sector.**
- 26.4. **Service providers should consider the different types of psychological profession and the diversity of their skills and specialisms when recruiting to ensure an appropriate skill mix able to meet the needs of people accessing treatment.** Considering the different levels of experience and skills that psychologists bring will enable recruitment to roles with the ability to lead a psychological professions workforce, provide clinical leadership, supervise, build psychosocial intervention capacity and skills across the unregulated workforce, and deliver training.

## 27. Training and skills development of psychological professions

- 27.1. **Service providers should encourage psychological professions to make strong links with each other via existing professional networks, including the**

Psychological Professions Network (PPN) and the professional and registering organisations for the psychological professions. This will enable the sharing of best practices and access to CPD and peer learning opportunities at a national level.

27.2. **Service providers must use the capability framework (expected Summer 2024) for psychologists and counsellors in addition to the training list (7.13.) under the whole workforce section when looking at training and development for psychological professions.**

27.3. **Service providers should ensure that psychological professions are trained to:**

- **undertake comprehensive, person-centred assessments** of people's drug and alcohol use and their psychological, social and health needs and strengths
- **enable them to develop a psychological formulation in order to plan, deliver and evaluate care collaboratively** using a range of evidence-based approaches, such as mapping techniques and motivational interviewing
- **use evidence-based psychological interventions and specific psychological therapies for the treatment and recovery of drug and/or alcohol use and co-occurring mental health conditions**
- **use evidence-based psychological interventions for families and affected others of people using drugs and/or alcohol**
- **develop a psychological formulation that facilitates understanding of difficulties, including drug and alcohol use, identifies diagnosis where appropriate and indicates evidence-based interventions to be used**
- **deliver psychoeducation around problematic drug and alcohol use and mental health problems and how these difficulties can co-occur.**

## Drug and alcohol workers

Drug and alcohol workers make up the largest proportion of the workforce at 50% across treatment providers<sup>4</sup>. The role is currently unregulated. These workers provide the bulk of the treatment interventions to people accessing drug and alcohol treatment and recovery services. The skilled, high-pressure work carried out by drug and alcohol workers requires significant levels of clinical supervision, support and training. Yet stakeholders reported that this is often not prioritised or protected within their workplaces and that there is a lack of distinct structured clinical supervision being offered.

Stakeholders spoke of times when clinical supervision and training were cancelled to meet the needs of clinical service delivery. In many services, clinical supervision and training were viewed as in addition to the role and not as a fundamental requirement for staff in these roles.

Drug and alcohol workers reported that job adverts are often misleading because job titles tend to be vague, using titles such as 'recovery worker,' without being clear about the nature and responsibilities of the role.

Drug and alcohol workers reported that they felt that job titles inadvertently downplay the skilled and frontline nature of their roles. They felt that the role often appeared more junior and less frontline in adverts than it is in practice and that some suitable candidates may be put off applying due to this. The majority (92%) of drug and alcohol workers are paid the equivalent of band 5 [NHS Agenda for Change \(AfC\)](#) or lower (<£33,000), compared with 73% within this salary range across all staff groups<sup>4</sup>.

While the lack of clinical supervision currently impacts across the workforce, this issue particularly impacts on drug and alcohol workers since they also often lack specific formal training and education. Clinical supervision is essential for delivering psychosocial interventions competently and is particularly important for drug and alcohol workers to support them to reflect on their practice, develop and maintain self-awareness, identify the emotional challenges of the role and identify strategies to deal with these challenges.

Drug and alcohol workers also report that there is a significant amount of inter-professional work required with multiple other agencies, including but not limited to: the criminal justice system; housing; employment support; mental health services; and social care. Interfacing with other services requires often complicated and carefully co-ordinated communication, with an understanding of other systems and services [to ensure that people with multiple needs receive integrated support from services](#). Clinical supervision allows drug and alcohol workers to explore the varied and interlinking needs of the people they support in a reflective and enriching manner.



## 28. Recruitment and retention of drug and alcohol workers

Figure 6 shows a turnover rate for drug and alcohol workers of up to 29% in the voluntary sector treatment provider workforce. To create sustainable workforce transformation, service providers need to prioritise retention and not just recruitment. In addition to the role-specific retention statement below, employers should also refer to the [whole workforce recruitment and retention section](#).

- 28.1. **Service providers must use the forthcoming capability framework when recruiting drug and alcohol workers with an appropriate range of capabilities, skills and experience.** The capability framework must be used to inform recruitment, job descriptions, training and development and career development. This will result in a workforce with a range of backgrounds, including drug and alcohol workers with years of experience, those new to the workforce, those with lived experience and graduates with relevant degrees, all of whom will bring with them useful insights. Bringing in both lived and learned experience to the workforce can strengthen service quality. Having lived experience can bring valuable insights to working with others. However, it is important that services recognise the full range of necessary capabilities, skills, experiences and qualities of potential workers to be able to meet the needs and build on the strengths of the population they serve.
- 28.2. **Employers should have career development conversations with drug and alcohol workers and actively support them to pursue specific career development opportunities.** For example, if they express interest in pursuing a role with a psychological focus, they could be given the opportunity to participate in psychology meetings, collaborate closely with psychologists, receive tailored supervision to further enhance their work and engage in other relevant developmental activities.

## 29. Training and skills development of drug and alcohol workers

- 29.1. **OHID, with support from NHS England, will commission the development of a curriculum for the role of drug and alcohol worker that aligns with the capabilities and role profile within the capability framework.**
- 29.2. **OHID and NHS England will support the accreditation of drug and alcohol worker training against the curriculum through a national body.** Stakeholders have given excellent examples of training and development happening within the sector. Accreditation attached to a national curriculum and based upon the capability framework would enable consistency throughout training, development and roles across the sector. National accreditation allows for a funding model to be agreed with OHID, supporting the implementation and further development in the sector.

29.3. **Service providers should consider apprenticeships to support drug and alcohol workers in formalising their training, knowledge and skills.** Examples of suitable apprenticeships include:

- Health and wellbeing worker
- Leader in adult care
- Lead practitioner in adult care
- Lead adult care worker

29.4. **Service providers should stay up to date with changes in apprenticeships and their relevance within the sector.**

29.5. **In addition to the training list (see 7.13.) under the whole workforce section, service providers should ensure that drug and alcohol workers are trained to:**

- **undertake comprehensive, person-centred assessments** of people's drug and alcohol use, their psychological, social and health needs and strengths
- **undertake comprehensive risk assessments** ascertaining psychological, physical and social risks to/from people who use(d) drugs and/or alcohol
- **plan, deliver and evaluate care collaboratively** using a range of evidence-based approaches, such as mapping techniques and motivational interviewing
- **develop risk management plans** that include risk and harm reduction interventions to manage identified risks
- **deliver a range of evidence-based treatment and recovery interventions**, including psychosocial interventions, motivational work and relapse prevention interventions
- **co-ordinate and key work complex care**
- **facilitate group work**
- **offer trauma-informed care and treatment**

## 30. Career pathway opportunities for drug and alcohol workers

30.1. **Service providers should support career development opportunities for drug and alcohol workers.** Drug and alcohol workers have a multitude of career pathway opportunities available, which they can access while remaining in the sector. Retaining a skilled and experienced workforce is critical to the stability of the sector,

especially during this time of workforce development. Progression into regulated professions via apprenticeships, training and education programmes, or moving into a senior drug and alcohol worker role, gives career development opportunities while remaining in a frontline role. There are also opportunities for progression into supervisory and/or leadership roles, which will be further defined within the capability framework, due to be published in Summer 2024.

### **31. Clinical supervision of drug and alcohol workers**

31.1. Refer to the [whole workforce clinical supervision section](#).

## Children and young people's drug and alcohol workers

While there are similarities between adult drug and alcohol workers and children and young people's drug and alcohol workers (CYP D&A workers), there are significant differences in the interventions, legal frameworks and therapeutic approaches. CYP D&A workers normally work with children and young people from ages of 12 to 17 with transition arrangements up to 24 years old in some cases, depending on local service models and commissioning arrangements. This means that they need a broad skill set to understand and meet the developmental needs of different age groups.

Stakeholders reported that CYP D&A workers need specific knowledge and skills in engaging with children and young people. It requires a different approach to working with adults who use(d) drugs and/or alcohol. There are additional considerations around the systemic nature of the work, often requiring working with parents/carers and schools as well as children and young people, and the need for an enhanced understanding of safeguarding processes and the implications of consent and capacity. For example, [the Gillick competence and Fraser guidelines](#) are used to assess whether or not a child under 16 has the capacity to consent to their treatment.

The need for effective inter-professional working remains important for CYP D&A workers; however, the agencies tend to be different. CYP D&A workers work closely with a range of agencies, including but not limited to: child and adolescent mental health services (CAMHS); education/schools; child protection and early help teams; youth workers; and youth offending services.

Stakeholders reported that, historically, CYP D&A workers work in children and young people's drug and alcohol services because of a passion for working with children and young people. They also reported that CYP D&A workers do not tend to leave services to work in other drug and alcohol services, but instead go on to other career development opportunities in services that also support young people, such as youth work, social work and youth offending work.

## 32. Recruitment and retention of CYP D&A workers

In addition to the role-specific retention statement below, employers should also refer to the [whole workforce recruitment and retention section](#).

- 32.1. **Service providers should assess the candidate's ability to engage and build therapeutic relationships with children and young people when recruiting CYP D&A workers and not rely on drug and alcohol knowledge alone.**
- 32.2. **Service providers must use the capability framework for CYP D&A workers to ensure an appropriate range of capabilities, skills and experience for the roles.** The forthcoming capability framework must be used to inform recruitment, job descriptions, training and development and career development. This will result in a

workforce with a range of backgrounds, including CYP D&A workers with years of experience, those new to the workforce, those with lived experience and graduates with relevant degrees, all of whom will bring with them useful insights. Bringing in both lived and learned experience to the workforce can strengthen service quality. Having lived experience can bring valuable insights to working with others. However, it is important that services recognise the full range of necessary capabilities, skills, experiences and qualities of potential workers to be able to meet the needs and build on the strengths of the population they serve.

- 32.3. **Employers should have career development conversations with CYP D&A workers and actively support them to pursue specific career development opportunities.** For example, if they express interest in pursuing a role with a psychological focus, they could be given the opportunity to participate in psychology meetings, collaborate closely with psychologists, receive tailored supervision to further enhance their work and engage in other relevant developmental activities.

### 33. Training and skills development of CYP D&A workers

- 33.1. **OHID and NHS England will commission the development of a curriculum for the role of the CYP D&A worker** that aligns with the capabilities and job profile within the capability framework.
- 33.2. **OHID and NHS England will support the accreditation of training against the curriculum through a national body.** Stakeholders have given excellent examples of training and development happening within the sector. Accreditation attached to a national curriculum and based upon the capability framework would enable consistency throughout training, development and roles across the sector. National accreditation allows for a funding model to be agreed with OHID, supporting the implementation and further development in the sector.
- 33.3. **Service providers should consider a working with children, young people and families apprenticeship to support CYP D&A workers in formalising their training, knowledge and skills.**
- 33.4. **Service providers should consider the specific training and CPD needs of CYP D&A workers, being mindful of the specific age and development needs of children and young people and that they differ from those of adults.** Specific training needs to be provided to CYP D&A workers to reflect the requirements of their role, including but not limited to: capacity and consent for young people; child wellbeing and safeguarding children; child development; and working effectively with children, young people and their families.
- 33.5. **Service providers should consider further training and development opportunities around delivering age-appropriate evidence-based psychosocial and pharmacological approaches and interventions to children and young**

**people.** Treatments often need to be adapted for CYP D&A workers to enable them to deliver age-appropriate psychosocial and pharmacological interventions to young people.

33.6. Service providers should ensure that CYP D&A workers are trained to:

- **work with children and young people**, understanding the differences in interventions, treatment, care, legal frameworks and support needs related to childhood, adolescence and young adulthood
- **recognise and work with a range of disabilities**, including but not limited to learning and developmental disabilities
- **offer evidence-based behavioural strategies** to manage symptoms and promote mental, emotional and physical health
- **recognise that trauma may present differently in children and young people** and enable an age-appropriate trauma-informed approach to working with children and young people
- **plan, deliver and evaluate care** collaboratively using a range of evidence-based approaches
- **undertake comprehensive, person-centred assessments** of children and young people's drug and alcohol use, their psychological, social and health needs and strengths
- **undertake a comprehensive risk assessments**, ascertaining psychological, physical and social risks to/from children and young people who use(d) drugs and/or alcohol
- **develop risk management plans** with children, young people, families, carers and affected others that include harm reduction interventions to manage identified risks
- **deliver evidence-based psychosocial interventions**, including harm reduction interventions for children and young people
- **work with children and young people and their families**, including understanding the implications of parental responsibility and the dynamic of parental and family-based relationships

## 34. Career pathway opportunities for CYP D&A workers

- 34.1. **Service providers should support career development opportunities for CYP D&A workers.** CYP D&A workers have a multitude of career pathway opportunities available, which they can access while remaining in the sector. Retaining a skilled and experienced workforce is critical to the stability of the sector, especially during this time of workforce development. Progression into regulated professions via apprenticeships, training and education programmes, or moving into a senior CYP D&A worker role, gives career development opportunities while remaining in a frontline role. There are also opportunities for progression into supervisory and/or leadership roles, which will be further defined within the capability framework (expected Summer 2024).
- 34.2. **Employers should have professional development conversations with CYP D&A workers to allow for career pathways, leadership progression or development opportunities within the drug and alcohol sector.** This would enable CYP D&A workers to continue to develop within the sector and provide a sense of progression within their roles.

## 35. Clinical supervision of CYP D&A workers

In addition to the role-specific clinical supervision statement below, employers should also refer to the [whole workforce clinical supervision section](#).

- 35.1. **Service providers must ensure that CYP D&A workers are provided with mandatory safeguarding supervision.** This should be delivered by an appropriately experienced and trained clinical member of the workforce who is able to support CYP D&A workers with the ongoing specific safeguarding considerations related to working with children and young people.

## Peer support workers

Peer support workers (PSWs) are adults who have direct lived experience of their own or a family members' problematic drug and alcohol use and recovery. They are trained and employed to support and encourage others using their lived experience as underpinning guidance. They are able and ready to use their lived experience, skills and knowledge to support others to reduce harm, engage with treatment and other support services, and initiate and sustain recovery. PSWs can provide inspirational guidance, advocacy and support to other people through their recovery journey.

Lived experience is the experience of people and families who were previously affected by problem drug or alcohol use and are now in recovery. This is distinct from learned experience, which people can get through studying, practising or exposure. People can, and typically do, have a mixture of both lived experience and learned experience.

Within LEROs, peer support and development roles make up the biggest proportion of the workforce at 55%, which compares to 8% of treatment provider staff in these roles <sup>4</sup>.

The role of the PSW is based on 'being alongside' the person they are supporting to enable them to access the appropriate treatment, care and recovery support they need without judgement or stigma. Stakeholders reported that this was a distinct position from that of other members of the MDT. They reported that PSWs break down barriers to being able to access treatment and other support by creating a sense of collaboration between people who use(d) drugs and/or alcohol and members of the MDT with which they are working.

Stakeholders spoke of the importance of PSWs in services and within an MDT. Bringing in both lived and learned experience to the workforce can strengthen the service quality.

Some stakeholders reported that PSWs were undertaking the roles and responsibilities of keyworkers, such as conducting initial and comprehensive assessments, developing and supporting treatment and recovery care plans and delivering treatment interventions. It is essential that there is a shared cross-sector understanding of what is in and out of the scope of PSW roles and how the role is differentiated from other roles. The forthcoming capability framework provides capability statements for the PSW role to clarify the skills, knowledge and responsibilities of PSWs as distinct from other roles.

The role of a PSW often does not have any academic entry requirements, specific training or work experience attached. Training for PSWs was reported as inconsistent by stakeholders, with some providing detailed internal training packages with multiple modules, including some that are accredited, whereas others reported minimal internal or external training being offered to them in their role.



PSWs have highly valued lived experience, but there is a risk of relapse for them in their own drug/alcohol use or a change in their own mental health needs<sup>16</sup>. PSWs need support to cope with potential triggers and the demanding nature of peer support, which can be emotionally draining and stressful. Given the nature of the role, people working with treatment and recovery services may be more likely to disclose difficult and sensitive information to a PSW. Services should be mindful and sensitive in cases where any employee, including but not limited to PSWs, need to access support from drug and alcohol services themselves.

A change in role from a member of staff to a person receiving support from the service can bring up a range of additional concerns, including confidentiality, privacy, non-judgemental access and treatment and professional boundaries. Where any employee, including a PSW, requires drug and alcohol-related treatment, this is sometimes arranged out of the area to protect confidentiality. Service providers, team leaders and managers have a responsibility to ensure that the PSW and wider workforce are supported in these situations.

OHID's [recovery support services and lived experience initiatives guidance](#) outlines the evidence for peer support, particularly peer-based recovery support services, and the types of peer support roles currently integrated into local alcohol and drug treatment systems.

### 36. Recruitment and retention of PSWs

- 36.1. **Service providers should prioritise the wellbeing of PSWs.**
- 36.2. **Service providers should ensure that their organisation's culture and processes will support PSWs to thrive within their roles.** [Preparing organisations for peer support: creating a culture and context in which PSWs thrive](#) can be used to ensure all fundamentals around recruitment and retention are fully considered.

### 37. Training and skills development of PSWs

The training and skills development for PSWs to meet the requirements of the capability framework can be achieved through the [training list \(see 7.13.\)](#) mentioned in the [whole workforce training and skills section](#).

- 37.1. **OHID and NHS England will commission the development of a curriculum for the role of the drug and alcohol peer support worker that align with the capabilities and job profile within the capability framework.**
- 37.2. **OHID and NHS England will support the accreditation of training against the curriculum through a national body.** Stakeholders have given excellent examples of training and development happening within the sector. Accreditation attached to a

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<sup>16</sup> Webster, R (2021) 'The best practice guide: a guide on how to support people with lived experience'. Available at: <https://peervols.russellwebster.com/best-practice>  
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national curriculum and based upon the capability framework would enable consistency throughout training, development and roles across the sector. National accreditation allows for a funding model to be agreed with OHID, supporting the implementation and further development in the sector.

37.3. **Service providers should consider a peer worker apprenticeship for formalising PSWs' knowledge and lived experience alongside their learned experience.**

37.4. **Service providers should support PSWs to take part in research by participating in or accessing training and skills development.**

## 38. Supervision of and support for PSWs

Although PSWs offer direct support and advice to people who use(d) drugs and/or alcohol, they do so in a manner that draws on the concept of peer support – using their own lived experience to guide the process. PSWs require regular access to supportive supervision, which should include an element of reflective practice (as defined in [Appendix 5](#)), offering them a space to review and reflect on their work with an appropriately trained clinician or senior PSW. This should also include an opportunity to discuss areas that they might experience as difficult or distressing and must be differentiated from line management or case management. It is vital that service providers ensure this is provided to promote and maintain the wellbeing and safety of both PSWs and the people they are supporting. Where PSWs are doing clinical work and delivering clinical interventions (including psychosocial interventions), they require clinical supervision.

38.1. **Service providers must ensure that PSWs are provided with high-quality management supervision and support from a suitably trained and experienced manager or senior staff member (pro-rata for part-time staff).** It may be helpful if this manager has lived experience or has been trained by someone with lived experience. PSWs should also have access to reflective practice where possible.

38.2. **Service providers must ensure that PSWs are supported with their own recovery.** PSWs may need additional flexibility in their role with the option to step out of employment for an agreed period if needed without any negative implications for their role.

## Volunteers

7% of the treatment provider workforce comprises volunteers, while a significant 75% of peer support and development roles within treatment services are unpaid<sup>4</sup>. This compares to LEROs, in which 29% of the LERO workforce are volunteers and most (58%) peer support and development roles are paid. Most volunteers in the sector are people with lived experience of problem drug and alcohol use who are passionate about supporting the recovery of others. Stakeholders reported a wide range of volunteer titles being used, such as 'peer mentor,' 'peer supporter,' 'peer volunteer' and 'recovery coach.'

It is important, however, to note that any such voluntary roles are different to the employed PSW roles within the sector and the capabilities expected of a volunteer are not the same as those in the forthcoming peer support worker capability framework. Stakeholders spoken with had different understandings of the roles and responsibilities of volunteers within services. Stakeholders spoke of volunteers supporting individuals and groups into or through treatment and recovery by providing advocacy and buddying and facilitating access to mutual aid and groupwork, while supporting engagement and helping to build positive relationships with people.

The lack of clarity on the difference between a volunteer and a paid peer support role is unhelpful for many reasons; it minimises clarity for people accessing services, it makes workforce data collection difficult and makes defining the capabilities and responsibilities of these roles difficult.

Several stakeholders expressed concerns about how some volunteers are being deployed. They described volunteers being asked to deliver clinical interventions and treatment in the same way as drug and alcohol workers, despite being unpaid and receiving insufficient training and clinical supervision for such work. There was also mention of a lack of management supervision in some services, leaving volunteers feeling unsupported or unclear about their roles and responsibilities. In rare examples, the combination of these factors had led to interpersonal difficulties between volunteers and people accessing services, such as overinvolvement, a lack of boundaries or a conflict of interest.

It is important to note that volunteers are an important asset to the drug and alcohol treatment and recovery sector and, when managed appropriately, volunteering can benefit the volunteer, people accessing services and the service itself. Volunteering can help to rebuild people's self-esteem, offer a sense of purpose and give people an opportunity to learn new skills. However, volunteers should be supervised and supported and should not be doing clinical work or delivering clinical interventions. Volunteers may be interested in moving into future paid employment within the sector and have the potential to provide a future workforce of PSWs, drug and alcohol workers and other roles with appropriate training and experience.

## 39. Recruitment and retention of volunteers

- 39.1. **Service providers have a duty of care to volunteers and must clearly define the role of volunteers and allocate tasks appropriately.** Volunteers should be supervised and supported and should not be doing clinical work or delivering clinical interventions.
- 39.2. **Service providers should consider using volunteer agreements.**
- 39.3. **Service providers must ensure that volunteers remain complementary to the workforce and work in a supernumerary capacity.** This means that volunteers are not to be factored into service provision, service delivery or workforce calculations.

## 40. Training and skills development of volunteers

- 40.1. **Service providers should provide volunteers with role-specific training and development.**

## 41. Supervision of volunteers

- 41.1. **Service providers must have clear guidance within their volunteering policy and procedure for providing support and supervision to volunteers.** Volunteers may have experienced trauma themselves and, as such, volunteering in drug and alcohol treatment and recovery services has the potential to be re-traumatising if support is insufficient. Regular supervision should be facilitated by an appropriately trained supervisor to ensure that volunteers are supported while they undertake the tasks they have been given.

## 42. Career development opportunities for volunteers

- 42.1. **Service providers should see the value in offering volunteers support and advice on career progression within and beyond the drug and alcohol treatment and recovery sector where interest is expressed.** This may involve supporting volunteers in progressing into paid employment, training or apprenticeships in the sector or other sectors, as well as offering advice or signposting to organisations who can advise on how to train in specific professional disciplines.

## Commissioners

Within this section of the strategic plan, the focus is on the role of commissioners. However, many elements will be applicable to all roles within commissioning.

In England, the majority of community drug and alcohol treatment and recovery services, and some inpatient and residential treatments, are publicly funded via the [Public Health Grant \(PHG\)](#), for which upper-tier LAs in England have responsibility. In addition to the PHG, LAs are currently receiving other drug and alcohol treatment and recovery grants from OHID. These include the:

- Supplemental Substance Misuse Treatment and Recovery Grant 2022–25
- Rough Sleeping Drug and Alcohol Treatment Grant (RSDATG) 2022–24 in 83 lower-tier LAs

Services are commissioned to meet local needs; the provider landscape therefore varies by area, with a diverse range of service providers.

Some elements of the wider treatment and support system for people who use(d) drugs and/or alcohol are commissioned by the NHS and provided by LA funding. These include:

- retail community pharmacies and hospital pharmacies
- substance misuse teams in secure settings
- alcohol care teams (ACTs)

Commissioners are a crucial component of the drug and alcohol treatment and recovery workforce. To enable commissioners to deliver and sustain the changes that are needed in the sector, it is important that they can access specific training, development and support. They play a critical leadership role in the sector but can find it difficult to access the support they need to do the job. Challenging circumstances will often mean that they need to make tough decisions that require a high level of insight, knowledge and organisational support. They have an essential and complex role to play in system leadership, particularly around workforce development in their localities, and leading on and supporting cultural changes within local services.

They should use a collaborative and transparent approach by encouraging genuine multidisciplinary work between the NHS, voluntary sector providers and other system partners. This is especially relevant within specialist drug and alcohol treatment and recovery services where both NHS and voluntary sector providers are sometimes commissioned within the same locality. They also have a key part to play in supporting and improving inter-professional working across different services while managing their own inter-professional relationships across local systems. Stakeholders reported challenges around drug and alcohol services interfacing with mental health services.

**Guidance on commissioning** has outlined that better care is required for people with co-occurring mental and drug and alcohol use conditions. Commissioners and service providers should use this guidance to inform the commissioning and provision of effective care. It also has relevance for all other services that have contact with people with co-occurring conditions, including people experiencing a mental health crisis. Commissioners have an important opportunity to enhance investment in the drug and alcohol treatment and recovery workforce by investing in recruiting MDTs with access to training and development opportunities, facilitating research, management and clinical supervision, and reduced caseloads at clinically safe levels.

This strategic plan recognises that the proposed move toward commissioning for workforce development may lead to a decrease in productivity and poorer outcome measures in the short term. It is however essential to move away from commissioning on a low-cost basis and instead to focus on commissioning and supporting a sustainable high-quality service delivering the best practice with a skilled, trained and robust multidisciplinary workforce.

### 43. Strategic actions for commissioners

- 43.1. **Commissioners must use procurement reforms to prioritise the stability and sustainability of services over current retendering cycles.** The Provider Selection Regime (PSR) came into force on the 1st of January 2024. The PSR is a set of bespoke rules which commissioners of healthcare services in the NHS and local government will follow when procuring or otherwise arranging healthcare services in their area. The PSR is designed to give commissioners of healthcare services more flexibility when selecting providers including flexibility to use competitive processes when it makes sense to do so. It is a flexible and proportionate process for deciding who should provide health care services, including LA commissioned drug and alcohol treatment and recovery services, through either a direct award, a competitive process, or by identifying the most appropriate provider. [A supporting toolkit and information on transitional arrangements](#) are available.
- 43.2. **LAs should look for commissioner training courses that supports their role in commissioning drug and alcohol treatment and recovery services** and enables them to meet the capabilities listed in the commissioner capability framework expected in Summer 2024.
- 43.3. **LA commissioners should have sufficient knowledge of the areas they are commissioning**, the wider landscape and the potential interfaces and interdependencies with other parts of the system. LAs and commissioners need to be aware of potential developments, challenges and barriers within the treatment and recovery sector.
- 43.4. **LAs should support commissioners to access skills and development training packages.** A significant part of this will be enabling commissioners to have the time and space required for proper learning and development.

- 43.5. **LAs, with the support of OHID, should develop networks or build on existing networks, such as the English Substance Use Commissioners' Group, to share best practices and work in collaboration.** This will help commissioners learn from one another, provide peer support and be aware of emerging practices.
- 43.6. **LAs must use the capability framework (expected Summer 2024) in addition to the training list (see 7.13.) under the whole workforce training and skills section when looking at training and development for commissioners.**
- 43.7. **LAs should invest time and resources to ensure that drug and alcohol treatment and recovery commissioners have effective and supportive management.** This will support the CPD of commissioners and help them to make difficult decisions when required.
- 43.8. **LAs should recognise that drug and alcohol treatment and recovery commissioners are well placed to be system leaders.** This needs to be supported by enabling access to leadership training and development.
- 43.9. **OHID will encourage the market to respond to the commissioner capability framework and develop education, training and development materials for commissioners.** While there are tools and packages currently available for commissioners, some are outdated or do not reflect the reality of the current role. The **drug and alcohol commissioning quality standard** be used to inform the development of any drug and alcohol treatment and recovery commissioner training tools and resources.

## Part 3: Action plan

This plan identifies the priority actions in each area of workforce transformation. It identifies who is primarily responsible for the action, a brief description of the action and which priority area it falls within.

To help you use this plan, the final column of the table identifies which sections in Part 2 provide further detail and guidance on the required action.

By March 2025			
Who	Action	Priority area	Section
OHID and NHS England	Clarify and promote high-quality clinical governance standards	Reform	2
OHID and NHS England	Clarify and promote high-quality clinical supervision standards	Reform	3, Appendix 2
Employers	Employee wellbeing initiatives	Reform	5
OHID with NHS England	Drug and alcohol worker, children and young people's drug and alcohol worker and peer support worker curriculum developed	Train, develop and retain	29.1, 33.1,37.1
NHS England	Work to secure additional addiction psychiatry training posts in 2024/25 to expand the bank of posts currently available.	Train, develop and retain	21.3
OHID	Explore with RCPsych development of a training pathway for consultants to train and demonstrate equivalence to become addiction specialists (credentialing)	Train, develop and retain	23.2
Employers	Recruitment of regulated and currently unregulated roles in line with drug strategy expansion targets, the capability framework and workforce calculator	Recruit	6, 9, 10, 11, 13, 14, 16, 18, 21, 24, 26, 28, 32, 36,39
Commissioners and service providers	Workforce planning underpinned by the standardised expectations set out in the strategic plan, capability framework and the tailored outputs of the workforce calculator	Reform	6.7,



## 10-year strategic plan for the drug and alcohol treatment and recovery workforce

<b>By March 2027</b>			
<b>Who</b>	<b>Action</b>	<b>Priority area</b>	<b>Section</b>
OHID and NHS England	Drug and alcohol worker, children and young people's drug and alcohol worker and peer support worker accreditation of training	Train, develop and retain	29.2, 33.2, 37.2
Employers	Continued recruitment of roles in line with drug strategy ambitions, the capability framework and workforce calculator	Recruit	6, 9, 10, 11, 13, 14, 16, 18, 21, 24, 26, 28, 32, 36, 39
Service providers	Expanded training placements for regulated roles	Train, develop and retain	12
Commissioners and service providers	Apprenticeship routes into regulated roles	Train, develop and retain	10
Service providers	Clinical supervision meets requirements	Reform	3, Appendix 2
Service providers	Training of all staff in line with this strategic plan and the capability framework	Train, develop and retain	7, 15, 17, 19, 22, 25, 27, 29, 33, 37
<b>By March 2029</b>			
<b>Who</b>	<b>Action</b>	<b>Priority area</b>	<b>Section</b>
Employers	Continued recruitment of roles in line with drug strategy ambitions, the capability framework and workforce calculator	Recruit	6, 9, 10, 11, 13, 14, 16, 18, 21, 24, 26, 28, 32, 36
Service providers	Clinical governance meets requirements	Reform	2
Service providers	First cohorts of drug and alcohol workers, children and young people's drug and alcohol workers and peer support workers complete accredited training.	Train, develop and retain	29, 33, 37
<b>By March 2034</b>			
<b>Who</b>	<b>Action</b>	<b>Priority area</b>	<b>Section</b>
Employers	Continued recruitment of roles in line with drug strategy ambitions, the capability framework and workforce calculator	Recruit	6, 9, 10, 11, 13, 14, 16, 18, 21, 24, 26, 28, 32, 36, 39

## Appendix 1: International recruitment resources

- NHS Employers – International recruitment toolkit
- NHS Employers – Recruitment of overseas nurses and midwives
- NHS Employers – Recruitment of overseas doctors
- Service providers should familiarise themselves with the World Health Organization (WHO) Code of Practice on ethical international recruitment. A revised [Code of Practice](#) is available. There is a [quick guide](#) to help NHS service providers and candidates understand what the WHO Code of Practice means for them.

## Appendix 2: Clinical supervision models

- NHS Employers – Clinical supervision models for registered professionals

## Appendix 3: Return to practice

### 1. Nursing\*

Return to practice: nursing

### 2. Allied health professionals, healthcare scientists and practising psychologists\*

Return to practice: allied health professionals, healthcare scientists and practising psychologists

### 3. Social work

Social Work England – apply for restoration

### 4. Medicine\*

Career refresh for medicine

### 5. Return to practice toolkit for service providers

Health Careers – return to practice – campaign toolkit

\*These resources were developed by HEE, now known as NHS England.

## Appendix 4: Workforce planning

Workforce planning includes establishing a baseline (such as understanding the working environment that the system operates in, collecting data and capabilities), assessing future needs, identifying strengths, issues and trends and, finally, action planning and delivery.

Workforce planning is a cyclical process and the workforce plan should be a live document that is reviewed and updated. It may be right for the system to manage some parts of the process centrally and some within teams, services or departments.

As outlined by the [Chartered Institute of Personnel and Development \(CIPD\)](#), workforce planning processes can:

- reduce labour costs in favour of workforce deployment and flexibility
- identify and respond to changing customer needs
- identify relevant strategies for focused people development
- target inefficiencies
- improve employee retention
- improve productivity and quality outputs
- improve employees' work–life balance
- make recommendations to deliver strategic value through talent

### Roles and responsibilities

Some of the types of roles and/or responsibilities that might be required for workforce planning are listed below. It is important to note that individuals may undertake a number of these roles, particularly in smaller organisations.

- **Workforce planner:** ensures the plan is in place, identifies workforce risks and issues and completes workforce data. If working within a collaborative structure, there may be more than one workforce planner needed to represent the different local, regional or national bodies to ensure plans are aligned.
- **Executive team:** senior management/board/chief executive who is responsible for signing off the plans.
- **HR lead:** ensures plans align with organisational policies and employment best practices.

- **Service lead:** ensures plans are representative of and realistic for the services being delivered.
- **Lived experience lead:** ensures plans keep people who use(d) drugs and/or alcohol at the heart of the process.
- **Finance lead:** ensures the workforce planning is financially viable.
- **Equality, diversity and inclusion lead:** ensures plans are fair and accessible to all.
- **Commissioning lead:** ensures local needs are identified and commissions resources accordingly.
- **Learning and development lead:** ensures plans identify learning and development needs and develops training packages.
- **HEIs/training providers:** can provide courses for the workforce.
- **Union:** if the workforce is unionised and has a local representative or if there is an engagement network that can represent staff views.

### Self-assessment

**Section 4.1** of the [OHID Commissioning quality standard: alcohol and drug treatment and recovery guidance](#) provides criteria by which the system will know if the workforce is meeting the needs of the people they treat, as well as examples of evidence it should have. This can be used as a self-assessment tool in workforce planning:

“You will know you are achieving this standard if you meet the following criteria.

1. Treatment services employ a multidisciplinary workforce who are competent to treat and support the treatment population, including people with co-morbidities.
2. All members of the workforce who provide care and support have a caseload that is clinically safe and appropriate to be able to deliver quality treatment.
3. Treatment service specifications and legal contracts make sure that service providers comply with treatment workforce standards. This also includes any mandatory training and development plans for the workforce and the partnership has dedicated funding to support this.
4. Any gaps in skills are identified by a training needs analysis.
5. Entry level roles and opportunities for trainee posts, including addiction psychiatry posts, are incorporated into workforce strategies and clear career progression routes are available.

6. All members of the treatment workforce receive regular supervision, including clinical supervision.
7. The partnership supports opportunities to exchange staff between different partner organisations to promote skill and practice sharing and to improve communication and collaboration.
8. There is a long-term local treatment and recovery workforce strategic plan to maintain a flexible and sustainable workforce model.

### Examples of evidence

You should have evidence available that you are meeting this standard. This could include the following examples.

1. Contract monitoring processes.
2. A workforce structure chart which is part of a service's contract.
3. Workforce skills analysis and training and development plans for the treatment workforce, which services can prove are routinely monitored and shared with their commissioner.
4. A record of continuous professional development (CPD) for each staff member, which is demonstrated in staff CPD records and in broader workforce consultation and feedback reports.
5. Evidence that service providers have met local management and clinical supervision standards.
6. The partnership's commissioning and delivery plan."

### Checklist

This checklist will help with workforce planning. It includes links to other practical resources and related guidance.

**Understand the working environment that the sector operates in – these may be internal and external.** For example:

- this strategic plan
- understanding of the various professions that comprise the workforce and the skills, competence and values that each profession brings to the workforce
- [Independent review of drugs by Professor Dame Carol Black](#)

- **From harm to hope: A 10-year drugs plan to cut crime and save lives**
- clinical guidelines, such as National Institute for Health and Care Excellence (NICE) and national **clinical guidelines on drug misuse and dependence**, and the forthcoming alcohol clinical guidelines
- legal requirements, such as **Care Quality Commission (CQC) standards**, the law, regulation and requirements of commissioners (where appropriate)
- critical incidents – what has gone wrong, been a near miss or not been done as well as the service had hoped?
- organisation/department/team’s vision, mission and values
- feedback from people who use(d) drugs and/or alcohol – trends and issues

**Research recent developments in workforce planning and assess different models and resources available to inform planning.** For example:

### 1. **Workforce planning – CIPD**

The CIPD is a registered charity with the highly respected Royal Charter. They are the go-to source of information regarding the workforce.

Their workforce planning fact sheet explores the benefits of activities involved in planning and the stages of the process. These are:

- understand the organisation and the operating environment
- analyse the workforce
- determine future workforce needs
- identify gaps in workforce skills and knowledge
- develop an action plan that is functional, numerical and flexible
- monitor and evaluate action plans and solutions

### 2. **NHS England Star: Accelerating workforce redesign**

The NHS England Star is based around 5 key enablers of workforce transformation. These are:

- supply
- upskilling

- new roles
- new ways of working
- leadership

### 3. **NHS England Multidisciplinary team (MDT) toolkit**

This toolkit is framed around 6 enablers of MDT working and presents evidence, supporting resources and success factors within each chapter. It covers:

- planning and design
- skill mix and learning
- culture
- shared goals and objectives
- working across boundaries
- communication

### 4. **Workforce planning, transformation and commissioning – Skills for Care**

Skills for Care is the strategic workforce development and planning body for adult social care in England.

These tools cover various aspects of workforce shaping, planning, commissioning and development:

- strategic workforce planning, shaping and commissioning
- operational workforce planning
- workforce change and transformation
- workforce learning and development
- integration
- quality of care

### 5. **Six steps methodology to integrated workforce planning – Skills for Health**

This is a practical approach to planning that ensures there is a workforce of the right size with the right skills and competencies.

The methodology identifies those elements that should be in any workforce plan, considering the current and future demand for services, the local demographic situation and the impact on other services.

6. **Who needs a workforce plan? A simple guide to workforce planning – Local Government Association**
7. A guide for councils to produce effective workforce plans, including roles and responsibilities, methodology and suggested project plans. A gov.uk email address is needed to access this – contact the Local Government Association with any issues.

**Gather information on the workforce.** For example:

- Headcount, demographics, employment status, length of service, job role, staff turnover, exit interviews, skills competencies, performance reviews, hiring patterns, staff survey results, career pathways and training access. The [first](#) and [second](#) national workforce census for drug and alcohol treatment recovery services enables collaborative working with key strategic partners to inform education and workforce planning and investments.

**Define future workforce needs**

- What are the needs of the people that the sector cares for? What capabilities and competencies are needed to meet the needs of the population? Are there professions who have these skills built in already?
- What are the capabilities and competencies that might be needed by future roles?
- Use resources such as the drug and alcohol treatment and recovery capability framework and the new workforce calculator and related implementation guides.

**Analyse gaps and develop an action plan, including a plan for education commissioning**

- Using the information that has been gathered, analyse what the gaps and the challenges are and how they will be overcome.



## Appendix 5: Glossary

### Clinical and clinician

The terms ‘clinical’ or ‘clinician’ are sometimes seen as synonymous with ‘medical’ and as implying that a particular model of care is being advocated. In this strategic plan, these terms refer to activities carried out by anyone in a role that is delivering or supporting treatment and care in line with clinical and treatment guidelines, directly to people using drug and alcohol treatment and recovery services. This includes drug and alcohol workers and children and young people’s drug and alcohol workers. The term in this context is not synonymous with the medical model. It refers to a range of evidence-based approaches, including psychosocial interventions, as detailed in national clinical guidelines. This use of the terminology is consistent with the [national clinical guidelines on drug misuse and dependence](#).

Although peer support workers (PSWs) are employed and paid to offer direct support and advice to people who use(d) drugs and/or alcohol, they do so in a manner that draws on the concept of peer support – using their own lived experience to guide the process. For this reason, and because they are not clinically trained, PSWs are not considered ‘clinicians’ for the purpose of this plan, nor are they considered to undertake clinical work in line with clinical and treatment guidelines. Of course, people with lived experience can and widely do work in a range of regulated and unregulated roles, beyond peer support roles.

While the PSW role is not clinical, PSWs require regular access to supportive supervision, which should include an element of [reflective practice](#), offering them a space to review and reflect on their work with an appropriately trained clinician or senior PSW. This should also include an opportunity to talk about areas that they might experience as difficult or distressing and must be differentiated from line management or case management. It is vital that service providers ensure this is provided to promote and maintain the wellbeing and safety of both PSWs and the people they are supporting.

### Clinical governance

‘Clinical governance’ describes the organisational frameworks, structures, processes and culture needed to ensure that healthcare organisations and individuals within them can assure the quality of the care they currently provide and thereby seek to improve it<sup>17</sup>.

Effective clinical governance will include: ongoing monitoring and assessment of clinical effectiveness; risk management; people’s experience of and involvement in services; communication; resource effectiveness; strategic effectiveness; and learning effectiveness.

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<sup>17</sup> [www.gov.uk/government/news/clinical-governance-guidance](http://www.gov.uk/government/news/clinical-governance-guidance)  
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## **Clinical supervision**

‘Clinical supervision’ is a collaborative, formal process that takes place in an organisational context. It is part of the overall training and development of clinicians and facilitates the development of the supervisee’s competences, ensuring that they practise in a manner that conforms to current ethical, organisational and professional standards and promotes their own wellbeing. It is important that clinical supervision involves reflective practice as defined below.

## **Lived experience**

‘Lived experience’ is the experience of people and families who were previously affected by problem drug or alcohol use and are now in recovery. This is distinct from learned experience, which people can get through studying, practising or exposure. People can, and typically do, have a mixture of both lived experience and learned experience.

## **Management supervision**

‘Management supervision’ focuses on ensuring that organisational policies and procedures are followed, performance is monitored and appraised, and operational issues, such as managing caseloads, are handled effectively.

## **People who use(d) drugs and/or alcohol**

Language differs across the drug and alcohol treatment and recovery sector. However, after considerable stakeholder consultation from a wide-ranging group of experts, including experts by experience, families/carers, PSWs, clinicians, including regulated professionals, and service providers, the term ‘people who use(d) drugs and/or alcohol’ is used in this strategic plan to describe those who require support and/or treatment for their drug and/or alcohol use.

## **Reflective practice**

‘Reflective practice’ is a process that allows a supervisee to think analytically about a situation and understand how it has affected them and/or their practice. It enables the supervisee to identify areas for learning and development and develop self-awareness. It also supports sharing and learning from other clinicians and offers a space for the supervisee to think about their own wellbeing.

## **Regulated workforce**

As defined in the [Professional Qualifications Act 2022](#), the ‘regulated workforce’ refers to roles that require an essential level of training for registration with a professional body to be able to fulfil the role. Some psychological professions are accredited and on voluntary registers. For the purpose of this document, they are considered registered and the statements for regulated professionals apply.

## Supernumerary

‘Supernumerary’ refers to staff in addition to workforce planning (often volunteers or students) and are not to be counted as part of the core service provision<sup>18</sup>.

## Treatment

In line with [NICE guidelines](#) and [Drug misuse and dependence: UK guidelines on clinical management](#), ‘treatment’ includes pharmacological and/or psychosocial interventions.

## Unregulated workforce

The ‘unregulated’ workforce are people who, at the time of writing, do not need to have an essential professional qualification and registration with a governing body for the purpose of their role. Unregulated roles currently make up the majority of the workforce, with 50%<sup>4</sup> of the workforce being drug and alcohol workers across treatment providers.

## Volunteers

All non-paid members of the workforce are ‘volunteers.’

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<sup>18</sup> Supernumerary (n.d.) Cambridge Dictionary. Available at: <https://dictionary.cambridge.org/dictionary/english/supernumerary> (viewed on 7 September 2023)

## Appendix 6: Acknowledgements

This strategic plan has been compiled with the support and input of the following project stakeholders:

- Department of Health and Social Care (DHSC) and Office for Health Improvement and Disparities (OHID)
- education providers, higher education institutions (HEIs) and academics
- lived experience recovery organisations (LEROs), the LERO workforce and LERO collaborative, the [College of Lived Experience Recovery Organisations \(CLERO\)](#)
- local authority commissioners, Directors of Public Health via the [Association of Directors of Public Health \(ADPH\)](#) and commissioner collaborative, the [English Substance Use Commissioners' Group \(ESUCG\)](#)
- National Workforce Skills Development Unit
- NHS England
- people with lived experience
- royal colleges
- specialist charities – voluntary registration body and network for the sector, [Addiction Professionals](#) and [Adfam](#) representing family members and friends affected by someone else's drug or alcohol use
- specialist drug and alcohol treatment and recovery service providers, the treatment and recovery provider workforce, and provider collaboratives, [Collective Voice](#) and [NHS Addictions Provider Alliance](#)

The time and input of all those involved – in particular, the frontline staff and volunteers who took time out of their busy schedules to participate and people with lived experience who shared their personal knowledge of services – have been crucial to the research and very gratefully received.

The following individuals were directly involved in the development of this plan:

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## 10-year strategic plan for the drug and alcohol treatment and recovery workforce

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## 10-year strategic plan for the drug and alcohol treatment and recovery workforce

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