Commissioning for Recovery

Briefing note following meeting in Manchester, February 2016

Intro

This briefing reflects the findings from an event facilitated and organised by Adfam, on behalf of the Recovery Partnership, which brought together a group of substance misuse commissioners to share good practice, challenges and concerns. The focus of the day was **commissioning for recovery:** how integrated or holistic services can be commissioned to facilitate the recovery of those with drug or alcohol issues. Given the varied and individualised nature of recovery for service users this necessarily means the pursuit of such a system at a time of immense financial hardships is difficult.

It was designated a 'safe space' for attendees to openly discuss any worries and challenges they face – consequently the whole day was conducted under the Chatham House rule, with nothing attributed to any individual.

Discussion

1. Contract length

I. The group identified a move, overall, towards shorter tender lengths – though some reported successfully awarding contracts over 7 or even 10 years; although often configured with termination clauses as, for example, 4+2+1.

II. Attendees valued being able to offer longer contracts to services – since retendering naturally puts a strain on all concerned and the time taken to bed-in services can get in the way of delivering recovery focussed services to service users. One reason given for why this doesn't happen more often is concern among some procurement teams about legal challenge from providers claiming that long contracts are anti-competitive. Nobody could cite an instance of this happening however.

III. Relationships with procurement teams and finance directors in local authorities were highlighted as absolutely critical.

2. Commissioning for multiple and complex needs

I. Attendees agreed that effective commissioning should be used to support service users with multiple / complex needs (usually but not limited to substance use issues, mental ill health, homelessness, criminal justice involvement).

II. Substantial challenges identified – with the various sectors working in silos on the strategic as well as operational level. One attendee spoke about a plan to develop a Behaviour Change service which included all of the above, plus more, which was met with reluctance from some services. This may be

due to simple pragmatic reasons – attempting to ambitiously bring together allied services, redesign tenders at a time of change, fragmentation and financial constraints is inherently challenging.

III. Another attendee suggested that a certain protectiveness of substance use services might be healthy and sensible since it could protect the substance use budgets for the moment and avoid them being sucked up in with other funding streams and lost.

IV. As well as reductions in resource a serious diminution of expertise was identified as being threatened in one area which was considering bringing drug and alcohol treatment under adult social care, with a loss of specialist workers. The value of these specialist services are not being recognised everywhere, it was suggested, and need to be vocally championed.

3. Commissioning models and challenges

I. Commissioners discussed the use of a commissioning framework broken down into smaller units of activity, each with several approved providers, from which commissioners can spot purchase with no guarantee of any business. This may allow flexibility, promote innovation in services, and offers potential cost savings.

II. "All our apples from the recovery tree fall in other people's gardens" as one attendee brilliantly put it; how do we demonstrate the impact and savings from our work to police, probation, NHS and other partners who benefit?

4. Clinical Commissioning Groups (CCGs)

I. Attendees reported substantial variation in their relationships with CCGs. One attendee reported having an excellent relationship with their CCG, and believed that the success had come down to the CCG management 'getting it' (the drug and alcohol agenda), rather than simply being dictated by what falls within their official remit. All agreed it was important to have a good relationship with CCGs, but more so to develop a two way, proactive relationship – where it's not the drug and alcohol commissioner always chasing the CCG but the CCG approaches the public health team with ideas, questions, etc.

II. Public health in many areas are paying for alcohol liaison, as well as detox and rehab, but the savings are made for the CCG even though they don't make the upfront investment

5. Community recovery funds

I. Value of community recovery funds discussed – several attendees mentioned local areas making available annual grants which third sector and community recovery groups can bid to for small pots for recovery activities, e.g. setting up a social enterprise, ETE activities, peer support groups etc.

II. Those who had experience of these were very positive, suggesting that some of these small, user-led ETE programmes may have had a larger positive impact than more formally mandated JobCentre Plus / government employment programmes. Since they are driven by the community and people in recovery they are seen as authentic, credible, and some have created real opportunities and real jobs. One attendee had taken their Director of Public Health to a recovery event where these projects were showcased, to positive effect.

III. It was pointed out that this kind of community fund is the closest people in recovery might get to personal recovery budgets.

6. Getting on to boards

I. It was agreed by attendees that drug and alcohol commissioners can engage effectively with other related agendas by pushing themselves onto a range of boards, including child and adult safeguarding and reoffending boards.

7. Family support

I. Most agreed the family support agenda is well established and usually specified in tenders, but that it could become even more important as a central driver for investment in treatment in terms of allied gains around statutorily required services such as children and child safeguarding.

II. Demonstrating (financial) impact of drug and alcohol services on areas of statutory responsibility including children's services was highlighted as of particular usefulness, eg through a cost calculator of some kind.

III. Quality standards for family support work were also highlighted as useful, with one attendee noting that there are some small, community, parent-run groups which are great, but it's hard to know if they are always effective, or safe. Is it possible for Adfam to develop some outcomes measures or a quality mark for family support?

8. Next steps – Commissioning for Recovery

I. If you are a substance misuse commissioner and would like to be part this group through 2016/17 please get in touch via recoverypartnership@adfam.org.uk.

II. The group will
- have a focus on the whole recovery agenda and not just treatment
- be small-medium sized to allow full and frank discussion with a chance for everyone to contribute
- be independent, with no attendance from PHE, central or local government
- be led by commissioners, for commissioners
- meet twice in 2016/17
- may focus in future on: getting out of commissioning silos, while protecting drug and alcohol services; drug related deaths; recovery housing; measuring meaningful recovery outcomes; measuring what *doesn't* happen e.g. the protective factors drug and alcohol services have for adult and child safeguarding.