DrugScope response to the Department for Work and Pensions Commissioning Strategy Consultation - September 2013

Key recommendations and conclusions

1. Current commissioning has not achieved the policy intent of providing effective, tailored support for people with histories of drug and / or alcohol use.

2. DWP must consider whether future commissioning features separate services for those furthest from the job market, or alternatively adopting a radically different approach within 'mainstream' commissioned services.

3. DWP should support and encourage more small-scale commissioning in response to local need, and should encourage more transparency and consistency in the way that the Flexible Support Fund is used.

4. There is a range of measures that could be taken to improve services and outcomes for people with histories of drug and alcohol use, including:
    a. Improved assessment and segmentation
    b. Earlier employment support
    c. More use of co-commissioning
    d. Use of 'distance travelled' alongside job outcomes
    e. Introduction of a fee for service for the hardest to help
    f. Support intermediate labour market approaches
    g. Pay heed to quality of service, including relevant accreditation

5. Strengthen and standardise minimum service offers, incorporate customer experience and opinion, and monitor the quality of work obtained.

6. Create a structure and climate that encourages innovation, and continue to play an active role.

7. Build on effective examples of local partnership working.

8. Work more closely with potential co-commissioners to remove barriers to the provision of holistic, wrap-around services.

About DrugScope

1. DrugScope is the national membership organisation for the drug and alcohol sector, supporting professionals working in drug and alcohol treatment, drug education and prevention and criminal justice. It is the primary independent source of information on drugs and drug related issues. DrugScope has around 450 members, primarily treatment providers working to support individuals in recovery from drug and / or alcohol use, local authorities and individuals.

2. DrugScope's members represent the full spectrum of provision of drug and alcohol services, including voluntary sector providers, NHS Trusts and local authorities, as well as every mode of treatment from low-threshold interventions to intensive structured day programmes, therapeutic communities and residential services.

3. There are in the region of 400,000 problem drug users (i.e. those dependent on heroin and / or crack cocaine) in the UK; around 80% are not in paid employment[1]. DrugScope has a particular interest in the vital role employment and employment support can play in addressing substance dependency, social integration and achieving financial independence. We work closely with the Department for Work and Pensions (DWP) both singly as and as a member of the Recovery Partnership (DrugScope, the Recovery Group UK and the Substance Misuse Skills Consortium[2]), across a number of strands, including labour market activation.

4. DrugScope welcomes the commitment to provide tailored support to help the most socially excluded into sustainable, paid employment in the 2012 Social Justice Strategy[3], in the 2010 Drug Strategy[4] and elsewhere. Drug and / or alcohol treatment and employment support can be mutually reinforcing and are often delivered as part of a single, coherent offer by treatment providers.

5. In London, DrugScope also delivers the London Drug and Alcohol Network (LDAN) Routes to Employment Project[5], funded by Trust for London. This has involved working closely with treatment providers, Work Programme providers, Public Health England and other key stakeholders to explore and disseminate best practice in employment support. A further element has been research with clients to look at aspirations, fears, factors for success and barriers to employment. Up to 180 clients participated in the quantitative and qualitative research, including almost 30 who participated in face to face interviews and focus groups. The findings of the work undertaken as part of this project have been incorporated in this response.

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[1] http://www.dtors.org.uk/reports/BaselineMain.pdf
[2] http://www.drugscope.org.uk/partnersandprojects/Recovery+Partnership
[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/49515/social-justice-transforming-lives.pdf
[4] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/118336/drug-strategy-2010.pdf
[5] http://www.ldan.org.uk/employment.html - research findings to be published late 2013

About the drug and alcohol treatment sector

6. The drug and alcohol treatment sector recognises that treatment, recovery and employment support are often mutually reinforcing activities and has considerable expertise and a strong record of provision of employment, training and education (ETE) services, whether through its own projects and services, through social enterprise or partnership with employers and other services, as part of DWP supply chains or through engagement with measures such as the Future Jobs Fund and Youth Contract.

7. With regard to DWP-funded provision in particular, the drug and alcohol sector played a significant role in progress2work[6] and progress2work-LinkUP, specialist programmes providing employment support to those furthest from the job market, including people with histories of drug and / or alcohol use, offending, or homelessness.

8. Since 2011, the sector has had a role in the current Work Programme, mostly as Tier 2 specialist subcontractors providing specific interventions on a call-off or spot purchase basis, but also as end-to-end specialists supporting jobseekers through the majority of their period on the Programme. The most recent Work Programme supply chain information published by DWP[7] indicates that the drug and alcohol sector is providing services in at least 15 out of 18 contract package areas (CPAs) with many CPAs having one or more drug and / or alcohol specialist providers on the supply chain of both or all prime contractors.

About this response

9. As the membership organisation for the drug and alcohol sector, we have generally focused on those questions which are particularly relevant to the role of the sector as specialist providers to DWP, either directly or as subcontractors. However, as the consultation states that the prime and subcontractor model will be retained for large-scale commissioning, there are clearly some matters that will primarily be of interest to the prime contractor sector that will also influence their ability to maintain diverse, responsive and effective supply chains. Where that is the case, we have also addressed those questions.

10. We have approached the issue of commissioning in a broad sense. However, as the Work Programme forms the largest single component of current commissioned services and is the commissioned service that the drug and alcohol treatment currently has the closest links to and highest level of contractual participation in, we have naturally considered both the current Programme and lessons for future commissioning in this response.

Q1. How should DWP balance its responsibility to strategically manage and steward a large, developing market with our desire to maintain and develop the right specialist capability throughout the supply chain?

[6] http://www.dwp.gov.uk/docs/p2w-feb-2010-specification.pdf
[7] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/208879/wp-supply-chains.xls

11. Market stewardship should primarily be concerned with strengthening outcomes and improving services for individuals. DWP has recently seen value in the certainty provided by relatively long-term contracts and the freedom to innovate that the 'black box' approach might enable. Both of these aims are admirable, but may not have fully met their objectives with regard to ensuring specialist participation in current commissioning.

12. The adoption of a black box approach has arguably entailed the department surrendering many of the levers by which it could have influenced the composition and form of service delivery supply chains. Thus, whilst relatively large numbers of specialist providers from the voluntary and other sectors remain nominally on Work Programme supply chains, the reality is that for many organisations this participation is peripheral to their core activities or, in cases where organisations have received a large number of inappropriate referrals, adversely impacts on them.

13. To ensure specialist provision within future commissioned services, the Department may wish to consider a range of options, including directly commissioning separate, specialist provision (as is currently the case with Work Choice and was previously the case with a number of specialist programmes including progress2work), or continuing the market-based approach based on differential pricing, where the intent is to design a funding model that more strongly incentivises the sort of behaviour that the Department would like to see on the part of prime contractors.

14. Separate commissioning of specialist services has some positive aspects. It would go some way to ensuring that specialist provision is available, and would support the engagement of services, such as those from the drug and alcohol sector, that have a strong track record of supporting disadvantaged claimants.

15. However, there may be less favourable aspects. *progress2work and progress2work-LinkUP: an exploratory study to assess evaluation possibilities*, commissioned by DWP, found that the issue of stigma could hamper efforts to engage employers[8] once the nature of the client group had become known. The issue of stigma has consistently been identified as a barrier to employment and reintegration, for example in the first Annual Review of the 2010 Drug Strategy[9], in the work of the UK Drug Policy Commission[10], and also in our own Trust for London-funded LDAN Routes to Employment project. Conversely, many drug and alcohol treatment providers manage to successfully engage employers even though the nature of their service is often evident.

16. If a market-based rather than specialist commissioning approach is preferred, we believe that the current single, binary, job-no job outcome for the Work Programme (unlike Work Choice and other interventions procured or funded by other departments) in conjunction with the current

[8] http://westminsterresearch.wmin.ac.uk/5044/1/Dorsett,_Hudson,_Mackinnon_2007_final_published.pdf – p.50 and elsewhere

[9] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/118345/drug-strategy2010-review-may2012.pdf

[10] http://www.ukdpc.org.uk/wp-content/uploads/Policy%20report%20-%20Getting%20serious%20about%20stigma_%20the%20problem%20with%20stigmatising%20drug%20users.pdf

funding model has failed to incentivise the provision of specialist services. Research by DrugScope and other organisations has found little or inappropriate use of supply chains and 'parking' of jobseekers furthest from the job market. This is reflected in *Work Programme evaluation: Findings from the first phase of qualitative research on programme delivery* which found "that many providers are prioritising more 'job ready' participants for support, ahead of those who are assessed as having more complex/ substantial barriers to employment".[11]

17. The report also states that in some cases, a less intensive approach may in fact be entirely appropriate for some claimants, which DrugScope would agree with, particularly (for example) in the circumstances where a jobseeker is participating in a structured day programme aimed at addressing any substance use needs, comparable to the flexibility accorded under tailored conditionality for Universal Credit claimants.

18. The reality is that whilst most people with histories of drug and alcohol use want to work, their journey towards the job market may be long, indirect and require very intensive support. The reality is that whilst the intention of the Work Programme is to provide support customised and tailored to need, the level of investment in the Work Programme is not sufficient to provide this (at around £1200 per participant over two years, declining to £900 per participant, assuming on-target performance[12]) and the differential payment structure, combined with the risk inherent in a model heavily weighted towards a single, binary outcome (i.e. either achieving a job outcome or not), means that providers appear not have been incentivised in the way intended.

19. Consequently, we believe that distance travelled should be incorporated as part of the payment mechanism for the hardest to help. This could include milestone achievements or intermediate outcomes (such as participating in formal, accredited training, reaching a defined level of job-readiness, volunteering, gaining a first competitive interview and so on) or, potentially, softer outcomes (e.g. attitude or motivation) using an evaluation system such as the Outcomes Star[13] or the JET model of monitoring soft outcomes[14]. We acknowledge that incorporating any subjective component or soft outcome would need to be subject to a degree of verification and quality assurance, and would recommend that any component of this sort should be one of a range of indicators of success, not the sole one. This approach would also almost inevitably have the effect of complicating any future payment by results (PbR) model used in commissioning.

20. One of the key assumptions underpinning the Work Programme in particular was that large prime providers, able to access the markets and with substantial resources, would shoulder some of the financial risk and burden. This has by and large not happened, although DrugScope is aware of a relatively small number of prime contractors who have offered specialist subcontractors a balance of risk and reward.

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[11] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/193324/821summ.pdf - p.6

[12] http://www.smf.co.uk/files/7713/2310/6676/WP_analysis.pdf - p.6

[13] http://www.outcomesstar.org.uk/work/

[14] http://www.thinknpc.org/publications/the-journey-to-employment/

21. Many providers from the drug and alcohol sector are working as Tier 2 subcontractors, largely on a spot-purchase basis. As many of the participating providers from this sector are organisations with existing infrastructure and staff in place to deliver, they may be better placed to manage the uncertainty that spot-purchasing brings, although it has undoubtedly been a barrier to smaller providers entering the market at all. Future subcontracting arrangements should include steps to address this, including mandating a minimum volume, a fee for service element or, for small agencies in particular, grant funding, the latter two being incorporated within the Ministry of Justice's Transforming Rehabilitation proposals.[15]

Q2. How can we make competition more effective? How can we break down the barriers to market entry through our contracting, for both our larger and smaller contracts? How could we increase competition through the procurement process? What role can Open Data play?

22. The Department could support market entry at all points by ensuring that procurement and commissioning is afforded sufficient time. We are disappointed to note that the consultation document proposes a period of 6-12 months for commissioning prior to a replacement for the Work Programme, the lower limit of which risks replicating the confusion and excessive burden of the Work Programme commissioning round, particularly for specialist subcontractors who may need to open discussions and submit proposals to multiple potential prime contractors. We acknowledge the work to develop a common expression of interest process undertaken by the welfare to work sector[16].

23. The commissioning of the Work Programme favoured organisations with the capacity to both analyse data, model and work-up bids across (often) more than one contract package area, a capacity that many voluntary sector specialist providers lack. It would be helpful if Open Data information is provided to all participants in a form that allows organisations with lower levels of capacity to analyse and understand complex data sets to participate. Potentially, commissioning support to build analytical capacity or else to provide it directly could have value.

24. For smaller-scale procurement handled more locally by Jobcentre Plus (JCP), the Flexible Support Fund (FSF) and related local commissioning has provided some opportunity for learning. Whilst the discretion given to local JCP managers has in some cases enabled them to build effective specialist local services that plug the gaps between different components of mainstream services – often a particular need in the case of people with histories of drug and alcohol use – improvements could be made. Whilst some FSF or similar opportunities have been advertised locally or nationally[17], many JCP districts have not chosen this approach, raising questions of fairness and lack of a level playing field. Whilst we would not advocate for an overly prescriptive or burdensome approach to local commissioning of relatively small, specialist drug and alcohol employment support services, greater transparency and a degree of commonality of approach would support the principles of fairness and equality of opportunity.

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[15] http://www.justice.gov.uk/transforming-rehabilitation
[16] Available via the Merlin website http://www.merlinstandard.co.uk/news.php#27
[17] E.g. https://www.gov.uk/government/publications/local-partnership-opportunities-with-jobcentre-plus

25. In keeping with the principles of Open Data, DWP could do more to provide timely performance data of a sort that allows interested parties to gain a fuller understanding of the performance of commissioned and contracted services. For example, in the case of the Work Programme, the Department has been able to provide data to a reasonable level of granularity, but has arguably presented it in such a way that makes general understanding of the Programme's impact difficult[18] and prevents specialist organisations, such as those from the drug and alcohol treatment sector understand the impact the intervention is having for its clients.

26. Taking measures to improve understanding of the impact of interventions by using more tightly defined cohorts would be helpful. For example, in the case of alcohol and drugs, individuals in 'structured, recovery orientated treatment' (i.e. treatment from services that report to the National Drug Treatment Monitoring System and the National Alcohol Treatment Monitoring System) can benefit from 'tailored conditionality' under Universal Credit. Applying the same measure to the Work Programme would allow a clearer understanding of performance for this group, would allow specialist non-commissioned services to compare their performance (and thus potentially compete in future commissioning) and would facilitate a clearer understanding of the opportunity costs of current supply-side labour market interventions compared to other approaches, such as intermediate labour market (ILM) models.

Q3. DWP wants to work with the market to improve the effectiveness of subcontractual relationships. What, if any, changes should be made to the Code of Conduct? What are your views on the way the Merlin Standard is used? How can we create supply chains with the inbuilt resilience and flexibility to cope with changing requirements and circumstances?

27. The Merlin standard is in many respects a welcome innovation, although there are ways in which it could be improved. A broadening of its scope to include a quality assurance system and the views of partners (in addition to supply chain members) would be welcome, or alternatively, a separate process for partner organisations (which include treatment providers across the country[19]) would enable the Department to gain a more rounded view not just of the way its commissioned services manage their supply chains, but also how they interact with other services. The difficulty of encouraging smaller organisations to be frank about the conduct of larger ones who may in effect be their sole customer of employment support in a given area remains problematic.

Q5. How should DWP develop the role of social investment in our commissioning?

28. Social investment may have a role to play in future commissioning. However, as New Philanthropy Capital[20] and the Social Market Foundation[21] have highlighted, it should currently be regarded as an emerging sector.

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[18] http://www.cesi.org.uk/social-inclusion-news/2013/jun/briefing-paper-measuring-work-programme-performance
[19] http://www.nta.nhs.uk/uploads/employmentandrecovery.final.pdf
[20] http://www.thinknpc.org/publications/best-to-invest/
[21] http://www.smf.co.uk/files/7713/7518/4818/Risky_Business_final.pdf

29. To be attractive to investors of any sort, any future commissioning will need to incorporate models of funding that are transparent and understood, responsive to external change and shocks, and financially viable. Open Data and a model that (unlike currently commissioned services) is responsive to the external environment would support this. However, the question of creating a model that will generate an attractive return for investors is likely to be challenging, even in the case of social investors who may accept a lower than market rate of return.

30. The complex nature of supply chains within currently commissioned provision may lead social investors to believe that rather than supporting a specialist voluntary sector organisation, they are supporting a large and economically robust company or, potentially, the Department itself; this may not be appealing.

31. Similarly, the return on investment available is likely to be contentious and consequently low, and if subject to externalities (as has been the case in the current Work Programme) the return on investment may be unacceptably difficult to quantify and at a higher level of risk than investors may be willing to tolerate.

32. As noted in paragraph 21, the majority of current subcontractors from the drug and alcohol treatment sector are large organisations who are comparatively well equipped to manage the cash-flow issues raised by participation in DWP commissioned services. However, one area where social investment could have a clear role to play is in providing working capital to allow smaller specialist organisations to participate in the contracted-out provision. However, this in effect risks replacing funding with debt, which in the long term may not be a strong enough incentive to encourage specialist provision.

Q6. How should DWP design outcomes and service standards for the hardest to-help within outcome-focused payment models?

33. Research by DrugScope has shown that the Work Programme is delivering very little for people with histories of drug and alcohol use.[22] Our 2012 research with clients found low levels of satisfaction, infrequent contact with providers, little specialist provision and a high level of sanctions incurred.[23] Qualitative research carried out in 2013 as part of the LDAN Routes to Employment project produced similar results, with a caveat that most participants made reference to the qualities – both positive and negative – of the various advisors that had worked with them on the Programme, which in some cases was as many as 6 in two years.

34. DrugScope recommends that the Department should take a range of measures to improve outcomes for the furthest from work in future commissions:

    a. Improve assessment and segmentation – benefit type as a proxy for need has proved to be a poor predictor of the barriers that an individual faces in participating in the job

[22] http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/WorkProgrammeInquiryDrugScopeHomelessLink.pdf
[23] http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/DrugScope%20Autumn%202012%20WP%20survey.pdf

market. Adopting an approach similar to that of the Australian Jobseeker Classification Instrument may be beneficial, as may also be incorporating evidence from the Work Capability Assessment process. Improved assessment and diagnostics would also improve the likelihood of jobseekers being offered an appropriate and effective service, and would help to provide transparency and clarity of customer expectations.

b. Offer more support at an earlier stage in the journey. Whilst there is no immediately obvious advantage to not offering people support immediately, there would need to be a degree of discretion to enable jobseekers to address issues such as substance use, for example, in accordance with the principles underpinning tailored conditionality under Universal Credit.

c. Consider ways in which joint or co-commissioning can be used to support clients with multiple needs. The integrated model that the majority of treatment providers now offer, where education, training and employment is part of the support offer from day one, is generally the preferred model and is often more successful than the frequently difficult and disjointed coordination between treatment providers and Work Programme providers working towards different outcomes, incentives and time scales.

d. Remove disadvantaged jobseekers from the binary job-no job payment model. This serves as a strong disincentive to provide support for those furthest from work, and fails to recognise that whilst most people with histories of drug and alcohol use want to work, the journey to employment may be long and indirect. As above, the Department must decide whether this necessitates commissioning separate, specialist provision for the hardest to help, or whether the work can be undertaken within a broader, mainstream programme.

e. Introduce (or re-introduce) a fee for service for the hardest to help where interventions can be transparently costed.

f. Many jobseekers with histories of drug and alcohol face a number of challenges. Educational attainment and general employability skills may be lacking, but also other barriers such as a lack of confidence, or little history of paid work. Supporting intermediate labour market initiatives would go some way to remedying this and could broadly follow the approach of the former Future Jobs Fund[24].

g. Where specialist services operate in an environment that already features operational standards, assessment and quality assurance, priority should be given to commissioning (or subcontracting to) those organisations that are demonstrably able to meet those standards.

Q7. How can DWP efficiently and effectively monitor and manage service quality within the wider framework described in this document?

[24] http://www.cesi.org.uk/sites/default/files/publications/CESI_future_jobs_fund_evaluation.pdf

35. The Department should consider external evaluation of quality of service, and incorporate service user experience into this. It should also strengthen the minimum service offers of prime contractors and other providers and ensure that they are widely available and understood. This has been a significant shortcoming of currently commissioned services, where minimum provider offers have been vague, inaccessible, non-specific and difficult to use to hold a provider to account.

36. DWP has taken an interest in in-work progression; this is welcome. However, beyond progression alone, we believe that a quality of work measure should be included as part of quality management to improve the understanding of the effectiveness of services within (and potentially between) CPAs, including (for example) measures of satisfaction, pay, hours, travel time and cost and in-work progression.

Q8. How should the Department, working with the market, develop its approach to performance management? For example, should we consider increased use of Market Share Shifting, focusing on directly performance managing individual providers or allowing claimant choice within CPAs? How can the market drive performance?

37. Whilst market share shift is beneficial at a contract package area level, it is of little use to the individual. There should be a mechanism by which individuals can transfer from one provider to another, particularly where a claimant can demonstrate that they have had little contact from their provider, or where the other provider(s) in a locality can offer a service that their original provider cannot. For drug and alcohol education, training and employment support, it is notable that whilst many CPAs have more than one provider with a specialist drug and alcohol service on their supply chains, this is not always the case and it is likely to be disadvantageous for a client to be referred to, and have to remain with, a provider without that specialist support.

Q10. How can DWP incentivise innovation in future welfare-to-work commissioning? How can we capture and share practice derived from successful innovations? What are the barriers?

38. DrugScope believes that a PbR model that is exceptionally heavily weighted towards hard job outcomes, subject to external influences (such as regional imbalances or a weaker than expected job market) and an overall funding level that is substantially lower than predecessor programmes[25] may mitigate against innovation and experimentation rather than incentivise it. Providers may feel the need to concentrate on traditional interventions that are known to work, rather than a bolder, experimental approach that might turn out to be financially disadvantageous.

39. Recent government initiatives have given an indication of possible solutions. A "What Works Centre"[26] for employment should be established to examine, identify and disseminate good practice and innovation unhampered by commercial confidentiality and the need to maintain

[25] http://www.smf.co.uk/files/7713/2310/6676/WP_analysis.pdf - p.6
[26] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/136227/What_Works_publication.pdf

competitive advantage.

40. This could be used not just to support the work of commissioned services but also to improve employment support offered elsewhere, including by the drug and alcohol sector itself and also with respect to JCP provision. It could serve as an information gateway between employers and employment support providers, and should place a particular emphasis on support to the most disadvantaged – people with histories of drug and alcohol use, homeless people, people with physical or mental health problems, ex-offenders and so on. A holistic approach including in-work support, retention and progression would be beneficial.

41. Within some sectors, including drug and alcohol services, there is already a broad understanding of what works. Aligning increased funding towards harder to help clients will hopefully encourage prime contractors to seek additional specialist input into their provision.

42. Within commissioned services, an innovations fund should be targeted at mitigating the risks of providers willing to take a more experimental approach – this may also have some appeal to social investors keen to encourage innovation rather than fund core services.

43. The Department itself has a role in encouraging innovation and experimentation. In April 2013, it introduced two pilots within the Work Programme aimed at testing approaches and incentives for claimants with histories of drug and alcohol use[27]. "Recovery and Employment" aims to develop closer working between Work Programme providers, supply chain members and treatment providers using existing funding, whilst "Recovery Works" introduces an additional payment of £2,500 at the job outcome point. This is a welcome step, and whilst it is too soon to have a sense of what the impact will be, we consider the Department to have an important and on-going role in actively encouraging experimentation and testing different approaches.

Q12. Working within the high-level framework articulated in this document, how could DWP become a more flexible partner, nationally and locally – what are the barriers to more effective partnerships?

44. By focussing on performance management of prime contractors and hard outcomes in much nationally commissioned contracted-out provision, the Department risks being seen as remote and inflexible. This can be contrasted with the approach shown by drug and alcohol policy leads who have been admirably keen to engage with services at a local level. Similarly, where drug and alcohol (and related) services have been commissioned locally under the Flexible Support Fund or are merely working in partnership with JCP, local JCP managers and staff are seen as valued partners in improving outcomes. DrugScope members repeatedly tell us that this sense of three-way working (treatment provider, Work Programme provider and JCP) is generally absent with regard to the Work Programme.

45. To become a more flexible partner of the drug and alcohol sector in the context of commissioned services would require a number of possible changes. More local commissioning, more interest taken by Work Programme performance managers in local supply chains and more

[27] http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Policy/WorkProgrammePilots.pdf

inquisitiveness in terms of looking beyond the headline data to gain a sense of how commissioned services are working for particular groups would be welcome.

46. Additional flexibility could be provided by trialling the introduction of personalised ETE budgets, for example by permitting groups with specific needs and barriers, such as drug and / or alcohol histories, to opt out of centrally commissioned services and purchase or otherwise access services from a suitable specialist.

47. Sub-contracting arrangements can be complex and costly. In locations where multiple prime contractors deliver across a limited geographical area, such as London, the burden on small providers of agreeing multiple contracts (and consequently multiple forms of reporting, client recording and so on) is prohibitive. In future commissioning, DWP should explore ways of mitigating this by, for example, providing an outcomes brokerage to enable smaller, specialist VCS providers to obtain payment for employment (and potentially intermediate) outcomes achieved.

Q13. What are the current barriers to co-commissioning?

48. We share the government's belief that employment support is a crucial component of "recovery capital"[28] – the assets that enable an individual to start and maintain the process of recovery from drug and / or alcohol use. As such it is vital that interventions are sequenced correctly and that scarce resources are, where practicable, pooled and used wisely. We are encouraged by innovations such as City Deals and Community Budgets, but believe that more could be done to join-up spending and effort to greater effect. This could include (for example) co-funding projects with local authority public health budgets (which largely fund drug and alcohol services from April 2013), building closer links with skills funding (which can itself be complex to navigate), and with other programmes and interventions commissioned either nationally or locally, with work around troubled families and Transforming Rehabilitation seeming to be a particularly good fit in terms of the range of outcomes desirable when working with a household or individual with complex needs.

49. There are currently 8 drug and alcohol PbR pilots across England[29]. Whilst employment was included in the long-list of potential outcomes[30], it was not included in the final outcomes, other than in a minority of areas that had exercised local discretion, as a consequence not least of concerns around attribution of outcomes. As an example of where some type of co-commissioning may have been advantageous, the Department should give consideration to how initiatives like this can be aligned with the intent to build 'recovery capital' underpinning the 2010 Drug Strategy. Options that might provide this support could include (for example) either more formal joint working and sharing of outcomes, or else allowing one or other of the main support providers (from either the drug and alcohol treatment sector or DWP commissioned

[28] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98026/drug-strategy-2010.pdf - p.18
[29] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/97806/pbr-lessons-learnt.pdf
[30] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215533/dh_128332.pdf

services) to undertake all the work for all the potential return.

50. Current barriers include the difficulties of paying for shared (or contested) outcomes, commissioning periods, and sometimes a sense of competition or (in extreme cases) mistrust between organisations working with an individual. Differing commissioning structures, monitoring requirements and IT systems will also be problematic at a service level, whilst agreeing joint outcomes is likely to be a challenge at a policy level.

51. Increased use of local commissioning, or alternatively devolving national funding and commissioning to local authorities (as in the case of the Youth Contract in three areas of England[31]) may enable 'smarter' commissioning that allows joined-up services to be wrapped around the individual or household.

52. Local Support Partnerships (LSPs), part of the system designed to assist claimants to manage the transition to the new benefit, could have a role to play in joining up services around the individual. DrugScope is on the Local Support Services Framework VCS Reference Group, and supports the intention that supporting clients towards job readiness is something LSPs could usefully do, although we currently have concerns about how this would fit in terms of the role of and payment mechanisms for JCP and commissioned services.

Q14. DWP recognises the importance of the Social Value Act, but also has a clear remit to deliver sustainable employment outcomes which offer good value-for-money to taxpayers. How can DWP best consider Social Value through its commissioning?

53. Community drug and alcohol treatment in the UK is delivered primarily by voluntary sector agencies of various sizes and NHS Trusts. The sector works across a range of delivery areas, and has experience in a range of social enterprises and other activities of social benefit to the community. We would welcome support from government to the sector to help providers, particularly smaller providers who may lack capacity, demonstrate the impact they have and can contribute towards meeting the policy intentions of the Social Value Act.

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[31] http://www.education.gov.uk/childrenandyoungpeople/youngpeople/participation/a00203664/youth-contract