
# “Outcomes don’t happen by accident”

## The SPARK model - what we’ve achieved together and how


**“Over the past 4 years we have seen our Collaborative grow from strength to strength and the impact of this is clear in our outcomes and in the voice of those accessing our services. We hear on a regular basis from those accessing our services that they feel they have choice, which is the heart of person-centred treatment and what we aim to achieve. We are so proud of what we have achieved so far, with the people working in our services showing genuine compassion and commitment to supporting people in Blackburn with Darwen everyday. “**

**Joanna Clarke**
**Service Manager**

# Purpose of this report

**“The difference in SPARK is not any single service or intervention: it is how the system holds together around the person.”**

This report sets out what SPARK has delivered over four years in Blackburn with Darwen, and, more importantly, how those results have been achieved.

SPARK is an integrated substance misuse and recovery partnership, bringing together multiple organisations to deliver a single, coordinated system of support.

It brings together evidence from across the partnership to show how people are supported through treatment, recovery and wider needs, and how the system operates as a whole, rather than as separate services.

It also captures the model behind delivery: how organisations work together, how responsibility is shared, and how continuity is maintained across complex journeys.

Over time, this approach has supported sustained engagement, with the number of adults in treatment increasing across the contract period while continuity of care has improved significantly from its starting point.

It documents what SPARK is at its best: a joined-up system designed to support people through points where services often fail, and to reduce the risk of people falling between them.

**Its purpose is simple: to provide a clear, evidence-based account of what makes SPARK effective, not just what has been delivered.**

# Why SPARK matters

SPARK was designed in response to a simple but difficult reality: people do not experience their lives, or their challenges, in neat service boundaries.

Before the partnership was in place, support was often shaped around organisational structures rather than people's journeys.

Individuals were expected to navigate different services at different times, telling their story more than once, and managing transitions that were not always joined up.

Some of the most vulnerable points sat between services. Individuals leaving prison, moving between treatment types, or trying to stabilise their lives alongside housing or mental health issues often experienced disruption at the point they need continuity most.

Even where individual services performed well, the wider system could still feel fragmented.

SPARK works differently. It brings organisations together as part of a single, coordinated system, with a shared focus on continuity, engagement and recovery.

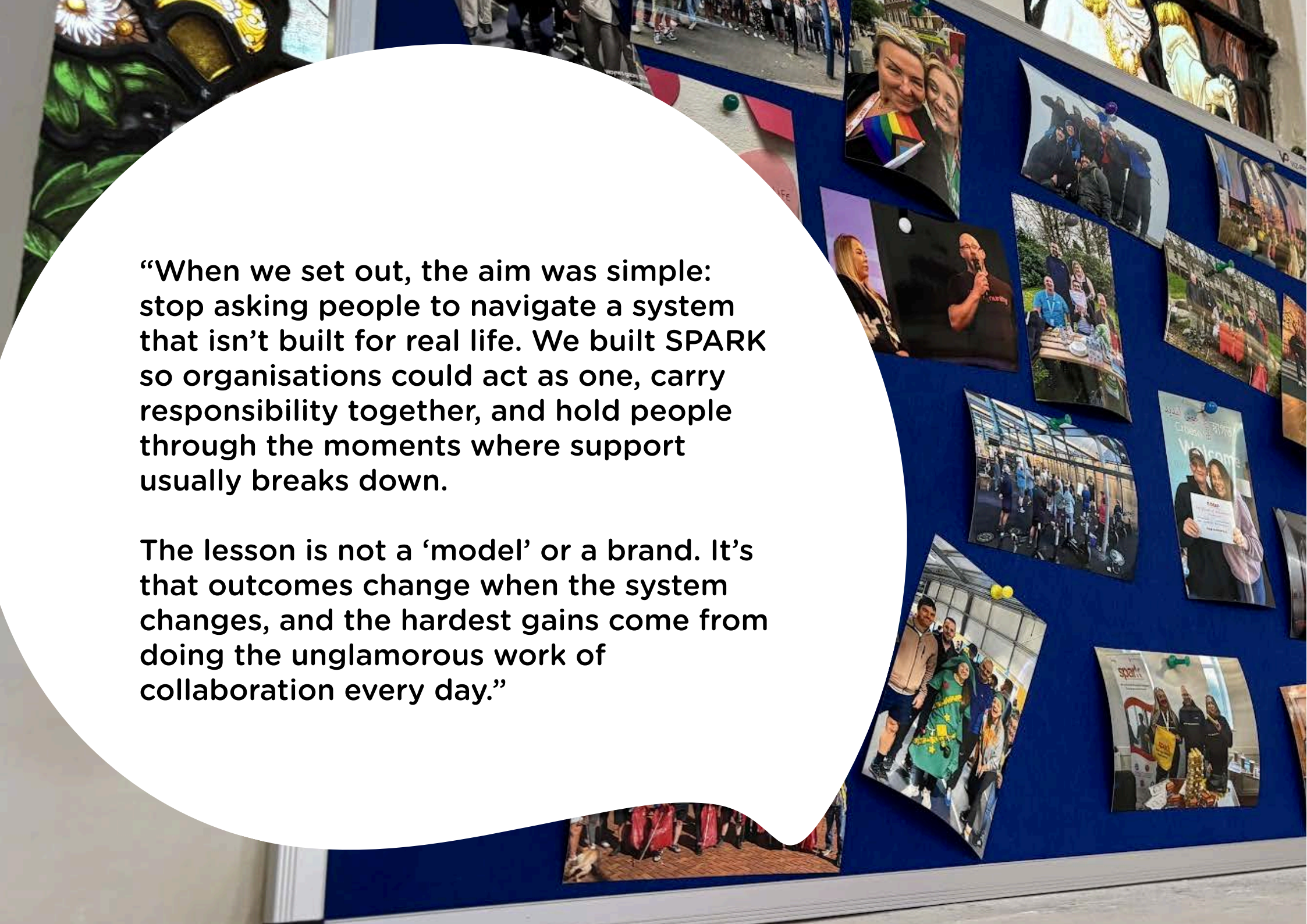
Rather than expecting people to move between services, the model is designed so that support moves with them.

This shifts how support is experienced. Handover points become points of connection rather than risk.

Relationships continue across different stages of a person's journey. The system works to hold complexity, rather than pass it on.

Integration does not happen by accident. It is built into how the partnership operates, shaping how teams work together, how information is shared, and how responsibility is carried across the system every day.

This is what SPARK sets out to prove, and why it works. As Tom Woodcock, Director of Partnerships and Collaboration, describes it:



“When we set out, the aim was simple: stop asking people to navigate a system that isn’t built for real life. We built SPARK so organisations could act as one, carry responsibility together, and hold people through the moments where support usually breaks down.

The lesson is not a ‘model’ or a brand. It’s that outcomes change when the system changes, and the hardest gains come from doing the unglamorous work of collaboration every day.”

# How SPARK works in practice

SPARK brings organisations together to operate as a single system, with a shared focus on continuity, engagement and recovery. It does not function as a set of separate services working alongside each other.

In practice, this means people are not required to navigate a complex system on their own.

They can enter support at different points, and the responsibility for continuity sits with the system rather than the individual. As Luke Bidwell, Early Break describes:

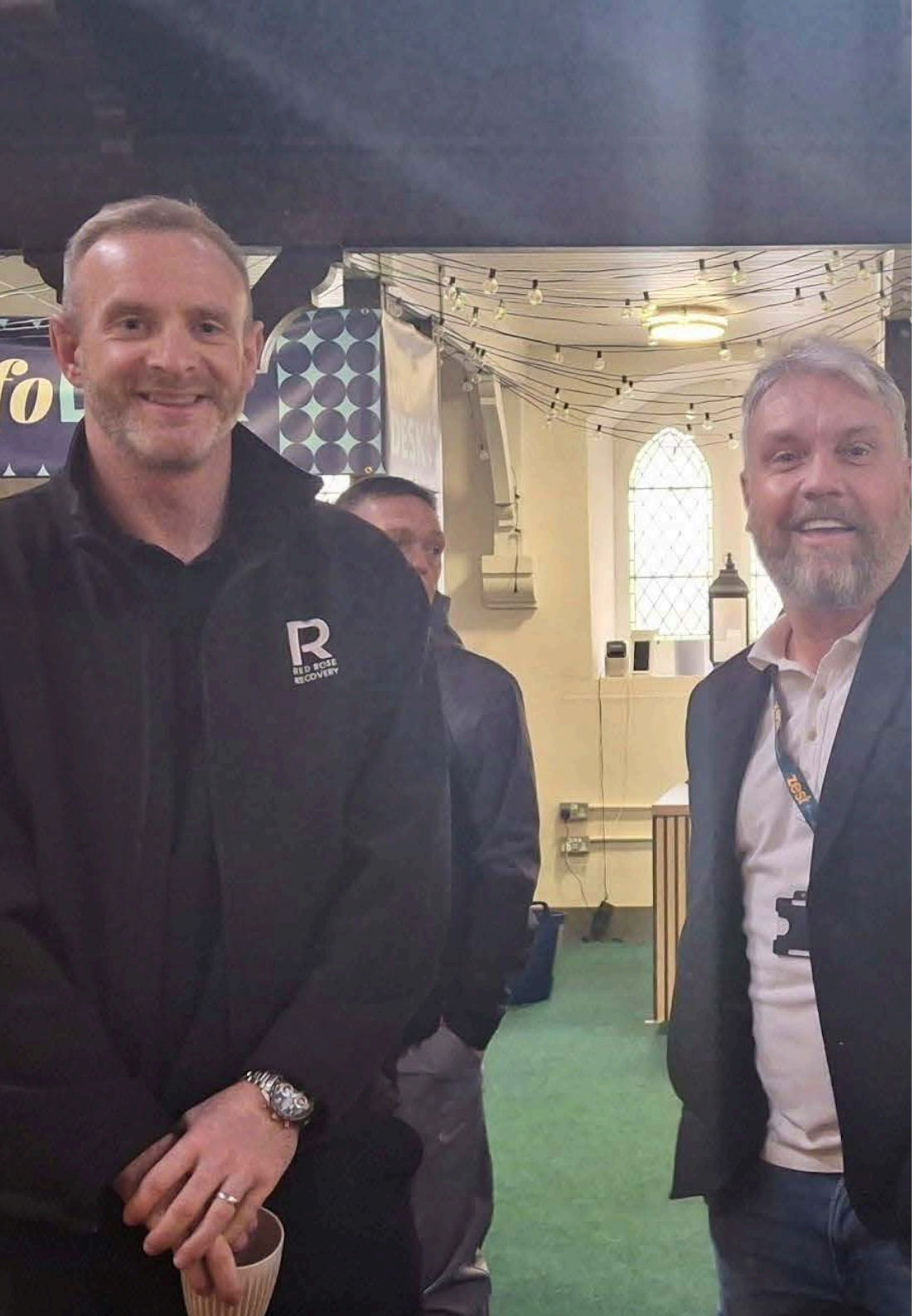
**“As a collaborative, you should be able to enter at any point in the treatment system and we should be able to navigate that. In other areas, people might get told ‘that’s not us, go over there’, but here there is a real focus on helping people move through.”**

This reduces the risk of people being redirected or left to find the next step themselves.

The model also relies on strong, day-to-day relationships between organisations. These relationships allow teams to resolve issues quickly, adapt pathways and respond to changes in need without delay.

Over time, this has created a more consistent experience for people moving through support; a stronger recovery offer, built around networks that give people choice and genuinely person centred care, rather than a one size fits all approach.

Transitions, which had previously been points of risk, become more coordinated. For example, collaboration between young people’s services and adult services supports smoother transitions for those approaching adulthood, with shared working and clearer pathways maintaining continuity of care.




The role of specialist organisations is a central part of this approach. Partners are not added as supplementary services; they are embedded within the system, contributing expertise, relationships and reach into different communities.

For some communities, this makes a visible difference in how support is accessed and sustained. Work with underserved groups requires time, trust and cultural understanding, particularly where stigma or concerns about confidentiality create barriers to engagement. As Salma Kathrada, IMO, reflects:

**“You need a real level of cultural understanding and sensitivity to sustain that engagement. People can be referring in, but if you can’t hold them and really understand where that stigma comes from, then you’re going to lose that person.”**

Through this approach, engagement increases over time, particularly among people who have previously been less likely to access support. This is not only about opening doors to services, but about creating the conditions to sustain relationships once people come forward.

The system also allows partners to work together in practical ways that extend beyond formal referral pathways. Individuals can be supported into a wider range of activity and provision through the connections across the partnership, helping to address broader needs alongside treatment.

This way of working does not develop instantly. It takes time for roles to be understood, for relationships to form, and for the system to operate with confidence.
As Carley Treagust, Early Break adds:

**“It took a while to get to the point where it really felt like a collaborative, but when it did, it became much clearer how it should work. It moved towards being more of a one-stop system, where people could access support across recovery, families and different needs.”**

# Where SPARK makes the biggest difference

Alongside the collaborative model, SPARK works closely with a wider system of local partners beyond the core partnership, including probation and prison services.

This broader system alignment supports continuity across custody and community settings, ensuring that responsibility is shared not just within the collaborative, but across the full pathway people move through.

A key part of this approach is the SPARK Operational Group model, which brings partners together in a structured, delivery-focused forum.

This was introduced through the collaborative to support joint decision making, coordinated responses and shared oversight of complex cases. It provides a practical mechanism for maintaining continuity, resolving issues quickly and ensuring that the system operates as a single, joined-up offer in practice

This was developed through SPARK as part of the collaborative model and embedded as a core part of delivery.

The impact of SPARK is most visible where systems typically struggle: at the points where people are most likely to disengage.

This reflects not just the collaborative model itself, but how it works across the wider system, including probation and prison services, supported by shared delivery structures such as the Operational Group model, developed through SPARK and embedded as a core part of delivery.

One of the clearest examples of this is at the point of release from prison, where maintaining continuity of care is widely recognised as difficult.

Across the contract period, engagement into community-based treatment following release remains consistently high, reaching 90.4%, significantly above regional and national averages.

This level of engagement suggests that the system is able to maintain contact and continuity at a point where people are often lost, with responsibility held across organisations rather than passed between them.

This approach extends beyond single transition points. Many individuals accessing support are navigating overlapping challenges, including substance use, housing instability, mental health and involvement with the justice system.

Rather than separating these into distinct pathways, the system works to hold these needs together, reducing the risk of people being moved between services without clear ownership.

In practice, this is supported by coordinated, on-the-ground activity that brings services together around people rather than expecting people to move between them.

For example, night-time outreach work with vulnerable women creates a consistent point of contact in settings where traditional services are unlikely to engage.

Delivered in partnership with community and voluntary organisations, this work provides immediate support such as food, harm reduction equipment and safety advice, while also maintaining relationships with individuals facing some of the highest levels of risk.



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The benefits of a coordinated system are also visible at a population level. Work to address Hepatitis C across Blackburn with Darwen reaches the national benchmark for micro-elimination, with testing embedded into routine support rather than delivered as a separate initiative.

By making testing part of everyday engagement, this approach reduces stigma and increases uptake, supporting earlier treatment and improved long-term health outcomes.

This progress reflects sustained coordination between partners, with outreach, clinical support and engagement working together rather than in isolation.

This is particularly important in a borough where experiences of services are not consistent across all communities. Blackburn with Darwen has a diverse population, with different barriers to accessing and sustaining support.

For some, concerns around stigma, confidentiality or cultural understanding influence whether support is taken up in the first place.

Work led by specialist partners, including IMO, shows that engagement can increase when services are delivered in ways that reflect these realities.

Building trust, demonstrating confidentiality and understanding cultural context are all critical to sustaining relationships, particularly with people who have previously been less likely to engage.

This points to a broader understanding of what impact looks like across the system. As Rolonde Bradshaw, Roots Community, comments:

**“People’s treatment journeys are often more complex than a single definition of success can capture, and success itself is about more than substance use alone.”**

**Within this context, the outcomes seen across SPARK can be understood not only in terms of entry into treatment or completion, but in the system's ability to maintain relationships, respond to changing needs and reduce the risk of disengagement over time.**

**This does not remove the challenges associated with complex recovery journeys. However, it creates a more consistent framework for responding to them, particularly at the points where people are most likely to fall between services.**

# Where SPARK makes the biggest difference

| Area | Evidence | What it shows |
|---|---|---|
| **System reach (12-month rolling)** | 1,246 in treatment at contract start (Apr 2022); peak 1,613 (Aug 2025); currently 1,552*(service performance data — provided)* | Sustained growth in engagement over the contract period, with reach remaining high after the peak; a larger active caseload supported year-on-year. |
| **Continuity at high-risk transitions** | 90.4% engagement into community treatment following prison release (above regional and national averages) | Continuity held at a known drop-off point; people were successfully connected into community treatment after release at scale. |
| **Population health: Hepatitis C** | Blackburn with Darwen met the national benchmark to declare micro-elimination among people accessing support, with testing embedded into routine delivery | A system-wide health outcome delivered through routine practice, not a one-off campaign; testing became part of everyday engagement. |
| **Frontline risk reduction (women's outreach)** | Night-time outreach supported around 25 women, providing 100+ hot meals, 40+ naloxone kits, 70+ clean injecting equipment packs, plus safety and health support | Direct harm reduction delivered where risk was highest, with repeat contact and practical support for women least likely to engage through standard appointments. |
| **Service quality assurance** | CQC rated the service Good across all five domains (safe, effective, caring, responsive, well-led) | Independent assurance of quality and governance, with Good ratings across every inspected domain. |
| **Strength of structured treatment offer** | Enhanced psychosocial (PSI) offer, moving beyond brief interventions towards more sustained support | A stronger structured treatment offer, with more depth than brief interventions alone and clearer support for sustainable recovery. |
| **Specialist capacity to reach new cohorts** | New roles: non-opiate workers, ketamine specialist, GP in-reach, hospital in-reach, older person alcohol worker | Targeted specialist capacity matched to need, with new routes into support for cohorts not always reached through standard models. |
| **Out-of-hours recovery community (non-opiate cohort)** | SMART Recovery introduced in 2025 (out of core hours), up to 25 attendees per session | Recovery support extended beyond office hours, with strong attendance and a clear offer for non-opiate cohorts. |

## Coordinating support across agencies

A woman engaged in street-based sex work was known to multiple agencies and experiencing drug use, poor mental health, and ongoing contact with services.

Engagement with structured treatment had been limited. Support was being provided by different services, including outreach and specialist teams.

Through SPARK, outreach, clinical, and community partners worked alongside each other to maintain contact and provide consistent support. This included harm reduction, access to wider services, and ongoing engagement through outreach activity.

Over time, this consistent approach supported continued contact and increased engagement with recovery support.

## Reaching communities through trusted partners

Some communities were less likely to engage with traditional services, particularly where trust, cultural understanding, or previous experiences created barriers.

Through SPARK, voluntary and community partners, including IMO and Early Break, worked alongside clinical and treatment services to reach people in different ways. These organisations brought local knowledge, lived experience, and established relationships within communities.

This approach supported increased engagement from individuals who may not otherwise have accessed support, including people from ethnic minority backgrounds and those described as harder to reach.

It also reduced the need for repeated assessments and supported earlier contact with services.

## Continuity across custody and community

People leaving custody were often expected to navigate housing, health, recovery, and probation support at the same time, with services operating separately.

Through SPARK, support is planned earlier and carried across custody and community settings. Partners work together rather than passing responsibility between services, maintaining involvement during the transition from prison.

New figures show that 89% of people leaving custody now engage with community support after release, compared with 26% four years ago; reflecting a significant shift in how support is experienced at this point of transition.


## Embedding health intervention within recovery support

Testing for Hepatitis C is often delivered separately from recovery services, creating additional steps for individuals already navigating multiple needs.

Through SPARK, testing was integrated into routine support, working in partnership with health organisations to make it a standard part of engagement. This reduced barriers to access and supported more consistent uptake among people at risk.

As a result, almost all people accessing the service who could be at risk were offered testing within the last year, contributing to progress towards local micro-elimination of Hepatitis C.

# What people say

## Understanding change and impact

"Going through treatment with Spark was life-changing for me. I was given tools to make positive changes that have not only had an amazing impact on my life but also on those around me."

DEAP graduate

"I got to look at some underlying issues I never would have addressed. Although I thought they were buried, they played a massive part in how I behaved and in my addiction."

DEAP graduate

## Working with families and relationships

"I used to tell myself the children weren't being affected, but [the support] helped me see what needed to change to make our family life better."

Parent accessing support

"The workers supported me to understand how my substance use was affecting my children, and they also worked directly with my children to help them make sense of what we were going through."

Parent accessing support

## Building connections and support

"During DEAP, I was supported not only in group, but out of group and provided with a variety of extra support and connections around recovery... which helped massively in my recovery and building those important connections."

DEAP participant

"I'd been going to regular NA meetings on the bus provided by Spark... even then I was in denial of the fact I needed help on another scale."

Recovery programme participant

## Confidence and stepping forward

"I was nervous just to speak... I found it difficult just speaking. I've been out of my comfort zone, but it's been a laugh and it's been joyous."

Group participant

"Coming to these classes has been an introduction to starting a new life. This is the way we're going to live our life now; getting out of our comfort zone without putting that substance inside us."

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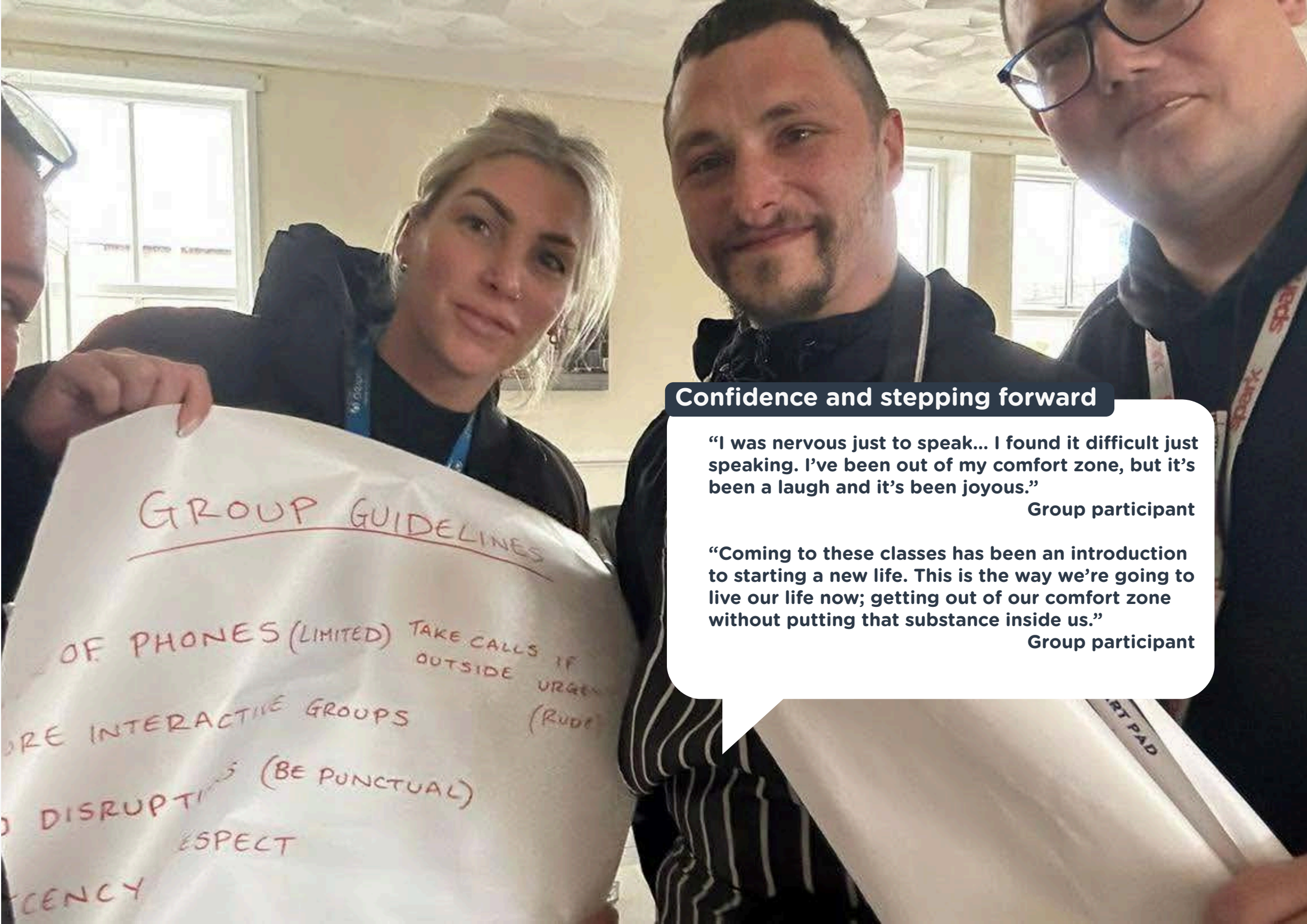


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# What makes these outcomes possible

The outcomes described in this report did not emerge by chance. They were shaped by the conditions under which SPARK was designed and delivered, and the way those conditions were maintained over time.

At its core, the model created a single system with shared responsibility. This meant that accountability for people's journeys did not sit with individual services alone, but was held across the partnership. Where challenges or risks emerged, they were more likely to be addressed collectively, rather than attributed to a specific part of the system.

This was reinforced by clearer lines of escalation and communication. Teams were able to respond to issues directly, working across organisational boundaries to resolve them.

In practice, this reduced the likelihood of gaps forming at transition points, and supported a more consistent experience for people moving through different stages of support.

Shared access to information and aligned priorities also played a key role. People were not tracked within a single service, but across their journey.

This created a more complete understanding of need, allowing support to draw on a wider network of provision and adapt as circumstances changed, creating a stronger and more flexible recovery offer with greater choice rather than a one-size-fits-all approach.

However, structure alone was not enough to sustain this approach. The effectiveness of the system relied on the relationships that sat behind it.

Partners described how day-to-day collaboration became embedded over time, as teams developed a clearer understanding of each other's roles, strengths and responsibilities. As

Salma Kathrada, IMO says:


**"Everybody's sharing their different skill sets and areas, and they come together with one goal of getting people who need treatment into treatment, and reducing harm where it's needed."**

This shift was gradual. Early stages of delivery required time to build trust, establish working relationships and develop a shared understanding of how the system would operate.

As these relationships strengthened, partners were better able to work jointly, drawing on each other's expertise and addressing complexity together.

A consistent theme across the partnership was the importance of collective ownership. Teams did not operate solely within the boundaries of their own organisations, but contributed to a wider system with a shared purpose.

This enabled more flexible responses, including joint working, shared delivery and the practical coordination of support across different settings.

As Luke Bidwell, Early Break reflected:

**"There's a collaborative of leadership across it. We all want to improve the service overall and deliver the best outcomes for people, and we're not afraid to challenge each other to make that work."**

This created an environment where challenge and support could sit alongside each other, allowing the model to adapt and improve over time.

Taken together, these conditions reflect a different way of organising support: one where responsibility is shared, relationships are prioritised, and outcomes are understood as a collective effort rather than the result of individual services working in isolation.

In practice, this meant the system was better able to maintain continuity at the points where people are most likely to disengage, and to adapt to the complexity of people's lives rather than simplifying them into fixed pathways.

These conditions did not sit outside delivery; they were how delivery happened.

# What we have learned over four years


SPARK did not begin as a fully established system. It developed over time, as organisations worked through how to operate collectively and build a shared understanding of roles, responsibilities and priorities.

In the early stages, this required active coordination. Referral pathways were not always clear, and differences in approach between organisations needed to be worked through.

As Carley Treagust, Early Break commented:

**“It took a while to get to the point where it really felt like a collaborative, but when it did, it became much clearer how it should work.”**

Over time, more consistent pathways and clearer relationships reduced this friction. This allowed the system to operate more confidently and respond more quickly to issues as they emerged.

Building trust, both between organisations and with people accessing support, was a continuous process. Engagement was not immediate in all cases, particularly where there were existing concerns around confidentiality, stigma or previous experiences of services.

As Salma Kathrada, IMO described:

**“We’ve had to spend a lot of time building trust and building that confidence, and that’s what’s helped more people come forward over time.”**

This reinforced the importance of consistency, cultural understanding and sustained contact, particularly for groups who were less likely to engage through traditional routes.

There was also a shift over time in how success was understood in practice. Early delivery placed a stronger emphasis on activity and volume, including the number of people entering treatment.

As the system matured, there was a clearer focus on the quality of engagement, sustained contact and the ability to support people over longer periods.

This shift reflected a broader understanding of recovery as a process rather than a fixed outcome. It also aligned with changes in the needs of the population, particularly in relation to non-opiate and alcohol use, where engagement can be less linear and require different forms of support.

Finally, the experience of SPARK highlighted that collaborative models require ongoing effort to maintain. Relationships, communication and shared ownership cannot be assumed; they must be actively supported through leadership, time and everyday practice.

Taken together, these lessons reflect the realities of building and sustaining a system-based approach: it can achieve strong outcomes, but it depends on continued investment in relationships, clarity and shared purpose.

# What this work shows

Over four years, SPARK demonstrated what was possible when services were designed and delivered as a single, coordinated system.

It showed that continuity of care can be maintained at points where people are most likely to disengage; particularly during transitions between services and following release from prison.

It showed that engagement can be sustained not only through access to support, but through consistent relationships, trust and shared responsibility across organisations.

It also showed that the structure of a system shapes how it performs. When responsibility is held collectively, when communication is direct, and when partners operate with a shared purpose, the experience of support becomes more consistent.

People are less likely to encounter gaps between services, and more likely to remain connected over time.

This was particularly relevant in a context where people's experiences of accessing support were not the same.

The work demonstrated that engagement can increase across different communities when services are delivered in ways that build trust, reflect cultural context and provide continuity of relationships, rather than relying on a single point of access.

The outcomes captured throughout this report; including sustained engagement, increased reach over time, and strong continuity at key transition points; reflect the way the system operated, rather than the contribution of any one organisation.

They were the result of multiple parts working together, in a coordinated way, over time.

The difference was not in any single intervention or service. It was in how the system held together around the person.

Where that happened, continuity was maintained, relationships were sustained, and risk reduced at the points where people are most likely to be lost.

Where it did not, those gaps remained.

And those conditions were not accidental.

# Acknowledgements

SPARK was delivered as a partnership. The outcomes described in this report were made possible through the work of many organisations and individuals who contributed their expertise, time and commitment over four years.

We recognise the core delivery partners who worked together as a single system:

- The Calico Group
- Acorn Recovery Projects
- Delphi Medical
- Early Break
- Inspire, Motivate, Overcome (IMO)
- Red Rose Recovery
- Community CVS

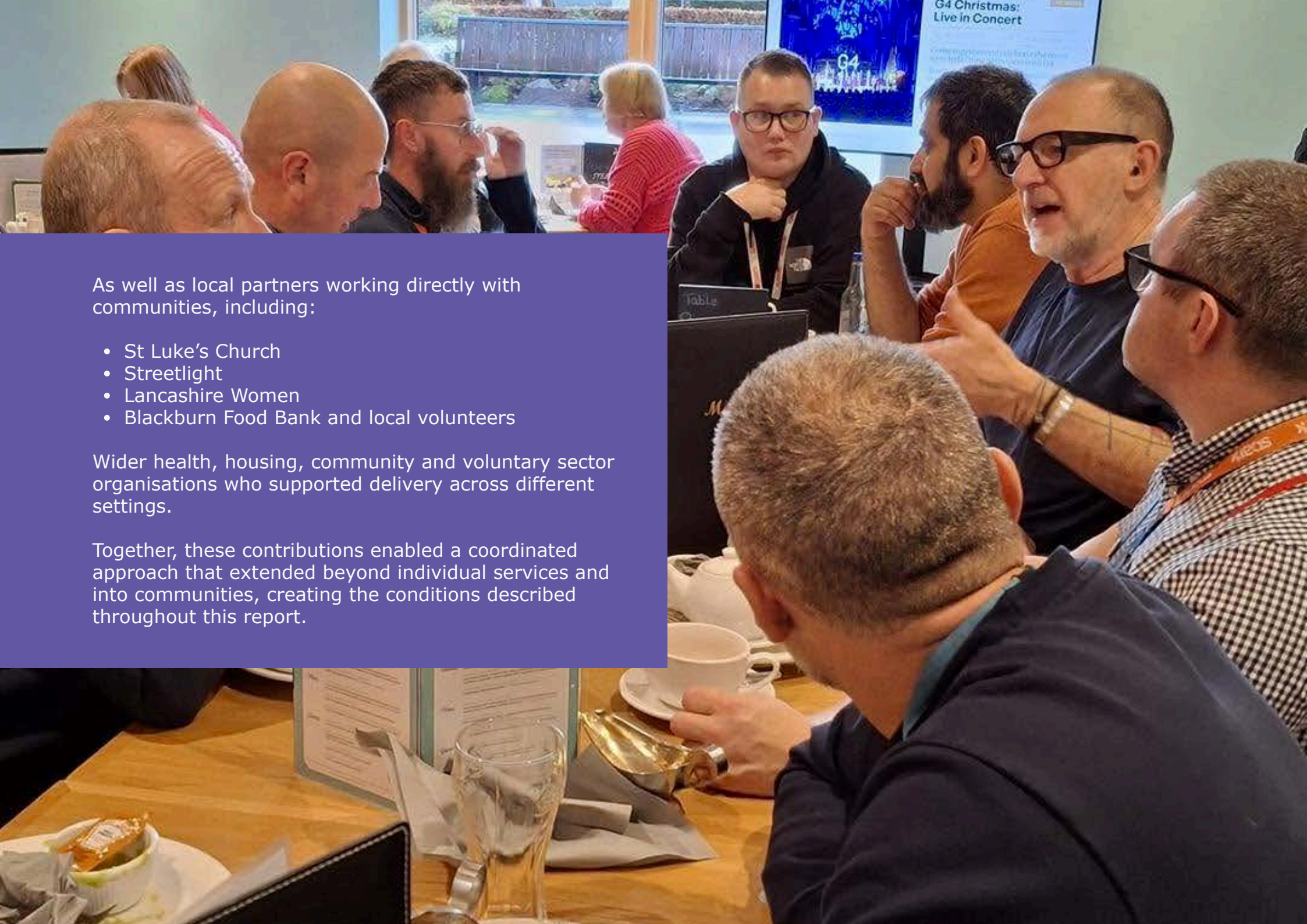

These organisations formed the foundation of the SPARK collaborative, working with shared responsibility to deliver treatment, recovery and support across Blackburn with Darwen.

We also recognise the role of Blackburn with Darwen Borough Council, as commissioner, in supporting and enabling the development of a collaborative, system-based approach to delivery.

Alongside the core partnership, a wide range of organisations and community partners contributed to delivery, particularly in supporting access, engagement and harm reduction.

These included:

- 180 Project
- Age UK
- East Lancashire Hospitals NHS Trust (ELHT)
- UK Health Security Agency (UKHSA)
- Department of Health and Social Care (DHSC)
- Gilead Sciences




As well as local partners working directly with communities, including:

- St Luke's Church
- Streetlight
- Lancashire Women
- Blackburn Food Bank and local volunteers

Wider health, housing, community and voluntary sector organisations who supported delivery across different settings.

Together, these contributions enabled a coordinated approach that extended beyond individual services and into communities, creating the conditions described throughout this report.