

Alliance Commissioning and Coproduction in Mental Health

Mental Health Commissioning:
Drivers and Opportunities to Improve



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1. Introduction

This paper uses published material, learning from commissioners, providers and people with lived experience, and our own knowledge and experience, to discuss the benefits and challenges of alliance commissioning and coproduction in mental health.

What this paper covers

- National and local drivers influencing the development of alliance contracting. A long history of service gaps, overlaps and inconsistencies and poor access, experience and outcomes for people who use services have been critical influences, along with national policies such as the Mental Health Five Year Forward View.
- Definitions of alliance commissioning and contracting and how these approaches differ from traditional commissioning approaches.
- The principles of coproduction, emphasising the differences between coproduction and consultation, and stressing the importance of mutual, blurred roles and responsibilities – critical to true alliance working.
- Common challenges faced by people using alliance contracting, including the challenge of working in partnership, dealing with conflict and managing expectations.
- Showcasing the work of two areas who have used alliance contracting and coproduction, with different effects and consequences.
- A discussion of the learning from our own and others' work, with a series of useful tips derived from experience. We emphasise the importance of building and nurturing positive relationships from the beginning – between commissioners and providers, between providers, and with people with lived experience.



2. National and local drivers

Despite national and local efforts and positive developments, local mental health commissioning arrangements for statutory and non-statutory services have tended to be historically based, with block contracts to large mental health trusts alongside a plethora of small contracts held by non-statutory providers. Commonly-reported concerns about local commissioning and delivery of mental health services include:

- Dissatisfaction from people with lived experience and other stakeholders
- Disproportionate spend on inpatient beds
- Lack of preventive and proactive services
- Lack of joined up services, with gaps and overlaps
- Poor outcomes, including a lack of emphasis on recovery
- Poor performance management and concomitant lack of clarity about what services are delivered to whom with what result
- Small non-statutory providers struggling for funding year on year, leading to insecurity of service provision.

In recent years, two key policy drivers have sought to address these issues: No Health Without Mental Health, and The Five Year Forward View for Mental Health.

In 2011, No Health Without Mental Health, the national mental health strategy, formally established the need to prioritise “parity of esteem”: the drive to put mental health commissioning, funding and services on a par with physical health. The implementation framework that followed No Health Without Mental Health advocated a different approach to commissioning that included:

- a clearer focus on outcomes
- working in partnership (including to develop mental health needs assessments)
- the need to develop robust systems to ensure the involvement of communities, people with lived experience and carers in the co-design and assessment of the quality of services

Subsequently, the mental health Five Year Forward View (FYFV) set out a number of principles for implementing mental health improvement including:

- Coproduction with people who have lived experience of mental health issues
- Working in partnership with local public, private and voluntary sector organisations
- Identifying needs and working proactively with people to avoid escalation of problems
- Designing person-centred services to support people to live fuller lives
- Using outcome focused and data-driven commissioning

For commissioning in particular, there were strong recommendations; for example about changing the block contract system, developing rewards for collaborative working across agencies and coproducing outcome measures with people with lived experience for payment systems.

To summarise, national and local drivers provide a strong impetus and opportunity for commissioners to rethink how mental health services could be commissioned more imaginatively, collaboratively and effectively, and in partnership with people who use services.



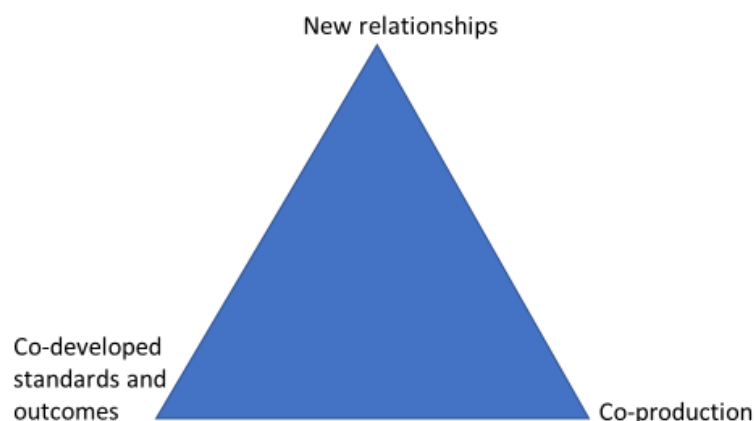
3. What is alliance commissioning and contracting?

Alliance contracting and commissioning arrangements have been defined as:

“A ...collaborative and collegiate approach that seeks to create cooperation between providers and commissioners... [The parties] enter into an agreement to work cooperatively and to share risk and reward, measured against... pre-agreed outcome indicators.”¹

The traditional mental health commissioning model involves working with one dominant provider and separately commissioning and contracting with them and a range of non-statutory providers. Commissioning arrangements are separate. Performance management is linked to individual contracts and individual organisations, expectations and outcomes (if identified at all) need not be aligned. By contrast, an alliance contract is a contract between commissioners and an ‘alliance’ of providers who deliver the project or service, and that can take a number of forms. Alliance commissioning arrangements have three key interrelated elements in their armoury (Figure 1) that, if successful, can address the issues associated with the traditional model.

Figure 1 Alliance contracting and commissioning: 3 key elements



- **New relationships:** Alliance commissioning arrangements require collaboration, cooperation and consensus between alliance providers, and between providers and commissioners, to develop, implement and monitor the service. This supports a sense of a

¹ McGough R & Dunbar-Rees R (2013) Team effort: Commissioning through alliance contracts., Health Service Journal 22 Nov 2013.

whole system that all providers are signed up to, and clarifies what is being commissioned. Services are more likely to be joined up, and pathways smoothed. Overlaps can be spotted, and resources shared to plug gaps. Crucial, too, is the principle that the relationship between alliance partners needs to be consensual and, alongside this, that decision-making must be focused on the good of the whole, rather than the good of individual partner organisations.²

- **Co-developed standards and outcomes:** The alliance agreement is about developing a whole system of care around performance-measurable, shared standards and outcomes. There is an opportunity for improved outcomes as providers share responsibility and are both accountable for, and financially rewarded for, performance against the agreed outcomes.

“We now have an alliance, driven by experts by experience, they are working together and focusing their energy and resource to outcomes.” Commissioner

- **Coproduction:** People with lived experience of the mental health services are at the heart of alliance arrangements. They are essential to the design, development, delivery and monitoring of services, ensuring the alliance delivers a service tailored to people’s needs and preferences, resulting in a likely increase in satisfaction with services.

“I’ve seen people within the alliance talking with each other and communicating over difficulties for patients. A person was about to be discharged into oblivion but the services coalesced around him, all started working together.”

Person with lived experience

It has been argued that alliance contracts in mental health have the potential to deliver better, flexible pathways leading to improved clinical and social inclusion outcomes³

² Kings Fund (2014) Alliance Contracting presentation LH Alliances Ltd (available online https://www.kingsfund.org.uk/sites/default/files/media/linda-hutchinson-alliance-contracting-27.03.14_0.pdf)

³ Clark M, Ryan A, Dixon N, (2015) "Commissioning for better outcomes in mental health care: testing Alliance Contracting as an enabling framework", Mental Health and Social Inclusion, Vol. 19 Issue: 4, p191-201



4. What is coproduction?

The Five Year Forward View for Mental Health (FYFV) called for coproduction to be adopted at every stage of the commissioning cycle. It explicitly stated that every person with a mental health problem should be able to be confident that services have been designed in partnership with people with lived experience, and recommended that standards for access and care should be coproduced.⁴

‘Coproduction’ has been defined in many different ways. A useful article has been written by the Social Care Institute for Excellence (SCIE) that summarises a range of definitions and features.⁵

For the purposes of this paper, we use a simple definition of coproduction to mean the following:

- professionals and citizens share power, knowledge, skills and experience...
- ...to plan, deliver and monitor services together,
- recognising that all partners have a vital contribution to make

Within this simple definition there are critical, interrelated components which have important implications.

Firstly, coproduction is not a synonym for ‘consultation’. It is much more of a cultural shift, requiring the sharing of power, knowledge, skills and experience. Professionals may find this challenging. Similarly, people with lived experience may find it difficult to recognise not only that they have valuable skills and knowledge, but that their very experience is essential to service change and improvement. Key to this issue, too, is the involvement of partners outside the usual framework – for example, primary care colleagues, housing partners, citizens involved in local community groups or faith organisations. Coproduction demands the recognition, valuing and harnessing of the skills and knowledge held in the wider community.

Secondly, coproduction is a thread that runs through service change from beginning to end, requiring commitment, energy, resilience and creation of opportunities (for example, generating employment of people with lived experience). It’s a process that requires resources, to ensure that contributions can be made by all and it also involves *sharing* of resources – another cultural shift for providers who have often competed for resources with each other in the past.

Thirdly, there is an important point to be made about the recognition of all partners’ contributions, and, by implication, responsibilities. Coproduction is not about handing over service change to people who use services; rather it is an acknowledgement of all the valuable contributions and responsibilities the various stakeholders bring to the party. At the same time, it is also not about giving undue power and attention to the loudest voice (such as a large mental health trust). Ensuring

⁴ DH (2016) The Five Year Forward View for Mental Health: A report from the mental health taskforce in England.

⁵ SCIE (2013). What is coproduction and how to use it.

that all voices are heard and valued is a key skill for those embarking on service change using coproduction.

Finally, coproduction is based on a number of principles, articulated in various ways by different commentators, but boiling down to (at least) the following:

1. People with lived experience are regarded as having strengths, skills and qualities
2. People's skills need building, supporting, developing and maintaining
3. Coproduction is based on mutuality of respect and responsibility
4. Roles and boundaries are necessarily blurred
5. People delivering, or commissioning services move to becoming facilitators rather than providers.

For further consideration of what coproduction is and the principles behind it, see our publications, both as sole publishers and with Skills for Care⁶.

⁶ NDTi (2016) *Progressing transformative coproduction in mental health* and Skills for Care with NDTi (2018) *Not another coproduction guide*.



5. Challenges of alliance contracting and commissioning through coproduction

Alliance commissioning and contracting with coproduction at its heart presents an opportunity to reconsider the whole service model and system of provision, to focus together on outcomes, to incorporate coproduction into the commissioning process and to deliver against national policy recommendations.

However, there are a number of challenges, including:

- The legal and regulatory context for alliance contracting can be complex, and it is important to get technical advice on the options to consider early on. As the Kings Fund point out, however, the alliance contract is merely the ‘scaffolding’ to deliver the service, and not a substitute for nurturing relationships and building trust⁷.
- Indeed, building and maintaining relationships across many different organisational and community boundaries can be challenging and tiring. Conflict is inevitable at times and getting through difficult periods takes commitment. Even agreeing the language that is being used and reducing jargon, so that all partners share a clear understanding of what is being discussed, requires thought, persistence and constant self-checking.
- In addition, people with lived experience and others can experience ‘consultation fatigue’. Many have had the experience of ‘consultation’ in various forms, where they have been asked for views and experiences and given time and energy, but have failed to see any real change as a result.
- Furthermore, working with different organisations can bring practical complications. For example, some smaller providers are branches of large national organisations. Governance arrangements can therefore be complicated to navigate, and local relationships may be outweighed by nationally-set rules and organisational norms.

“It’s a bit like writing a book in several different languages!” Commissioner

- Managing expectations and the process of change itself can be highly challenging, especially given the range of partners involved, and in the face of the current climate of needing to secure ‘quick wins’ in service commissioning and delivery. All change takes time, and working with a plethora of organisations and people, carefully ensuring inclusive and consensual decision making along the way is arguably even more time-consuming, requires resources and, some have suggested, training.

⁷ Kings Fund (2014) Commissioning and Contracting for Integrated Care.

“All the stakeholders were at risk of seeing the Alliance as the solution to their particular dissatisfaction with the existing mental health pathway.”

Project manager

- There are costs involved in developing an alliance, and ensuring coproduction is at its heart. However, there are expected economic benefits, as suggested for example by new economics foundation (nef), as well as personal and service benefits. Further, a whole-system approach to mental health care with an emphasis on prevention is likely to result in less use of crisis services and possibly less inpatient bed use, although again this is difficult to prove. While there is little or no empirical evidence of long-term cost benefits, there is anecdotal evidence of better use of resources from commissioners and providers working through alliance contracting.
- Our own work on coproducing transformation in mental health care⁸, itself coproduced with experts by experience, suggests that there are three key challenges to overcome on the coproduction element:
 - Setting the scene – understanding the context and environment in which coproduction is going to take place, including power and hierarchies
 - Coming together – creating the right conditions for coproduction to work, including time and planning and developing shared values and language
 - Working together – achieving genuine collaboration.

⁸ NDTi (2016) Practical Guide: Progressing transformative coproduction in mental health



6. Are there examples of successful alliance contracting involving coproduction?

Although alliance contracting is widely used in some industries and countries as a mechanism for encouraging collaboration, the first alliance contract was established in a UK care setting only in 2013. Experience and learning is therefore still at an early stage, although a small number of local examples have been described and evaluated. Two developments in mental health are summarised below. Both were part of NESTA's People Powered Health Programme, which aimed to test out new models of care and support that make the most of the assets offered by individuals and communities.⁹

Example 1 - Lambeth Living Well Collaborative

What is the background?

Mental health services in Lambeth were struggling to cope with rising demand. Waiting lists were increasing and large numbers of people were in hospital settings. It was difficult for people to access the support they needed before they reached crisis point. In 2010, an initial meeting brought together a group of key people, including people who use services, commissioners, and service providers, to develop a shared solution to an increasingly unsustainable situation.

What outcomes did they want to achieve?

Lambeth is working towards what they call the 'big three' outcomes:

- To recover and stay well
- To make their own choices and achieve personal goals
- To participate on an equal footing in daily life

What did they do?

The original grouping formed the core of the Lambeth Living Well Collaborative, which continued to meet fortnightly over breakfast in a community café run by current and former users of mental health services. These breakfasts became the focus for building a shared culture and way of working, and for finding solutions to issues as they arose.

A number of linked service developments were set up. These included the Lambeth Living Well Network, which offers early support to help people live well, building on their assets and strengthening their community connections.

Cont...

⁹ http://www.nesta.org.uk/sites/default/files/health_for_people_by_people_and_with_people.pdf

The Network acts as a new front door to mental health services, bringing together primary care, the third sector, triage from secondary care, a user led information resource centre and peer support. There are no eligibility criteria, so people can self-refer.

Alongside the Living Well Network, five organisations entered into an alliance to transform mental health rehabilitation services in Lambeth. The goal was to enable people with serious mental health conditions to live independently in the community. A new alliance contract was negotiated that brought together two third sector organisations, the local mental health trust, the CCG and the local authority.

How was the work coproduced?

The 'big three' outcomes were codeveloped with people with mental health needs, who also form part of the Collaborative, as described above. 1600 local people have been actively involved in designing and delivering the new approach. Peer support is a key element of the new front door.

What was the impact?

Two evaluation reports have been published. Both show considerable benefits of the approach:

- Referrals to secondary care fell by 43% in year one and by 25% in year two.
- 400 people per month were supported by the network in year one, many of whom would not previously have met eligibility criteria. By year two the network were offering support to over 5000 people.
- Waiting times in secondary care fell from one month to one week and long-term care caseloads were reduced by 27% in year two.
- Early evaluation also identified savings of about 20% and a comparatively low cost per person.
- The alliance contract (used for rehabilitation services) has shown that this form of contract, in which a group of providers work to deliver a shared set of outcomes, promotes transformation and better use of resources.

What next?

Experience to date in Lambeth has demonstrated the value of adopting an approach that is rooted in coproduction, and aligns services around shared outcomes. Since the initial approach was tested, the Collaborative has gone on to:

- Expand the approach to include all mental health services in the borough
- Introduce alliance contracts across all mental health services, covering a total budget of over £66 million between the council and NHS.

More information

Lambeth update and future plans: <http://lambethcollaborative.org.uk/>

Example 2 - The Stockport Mental Health Alliance

What is the background?

Stockport's alliance was also developed as part of their contribution towards NESTA's People Powered Health Programme. The focus of the development was to drive a more integrated and personalised approach to the recovery journey of individuals.

Who was involved?

The alliance in Stockport brought together third sector providers, secondees from the Mental Health Trust and a User Led Organisation (ULO).

What outcomes did they want to achieve?

A coproduced Social Inclusion Outcome Framework (SIOF) was developed. Its focus was what one person with lived experience called 'getting my life back', and included the following recovery dimensions:

- Mental wellbeing
- Community participation and leisure
- Social networks
- Physical health
- Education and training
- Volunteering
- Employment
- Finance

Outcomes were measured according to clearly articulated coproduced standards from 'poor' through to 'stretch' and 'outstanding'. Six key mental health outcomes were identified with 'I' statements from the perspective of people with lived experience and carers.

What did they do?

A collaborative approach to commissioning and a strong consortium of providers underpinned the Prevention and Personalisation Service run by Stockport Mind and All Together Positive, a user-led social enterprise. The service worked alongside users of mental health services to co-design their pathways to recovery, guided by a Wellbeing Pathway Planner and supported by access to a wide range of services and opportunities, including community assets.

Strategically, the alliance has been working across four programme areas to develop an integrated service:

- Prevention and empowerment
- Urgent Care
- Proactive Care
- Planned Care

Cont...

How was the work coproduced?

The SIOF that underpins the work was coproduced with people: the Prevention and Personalisation service is jointly delivered by a user-led organisation, and people co-design the pathways they follow. Coproduction underpins the development at every level.

What was the impact?

The process of working together to develop the SIOF helped to forge stronger relationships across the system, together with a shared vision and agreement about key outcomes. All the partners are now able to draw on better data on the impact of services. In addition, the alliance showed a number of improvements, such as:

- The wellbeing of around 80% of people had improved
- Fewer people were in expensive services, and for shorter periods
- Reduced length of stay for older people in hospital who were ready to leave

What next?

Following the success of the mental health alliance, the approach was extended to cover a much wider group of people, including older people and people with complex conditions. The aim was to build a collaborative, asset-based approach to supporting people to live well in their communities.

A Targeted Prevention Alliance was established to focus on providing early advice, help and support to people with multiple challenges preventing them from living independently. This is a partnership of a group of non-statutory organisations working together with Stockport council.

However, things have not run completely smoothly with all aspects of alliance working in Stockport. Commissioners in Stockport noted problems with true partnership working and governance arrangements, with real issues around accountability. Their learning has been that when there are challenges, relationships can quickly go from collaborative to strained. They are now considering retendering services without mandating an alliance contract.

More information

The Targeted Prevention Alliance can be found at <https://stockporttpa.co.uk>

Evaluation of Stockport's alliance contract, carried out by LSE:
http://eprints.lse.ac.uk/64327/1/Clark_Commissioning%20for%20better%20outcomes.pdf



7. Critical lessons and key tips

Some critical lessons emerge from reviewing the evidence and the experience of those who have implemented mental health alliance contracts using coproduction. There is no doubt that the process and outcomes are rewarding, energising and highly valued, but it is a tricky road to travel and the following tips are likely to help navigate it.

Alliance contracting and commissioning: top tips from experience

- Forge relationships, including beyond traditional services
- Not a quick fix
- Role change is required, including redistributing power relationships
- Traditional commissioning processes need to change
- Prepare for some difficult decisions
- Focus on outcomes: be clear about what do you want to achieve for whom & manage expectations
- Think small at first to learn and demonstrate success
- Build in thinking time

1. It's all about relationships

The most obvious tip is that, for alliance contracting to be successful, relationships and partnerships need to be built, sustained and nurtured. This is easier said than done. Relationships between organisations, across agencies and sectors, and between people with lived experience and services, can be difficult, fractious and fraught with historical power struggles. One person said a key to relationship building is to move away from thinking about organisations and institutions, and instead realise you are talking with people.

"It's about making relationships with individuals rather than relationships with organisations." Provider

Some relationships don't yet exist and need to be built, such as relationships between the statutory sector and non-service-based community groups. Both the case studies above built relationships with faith groups, for example, as part of their alliance service development.

Key to the tip about relationships is that these cannot be forced. We came across some instances where an alliance was almost instructed rather than partners coming together to deliver the best service. In these circumstances relationships can be difficult to sustain. This was felt to be an issue in Stockport as described earlier and they have decided not to mandate an alliance.

“Where you mandate an alliance, you snuff out creativity.” Commissioner

2. It’s not a quick fix

So, a second tip is that this process takes time, effort, determination, curiosity and humility. It is not a quick fix, and those involved have reported many struggles along the way. Sometimes the need to make change at speed – because of outside pressures, targets, funding timelines – can be imposed on the alliance contracting and coproduction work. The people who have experienced this counsel strongly against it.

“Change happens at the speed of trust, to use that well known quote!” Provider leader

3. Role change is required

With relationship change, comes changes in role, which can be difficult for some to inhabit. Alliance contracting requires commissioners, for example, to be much more involved with delivery compared with the traditional commissioning role.¹⁰ Similarly, some staff can be challenged by a change of role in which they work alongside people with lived experience, sharing power and decision making, yet recognising and valuing the assets and contributions of all those involved has been essential to effective alliances. One way of demonstrating a willingness to rethink power and roles is to step away from the obvious candidates when thinking about leadership and chairing roles. One alliance used a small third sector organisation CEO to chair the alliance leadership group, for example, rather than going with the very big statutory sector mental health provider.

“I attend all the Steering Group meetings. I always come away smiling!”
Commissioner

4. Traditional commissioning needs to change

It is not only roles that require rethinking, but also processes. Commissioning processes need to adapt to incorporate alliance thinking, moving away from straightforward procurement towards contracts in which the person’s experience and outcomes are at the centre and collaborative provision and governance can be handled. Bringing in commissioning support early has been recommended by many involved in this process.

5. Prepare for some difficult decisions

Thinking differently about commissioning services will very likely mean radical changes to existing services; some will need to be decommissioned. In all the areas we have looked at, this has happened – from larger scale service provision through to small individual services. This has rarely been popular. Those involved therefore need to be ready to make difficult and probably unpopular decisions. It takes courage and strong leadership.

¹⁰ Acevo (2015) Alliance Contracting: Building New Collaborations to deliver better healthcare.

Sometimes even the alliance approach must be rethought, as has happened in Stockport.

Difficult decisions also have to be prepared for, and to do this, there needs to be a clear structure for the alliance including clear governance arrangements. How are decisions going to be made, who can make them, how are complaints going to be dealt with, what happens when there is conflict between partners? Preparing for these questions in advance and setting up processes to handle them appear to be central to enabling alliances to work.

“We all get bored with detail and governance, but you will wish you had it. Plan early on.” Commissioner

6. Focus on outcomes

The driver for these difficult decisions has to be improved outcomes for people with mental health needs. Therefore, critical to alliance contracting with coproduction is clarity about outcomes and remaining very focused on them when planning and implementing change. Working together with partners to define a vision is key: what could be different, how could it be different, how will this novel approach change outcomes for people. Without a clear focus on outcomes, the alliance may try to be all things to all people, become unwieldy and unstuck. Expectations will be too high and it may be difficult to demonstrate success.

7. Start small and demonstrate success

This leads to another important lesson: those who have achieved positive outcomes through alliance partnerships have often started relatively small. They have focused on a particular set of outcomes, group or services. Once they have been able to demonstrate success in a targeted area they have been able to expand – and they have a head start as they have already built relationships, experienced and worked through conflicts and culture change, and established new processes.

Having data available to demonstrate process, satisfaction, savings and some outcomes in its initial relatively small-scale alliance really helped Lambeth, for example, make the case to deliver a much larger alliance contract.

“We had evidence and that really helped.” Provider leader

8. Time to reflect

Finally, those who have experienced this way of working all talk about the need to reflect and review how things are going, changing and adapting as necessary.

