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Michael Clark, Tony Ryan and Nick Dixon

Commissioning for better outcomes in mental health care: testing Alliance Contracting as an enabling framework

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Abstract

Purpose –Commissioning has been a central plank of health and social are policy in England for many years now, yet there are still debates about how effective it is in delivering improvements in care and outcomes. Social inclusion of people with experience of mental health is one of the goals that commissioners would like to help services to improve but such a complex outcome for people can often be undermined by contractual arrangements that fragment service responses rather than deliver holistic support. In this paper we discuss a form of commissioning, Alliance Contracting, and how it has been allied with a Social Inclusion Outcomes Framework (SIOF)in Stockport to begin to improve services and outcomes.

Design/methodology/approach – The paper is a conceptual discussion and case description of the use of Alliance Contracts to improve recovery services and social inclusion in mental health care in one locality.

Findings – The paper finds that the Alliance Contracting approach fits well with the SIOF and is beginning to deliver some promising results in terms of improving services.

Research limitations – This is a case study of one area and, as such, it is hard to generalise beyond that.

Practical implications – The paper discusses a promising approach for commissioners to develop locally to guide service improvements and better social inclusion outcomes for people.

Social implications – Rather than developing good services but fractured pathways of care across providers and teams, the Alliance Contracting approach potentially delivers more holistic and flexible pathways that ought to better help individuals in their recover journeys.

Originality/value – This is the first paper to set out the use of alliance contracting and social inclusion measures to help improve services and outcomes for people experiencing mental health problems.

Keywords social inclusion, mental health, commissioning, alliance contracting

Paper type conceptual paper and project evaluation

Introduction

Mental health and mental illness continue to present significant challenges to individuals and society. For example, mental illness represents the largest single cause of disability, 23% of the national disease burden in the UK, costs the UK economy £70–£100 billion per year (or 4.5% of Gross Domestic Product), and people with mental health problems die on average 15–20 years earlier than those without (Davies 2013). In London, for example, it has been estimated that the wider impacts of mental health problems cost its economy around £26 billion per year (Greater London Authority (GLA) 2014).

English national policy in mental health care has continued to stress the need for a recovery focus, the goal being that people receiving services achieve better wellbeing and social outcomes (Department of Health 2011, Department of Health 2014a). There has continued to be a search for policy and practice developments that will enable and provide incentives to local commissioners and providers of services to realise these.

One focus in these developments has been a series of overlapping policy initiatives in health and social care that have stressed the desire for members of the public to be more involved in decisions about their care and support (see Foot et al. 2014 for a discussion of the history of this area of policy development). One policy move aimed to facilitate this involvement and control was that towards a form of personalisation of care, notably using statutory funds in the form of personal budgets for people receiving support – for social care budgets and, more recently, health care ones also (Department of Health 2012, and see Rodrigues & Glendinning (2014) for an overview of these developments).

Personal budgets in social care remains an area of developing practice and evidence (see, for example, the reports from various research studies on personalisation and personal budgets from the National Institute for Health Research School for Social Care Research (http://sscr.nihr.ac.uk/findings.php accessed 21 March 2015). In health care the use of personal budgets is even newer and, hence, at an earlier stage of development and evidence (Forder et al. 2012). More specific to the area of interest of this paper, there is not clear evidence of the effectiveness and cost effectiveness of personal budgets for

supporting people with mental health problems (Webber et al. 2014). However, what is clear is that moves to more personalised services and the use of personal budgets in health and social care remain policy commitments in England and one for further development for people with mental health problems.

Taking these moves for more public involvement in the organisation and delivery of health and social care further are the overlapping concepts of co-production, co-design and co-delivery (e.g. Department of Health 2014b, NHS England 2014, Needham & Carr 2009, Health Foundation 2008, Boyle et al 2010, Nesta 2012). Again, though, these are aspects of practice that require more development and evidence.

Another focus for policy developments to encourage services to work to attain outcomes for those they support have been national policies aimed at defining, performance managing and providing financial incentives for achieving this. These include the Commissioning for Quality and Innovation (CQUIN) payment framework in health care, nationally defined Outcomes Frameworks for health, social care and public health, and moves to develop Payment by Results models (Clark 2011, Jacobs 2014) which are all shaping how mental health services are organised.

Commissioning of services has been another specific area of focus for trying to achieve these goals of a more personalised, recovery and outcomes focused mental health system in England. It is loosely and diversely defined and operationalised but is intended to take a view beyond short-term contracting and play a role in longer-term improvement of services and outcomes (Rees et al. 2014). Along with developing commissioning has been a move to create more markets of providers of care, most clearly developed in social care (Rodrigues & Glendinning 2014) rather than health.

There continue to be debates and doubts about how commissioning is organised and whether it can deliver the kind of improvement in care felt to be needed (Checkland et al. 2012; Ham 2014; Rees et al 2014). There are arguments about the strengths and weaknesses of commissioning processes but overall the evidence about its impact is lacking (Checkland et al. 2012, Gilburt 2014). However, it is clear that commissioning remains an important focal point in trying to develop improvements in the quality of health and social care and the outcomes they deliver, integration between the services, and the level of efficiencies across care systems to deal with pressures on public sector budgets (NHS England 2014; Billings & de Weger 2015).

It can be difficult, though, to develop a coherent approach to commissioning across complex systems of care that span several providers (potentially across statutory, private and third sectors of the economy), health and social care and a range of different funding streams and budgets. The diversity and complexity can be exacerbated by contracts aimed at individual providers rather than at coordinated attainment of outcomes for people across services. There has been a call for commissioners and providers to develop more coordinated

approaches to planning and organising local services (Gilburt et al. 2014) and developmental frameworks to assist commissioners have been developed (e.g. Health Services Management Centre & Institute of Local Government Studies n.d.). These viewpoints are based on reducing the compartmentalisation of services based on discrete budgets that only take account of the service being commissioned and not the wider system it operates within nor, often, of the complexity of needs people present with.

Improving mental health and social care systems and the outcomes they produce is an ongoing challenge (Department of Health 2014), and one that will require multifaceted national and local endeavours. Work continues, then, to find ways locally to operationalise these many policy and practice developments discussed above in a coherent manner. The national Integrated Personal Commissioning Programme (http://www.england.nhs.uk/2014/07/09/ipc-prog/ accessed 21 March 2015) is one such general example that may also be useful in mental health.

In this paper, we discuss the experiences in a local area case study in England, namely Stockport, of work to develop a coherent operational approach to bringing these themes together through a commissioning approach to improve mental health services and deliver better outcomes for people. Two key aspects of this work have been the piloting of Alliance Contracting and the development of a Social Inclusion Outcomes Framework (SIOF). We will discuss these in more detail in the paper.

The Stockport Vision for local mental health services

Stockport, a town in the Greater Manchester area of England, has a population of around 280,000. The Metropolitan Borough Council has responsibility for, amongst other things, social care and public health. In line with national policy, a Health and Wellbeing Board brings the council together with local health care organisations to plan a coordinated approach to delivering public health, health and social care services and outcomes for people using them.

The area has been moving to a vision of 'People Powered Health' (Corrigan et al 2013, Nesta 2012) for mental health care. This is based on a set of principles, namely:

- **A health and social care system that mobilises people** and recognises their assets, strengths and abilities, not just their needs

- **An ability to live well with long-term conditions powered by a partnership** between individuals, carers and frontline professionals

- **A system that organises care around the individual** in ways that blur the boundaries between health, public health, social care, and community and voluntary organisations

Operationalisation of the vision is underpinned by moves to change practice and develop practical, outcome-focussed, interventions, for example:

- New forms of consultation with service users focused on the above principles

- Support for self-management and self-directed support by service users

- Peer support models and coaching, mentoring and buddying between service users

- Social prescribing of non-medical interventions

- Time banking

- Health trainers and navigators

- Co-designed pathways of care and support

These provide the developments in Stockport with a recovery-based set of values in keeping with principles already subscribed to by local providers and commissioners, and an emerging set of supportive interventions and pathways to deliver these in practice. Structural matters that are central to achieving these changes include giving meaningful choice and control through personalisation, the use of Personal (health) Budgets and organising better-integrated support and care across providers. In supporting the latter more collaborative and partnership approaches between providers, and with commissioners, is vital, and it is here that Alliance contracting is coming to play a key role.

In 2011, Stockport began its mental health pathways projects under this people-powered health programme. It began with a focus on access to service and discharge from them. It was realised that enabling people living with mental health problems to recover a life (social recovery) needs agencies and services to support them in this to come together to deliver a coordinated approach to achieving each individual's recovery goals. A question was, how does the commissioning framework support this?

It was in this respect that commissioners in Stockport examined the Alliance Contracting model. This approach to contracting for complex projects across multiple organisations began in early 1990s in UK North Sea Oil projects, where it was found that strategic alliances, partnerships and other attempts to drive collaboration had not changed behaviours. Their experience was that a move to a genuine risk share through alliance contracts led to outstanding results (Billing & de Weger 2015; Association of Chief Executives of Voluntary Organisations ((ACEVO) 2015). The experience was that it can contribute to a collaborative culture of learning and improvement, and, hence, better delivery of complex projects.

Since then the approach has been used across the world and in different sectors of the economy, including construction, infrastructure, defence and energy in the UK, and in health service alliance contracts in New Zealand (Timmins & Ham 2013; Gould 2014; Billing

& de Weger 2015). The first UK alliance contract in health and social care was in April 2013 (see http://www.hsj.co.uk/home/commissioning/team-effort-commissioning-through-alliance-contracts/5065272.article#.VTtu4SFViko (accessed 24/4/15), Addicott (2014) and ACEVO (2015) for an overview of Alliance contracts). Unsurprisingly given its comparative newness, there is little robust evidence about the use of alliance contracts in health and social care in England. Billing & de Weger (2015) found that this was the case for other innovative approaches to commissioning in heath and social care, that generally there was a lack of evidence and especially so from a social care perspective.

The general basis of Alliance Contracting is that collaboration creates value because not one person/organisation has all the answers to deliver complex projects. Each organisation is dependent on others to deliver the overall project successfully, and that pooling of energy, ideas and resources makes for a greater sum of these parts. This has been the experience in, for example, Wiltshire County Council where the local authority has sought to move to relate payment to providers of social care on the basis of achieving outcomes, but have recognised that often outcomes for people cannot be delivered by one organisation (Bolton 2014).

In traditional contracting, a commissioner would have several separate contracts with individual organisations providing parts of the local system or a single contract for multiple services within the organisation and nothing that ensured they work together as a system. Typically, in the former, there would then also be separate objectives for each contracted party, and their performance would be individually judged according to these. Two problems this presents are fragmentation and inflexibility, such that in health and social care it is hard to respond across a series of provider organisations to individual needs and to adapt with changes over time. This can be even more so in mental health care where conditions and needs are often long term and fluctuate over time. We also have to recognise that moving to more competition brings opportunities and risks to both commissioners and providers, and different forms of contracts with providers bring varying combinations of these (Rodrigues & Glendinning 2014).

The Alliance Contracting approach requires a common vision across partners so that everyone is clear about and agrees the same goal(s) and risks that each holds. It also needs a single set of agreed outcomes (so that success can be judged in the same way), and then an alliance of organisations (all agreeing to work together to deliver the vision and outcomes) signed up to the contract codifying these outcomes. This also sets out a single, agreed performance framework, with aligned objectives and shared risks across providers and with commissioners. Success is judged against overall performance rather than the performance of individual organisations. This brings collective accountability and incentives to share learning and coordination of responses to individual needs. The development of the contract and performance framework models the kinds of behaviour expected in delivery, and builds communication and trust between all parties, which can be positively

reinforcing as the contract is operationalised. Flexibility and innovation are built in as expectations. In theory, the Alliance contract forms a collaborative environment, without the need for reorganisation. It is an approach that combines relational as well as transactional elements to build trust and help deliver expected outcomes (Addicott 2015).

This form of contract can address some recognised failings in many previous attempts to develop more integrated care, especially across health and social care, especially that services are based around responsibilities and skills of providers rather than the needs of service users (Wistow 2012), which can often lead to "silo working". However, integration of services should not be seen as purely an issue of merging organisations, rather 'effort needs to be put primarily into the development of alliances and networks between providers rather than mergers' (Ham 2014:53). The Alliance Contract is a more formalised means of seeking to achieve this and influence the behaviour of providers in the system.

Some key factors that from Stockport's experience lead to successful development of Alliance contracts include:

- Recognition across all commissioning and provider parties of the dysfunctional nature of the traditional systems;

- Leadership by all parties agreeing this innovation is the right move and set the expectations for everyone in their organisations;

- Developing an agreed vision and purpose;

- Coproduced performance framework and outcomes to monitor success against;

- Agreed financial framework based on results.

Here leadership has to focus on relational aspects of integrated working, i.e. modelling the expected behaviours, actively building trust and understanding the position of others (Clark et al 2014), beyond merely managing transactional behaviours and performance indicators.

To date the Alliance Framework has been used to develop the Stockport Mental Health Recovery Alliance, involving two local charities as signatories with the Council; Stockport and District Mind and Stockport Progress and Recovery Centre (SPARC). Providing nursing and social care expertise, the local mental health trust, Pennine Care NHS Trust, has co-located two workers within the Alliance, and a User-led Organisation, Altogether Positive works to a Service Level Agreement with the Alliance partners. This brings a sharing of resources and skills across providers to offer a more personalised and flexible service to help people on their individual recovery journey. All support to service users should be outcome driven based on a recovery approach and a common outcomes framework. The integrated nature of the service should also provide more continuity for service users. It is expected that it will also be more efficient and add greater value than the previous ways of contracting for support for service users.

The value of the work organised under the Alliance Contract is currently £332k per annum. Discussions are underway with Pennine Care NHS Trust and the Clinical Commissioning Group to incorporate NHS contract elements in to the Alliance Contract.

As has been noted, a common outcomes framework is vital to the Alliance Contract. More generally in social care (Bolton 2014) and in mental health care (Clark 2011) there is interest in defining meaningful outcomes for people using services and relating payment to providers to achieving these outcomes. For the work in Stockport a framework that facilitated recovery journeys of individual service users was also crucial and a Social Inclusion Outcomes Framework was agreed, which we discuss in more detail next.

Social Inclusion Outcomes Framework

The Social Inclusion Outcomes Framework (SIOF) for the Alliance Contract initially drew on work developed by the then mental health National Social Inclusion Programme (2010) and was operationalised for the local context (Ryan et al 2013). It drew on theoretical understandings of social inclusion/exclusion and previous work (for example, Social Exclusion Unit 2004). At the time, the SIOF was based on priorities defined for services by agreements between the Treasury and central government departments, called Public Sector Agreements. It was recognised, though, that the SIOF was not exhaustive in terms of possible measures of social inclusion. It provided a helpful starting point for discussion of the outcomes framework for the Alliance Contact. The SIOF for the Alliance Contract was then coproduced in Stockport between services users, service providers and commissioners. It is based on "social recovery" or "getting my life back" as one user described it. The eight areas of recovery used in the Stockport SIOF cover:

1   Mental wellbeing

2   Community participation and leisure

3   Social networks

4   Physical health

5   Education and training

6   Volunteering

7   Employment

8   Finance

The SIOF contains *process measures* that describe the processes or interventions that lead to an outcome i.e. the activities that (should) take place and can be counted. Examples of these include that service users are:

– Given advice on smoking cessation

– Involved in Co-producing a Wellness, Recovery Action Plan (WRAP)

– Given information to manage their own medication

– Helped to open a Bank Account

– Assisted to obtain a Bus Pass

– Joined to a walking group, or other activities available through social prescribing

Following these the SIOF then details *outcome measures*, which measure the *effect* (or outcome) of the intervention (process), rather than the number of times it was delivered i.e. it measures the *impact* for the service user of the interventions (processes). Examples are counts of the number of people who, for example:

– Stopped smoking

– Actively began to use a WRAP plan to maintain their mental health

– Started to manage their own medications

– Began to manage their own finances

– Started to use a bus pass to increase their independence

– Commenced attendance with a walking group to improve their physical health and social networks

In addition, the SIOF details *sustainable outcomes*, meaning those that have been achieved by the intervention (process) *and* have lasted a specified period of time. Examples are counts of the number of people who for six months have:

– Stopped smoking

– Actively used a WRAP plan to maintain their mental health

– Managed their own medications

– Managed their own finances

– Used a bus pass to increase their independence

- Attended a walking group to improve their physical health and social networks

Within the SIOF a number of detailed measures are used. We have mentioned frequency counts already, but validated tools to measure specific phenomena can also be incorporated in the framework, for example to measure social capital or mental wellbeing (e.g. WEMWBS (Tennant et al, 2007)). Other tools that are not validated but are widely used or are designed specifically for the SIOF can also be agreed by the participants and incorporated. Examples of the SIOF used in Stockport are in table 1.

Table 1: Example of the SIOF outcomes for community participation & leisure.

Intended Outcomes	Outcome Indicators
Increase the number of people with experience of mental distress participating in or engaging with local community activities	Number of people taking up a new or develop an existing/dormant leisure pursuit
Process Measures	
Offer newly referred people opportunity to increase or sustain activities	
Complete baseline measures: Establish the number, type and frequency of activities/outings if any	
Record any past activities that have ceased	
Reasons why past activities have ceased	
Discuss opportunities to start new/previous activity	
Source information regarding activities	
Agree new activity with person and levels of activity	
Work with person to start new activity	
Outcome: Person starts new or increase existing activity to agreed level	
Sustainable outcomes: Person has been doing new activity on ongoing basis for six months.	
Measures: Frequency counts and WEMWBS (5) (7) (8) & self report	

Evidence of impact to date

The use of the Alliance Contract and the SIOF have been in place for two years, and while they are still to some degree developmental, there has been evidence of improvements for people using the services and providers actively delivering the vision for the local mental health system. Crucially developing the framework of the contract and the outcome tool (SIOF) has brought together a range of organisations in a collaborative process that itself models the kind of behaviours needed to make the Alliance approach work and to achieve better outcomes and recovery for service users. Associated with this is clear relational

leadership to build and sustain commitment to the developments. The approach has also led to better data about care pathways, processes and outcomes that commissioners and providers in Stockport are beginning to digest and which provide intelligence for ongoing evaluation and service and system improvements.

The Alliance engages people throughout the treatment and recovery pathway, in-reaching to the acute wards, attending CMHT meetings and, when appropriate and timely to the individual, engaging the person in moving on to sustainable independence. In order to make the pathway "joined up" and prevent the need for individuals to be referred on (and indeed risk falling between), in April 2015 the Prevention and Personalisation Service (PPS), a then separate contract and service between the Council and Stockport Mind, including staff from within Pennine Care NHS Trust's Recovery and Inclusion Team formally joined the Alliance. The PPS works with people entering or leaving mental health services. It provides another option to secondary mental health care to access as a pathway out of their services. It has developed a strong focus on social and financial issues related to maintaining good mental health. The aims of the PPS are to:

- reduce the use of secondary mental health services,

- prevent dependence on clinical approaches and

- maximise preventative and recovery strategies alongside clinical approaches

Achieving outcomes is based on individual recovery goals and is the responsibility of all partners in the service, and based on needs matching provision across partners, not only on the skills available in any one organisation. Achieving the goals moves at the pace of the individual and his/her recovery plan, rather than dependent on service timetables.

Table 2 provides information about achievements to date from the PPS against some of the SIOF measures. Figure 1 demonstrates the impact of the PPS on the Warwick-Edinburgh Mental Well-being Scale (WEMWBS) (Tennant et al. 2007).

Table 2: achievements of the Prevention and Personalisation Service against SIOF indicators (February 2012-March 2015)

Support Indicator - SIOF	TOTALS	Achieved	% of SIOF Achieved	Closed	Not Achieved	Progressing
Mental Wellbeing	184	70	38.0%	26	14	74
Community Participation - Leisure	63	27	42.9%	7	1	27

Social Networks	79	43	54.4%	7	2	26
Physical Health	55	10	18.2%	12	3	30
Education / Training	43	15	34.9%	2	0	26
Volunteering	48	21	43.8%	4	0	23
Employment	35	10	28.6%	2	0	23
Finance	88	67	76.1%	5	1	15
Total Number	595	263		65	21	244
Percentage			44.2%	10.9%	3.5%	41.0%

Figure 1 demonstrates the impact of the PPS on the Warwick-Edinburgh Mental Well-being Scale (WEMWBS)
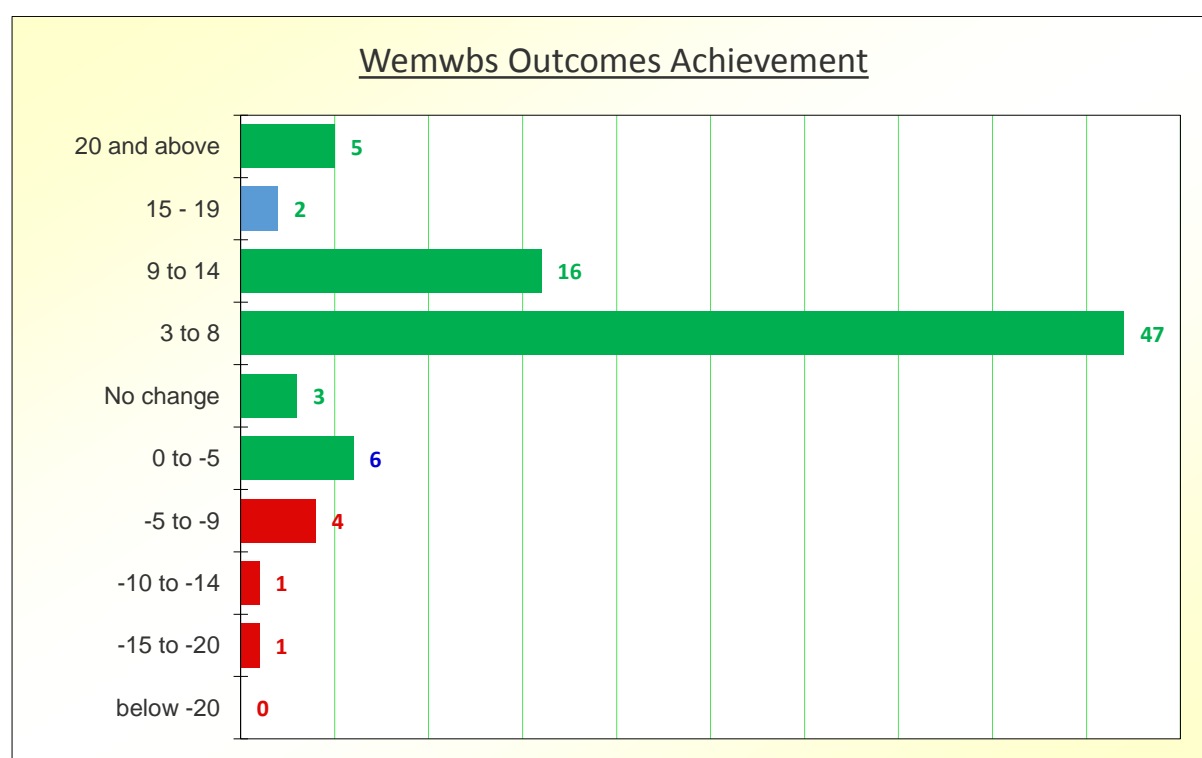
Key

Increased Scores	70	82.4%
Decreased Scores	12	14.1%
No Change	3	3.5%

Next steps

The Stockport experience is that developing the Alliance Contract brings together people who commission and provide services to begin to develop a clearer view of a shared goal.

Combining this with the SIOF, co-produced with commissioners, providers and, crucially, people who will use services, creates a focus for creating ways of working and learning together to effectively help people in their mental health recovery. It also helps clarify the outcomes that people want from the services they use. It allows the services to work backwards from the desired outcomes to coproduce the interventions required and use this as a way of structuring the services they deliver.

Some next steps in the development of the approach in Stockport are:

i)   to continue to collect data about the Alliance Contract and SIOF now in place and learn about their operation and impact;

ii)   to continue to explore the payment by results basis of the Alliance contract and how this works to provide (dis)incentives towards the overall goals;

iii)   to examine how the approach can best work with implementing personal budgets from social care and, as these develop, health care;

iv)   to explore widening the Alliance contract to bring in more aspects of the local mental health care system and more providers.

v)   draw on the success and learning from mental health; a cross Adult Social Care Targeted Prevention Alliance Contract was competitively tendered and was signed by six third sector organisations in May 2015

Conclusion

Mental health and illness continue to present challenges to society and individuals. Whilst there is a national vision for what services should be working to achieve with people, there is no clear sense of the best mechanisms to enable and encourage services to work to achieve this. Various approaches have been tried to achieve this. Some of these are well established, such as the commissioning function (and the split from providers), and the use of markets and personal budgets in social care. Others are less well developed, including the linking of payments to outcomes, and personal budgets in health and social care. Challenges remain to develop a coherent approach to implementing these in ways that overcome some of the risks of individual mechanisms of planning and organising services and that ensure synergies between each one.

In this paper we have discussed the developments in Stockport aimed at addressing these challenges. The Alliance Contract model potentially provides an approach that can create the right kind of environment in which people who use services, service providers and commissioners can come together to explore and learn together how to co-design and operationalise a system that is adaptive to individual needs and goals and helps each person on a recovery pathway. It also provides a framework within which a coproduced approach

to describing and measuring outcomes desired by people using services can thrive. Billing &
de Weger (2015) point out that there is little robust evidence concerning the use of new
models of contracting and of how they might help to deliver better integrated services,
especially lacking perspectives from social care, and relies on narratives from a limited range
of authors. In this paper we have sought to contribute to addressing these deficits in the
evidence base by detailing the use of alliance contracting and a social inclusion outcomes
framework to deliver improvements in mental health care in one local authority area.

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