Joint Commissioning Panel
for Mental Health

www.jcpmh.info

Guidance for implementing
values-based commissioning
in mental health

Practical mental health commissioning
Joint Commissioning Panel for Mental Health

www.jcpmh.info

Co-chaired by:

Royal College of General Practitioners
Royal College of Psychiatrists

Membership:

Mind
NSUN
Rethink Mental Illness
The British Psychological Society
Promoting excellence in psychology

HFMA MH Finance

Mental Health Providers Forum
Mental Health Network
Royal College of Nursing

The Afiya Trust
ADASS
National Involvement Partnership
The New Savoy Partnership
# Contents

<table>
<thead>
<tr>
<th>Ten key messages for commissioners</th>
<th>Introduction</th>
<th>What is values-based commissioning?</th>
<th>Why is values-based commissioning important to commissioners?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>05</td>
<td>06</td>
<td>08</td>
</tr>
<tr>
<td>What do we know about current values-based commissioning practice?</td>
<td>09</td>
<td>What would good values-based commissioning look like?</td>
<td>Supporting the delivery of the mental health strategy</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>20</td>
<td>21</td>
</tr>
</tbody>
</table>

References and resources
Ten key messages for commissioners

What is values-based commissioning?

1 Values-based commissioning (VbC) is an approach where the commissioning process rests on three equal pillars:
   - patient and carer perspectives and values
   - clinical expertise
   - knowledge derived from scientific or other systematic approaches (evidence).

2 VbC builds on existing commissioning models by ensuring that service users and patients are involved at every stage of the commissioning process, and at all levels of decision-making. This includes:
   - the assessment of local need
   - reviews of current services and opportunities
   - deciding priorities
   - risk management
   - strategic planning
   - implementation of contracts, procurement and purchasing
   - provider development and performance management (see pages 6-7).

3 The benefits of VbC include the delivery of more service user/patient-focused services, potentially improved cost-effectiveness, and the achievement of key outcome measures.

How can Clinical Commissioning Groups (CCGs) ‘do’ VbC?

4 Appoint a mental health lead at a senior level – a dedicated GP mental health lead should oversee mental health commissioning, advise the CCG Board on local population needs, ensure integration of primary and secondary mental health services, and make links with voluntary and community mental health organisations.

5 Establish a CCG sub-committee comprising mental health professionals and local voluntary mental health organisations. Membership of a larger network can enable mental health leads to share intelligence and best practice, work through problems, and learn together. Such networks could also provide access to practical guidance and frameworks, or opportunities to hold workshops and training.

6 Set up a VbC panel, bringing together NHS, public health and social care commissioners, statutory and non-statutory providers, to develop patient and service user involvement in commissioning – experience in the West Midlands and elsewhere provide examples of existing models of practice (see page 10).

7 Establish a patient, service user and carer advisory panel, including people from different backgrounds, with experience of different mental health problems and services. The panel will need to use other means to engage a broader group, to prevent it becoming unrepresentative or insular.

8 Use out-reach mechanisms to engage with the local population – many people will be unable/unwilling to participate in formal panels (due to their mental health condition, employment, family life, language, cultural barriers, or lack of confidence). Innovative use of social media can also help encourage wider patient and public participation.

9 Provide formal support and capacity-building – this should include training for panel members to support their general personal development and equip them with particular skills. Training and development in this area should focus on mainstreaming mental health commissioning skills. This will enable it to become part of normal cultural and organisational practice.

10 Use mechanisms and levers to ensure services are also values-based – this includes an organisation’s values-base as a criterion in awarding contracts or funds, and in the assessment of performance.

Acknowledgements

This guide was written by Elizabeth England¹, Fran Singer², Emma Perry³, and Jo Barber³.

¹ Commissioning Lead for Mental Health, Royal College of General Practitioners
² NSUN Network for Mental Health
³ Independent consultant
Values and principles of values-based commissioning

- an approach and style that enables a context conducive to user, patient and carer leadership
- ensuring a diverse range of people can participate, by employing a range of engagement mechanisms
  - using a mix of face-to-face, telephone, paper and online methods, including out-reach through working with community groups that have access to more marginalised groups
- openness and transparency about the level of involvement and influence service users will have
- clear written policy on how service users will be reimbursed and rewarded
- meaningful service user and carer collaboration in the commissioning process (at all levels from decision-making to service specification development as “co-commissioners”)
- provision of accessible information which focuses on the context of the commissioning project, government policy guidance and other relevant material

- an agenda of broader social change and a holistic approach to service development
- investment in:
  - building relationships between communities, professionals and service users
  - developing people’s potential, turning the focus away from their mental health status
  - staff training to support communication and co-production of organisational change

Figure 1: Summary of values and principles of VbC
Introduction

The Joint Commissioning Panel for Mental Health (JCP-MH) (www.jcpmh.info) is a new collaboration co-chaired by the Royal College of General Practitioners and the Royal College of Psychiatrists. The JCP-MH brings together leading organisations and individuals with an interest in commissioning for mental health and learning disabilities. These include:

- people with experience of mental health problems and carers
- Department of Health
- Association of Directors of Adult Social Services
- NHS Confederation
- Mind
- Rethink Mental Illness
- National Survivor User Network
- National Involvement Partnership
- Royal College of Nursing
- Afiya Trust
- British Psychological Society
- Representatives of the English Strategic Health Authorities (prior to April 2013)
- Mental Health Providers Forum
- New Savoy Partnership
- Representation from Specialised Commissioning

The JCP-MH is part of the implementation arm of the government mental health strategy No Health without Mental Health.

The JCP-MH has two primary aims:

- to bring together people with experience of mental health problems, carers, clinicians, commissioners, managers and others to work towards values-based commissioning
- to integrate scientific evidence, the experience of people with mental health problems and carers, and innovative service evaluations in order to produce the best possible advice on commissioning the design and delivery of high quality mental health, learning disabilities, and public mental health and wellbeing services.

The JCP-MH:

- has published Practical Mental Health Commissioning, a briefing on the key values and principles for effective mental health commissioning
- has so far published 15 other guides on the commissioning of primary mental health care services, dementia services, liaison mental health services to acute hospitals, transition services, perinatal mental health services, public mental health services, rehabilitation services, community specialist mental health services, drug and alcohol services, forensic mental health services, acute care (inpatient and crisis home treatment), mental health services for people with learning disabilities, older people’s mental health services, eating disorder services, and child and adolescent services.
- provides practical guidance and a developing framework for mental health
- supports commissioners to deliver the best possible outcomes for community mental health and wellbeing.

WHO IS THIS GUIDE FOR?

This guide sets out some examples of innovative and successful practice in service user, patient and carer involvement in commissioning. It also includes recommendations on how VbC can work in practice for CCGs (individually and collectively), local authorities, Health and Wellbeing Boards, Commissioning Support Units, and local, regional and national levels of NHS England.

HOW WILL THIS GUIDE HELP YOU?

By the end of this guide, readers should:

- be more familiar with the principles, values and application of VbC
- be better able to use VbC to develop a robust framework, which supports equitable service user or patient participation and leadership in all mental health commissioning activity
- understand how VbC can contribute to achieving recovery outcomes and improvements in individual health and wellbeing
- understand how VbC can make it possible to involve and empower service users and patients to work in partnership with commissioners in developing mental health services that achieve the objectives and outcomes of the English mental health strategy
- understand how VbC can support commissioning for best value in the NHS as part of the QIPP (Quality, Innovation, Productivity and Prevention) Right Care Workstream.

WHO WROTE THIS GUIDE?

This guide has been written by the JCP-MH, a group of professionals, service users and carers, representatives from a wide range of service user organisations, third sector organisations and provider organisations. It draws on both evidence-based and values-based examples of best practice in order to highlight the equal status of evidence and values in the commissioning process.
What is values-based commissioning?

The term ‘commissioning’ has been defined by the No Health Without Mental Health strategy as “the process of assessing the needs of a local population and putting in place services to meet those needs”.

VbC is an approach where the process underpinning commissioning rests equally on three pillars:

- patient and carer perspective or values
- clinical expertise
- knowledge derived from scientific or other systematic approaches (evidence).

Commissioning decisions have traditionally been guided by ‘evidence-based practice’ – this is the idea that policy-making and practice will be more effective if based on scientific research and evidence. However, some critics have suggested that evidence-based practice has the potential to overlook the thoughts, feelings and opinions of patients and carers. Values-based practice has been suggested as an alternative.

The concept of ‘values-based practice’ does not seek to replace evidence-based practice, but instead aims to make clinical decisions on the basis of ‘values’ as well as ‘facts’. It aims to empower service users and carers to have more direct control over decisions relating to treatment, access to services and choice about care. It also aims to identify and make explicit the diverse values of all those involved in the process of clinical decision-making.

In addition, the VbC process aims to bring people together around a common set of goals, and by empowering service users and carers (both directly and through representative bodies), places them in the ‘driving seat’ of commissioning strategy and creates a greater sense of ownership.

Direct involvement of the public in this way can achieve several positive outcomes:

- **radical aspirations** – participants bring fresh thinking to what excellence looks like in health and social care
- **engagement** – including active patient and carer participation, shared ownership of the process, and responsibility for completing specific tasks and actions
- **community contribution to the commissioning agenda** – through the representation of service user and carer views
- **marginalised groups** – disadvantaged or seldom heard communities can be more involved and be encouraged to participate within their communities
- **informed service development** – including the development of more effective services, which better reflect the needs, values and experiences of patients and carers.

The distinct characteristics (and benefits) of VbC are described in Table 1.
<table>
<thead>
<tr>
<th>Commissioning activity</th>
<th>‘Traditional’ model</th>
<th>‘Values-based’ model</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Assessment of needs</td>
<td>A systematic process to understand the health and health care needs of the CCG resident population.</td>
<td>Service users and carers are made full members of any groups responsible for assessing health care needs such as the Joint Strategic Needs Assessment. By using the principles of the VbC approach, commissioning organisations will enable inclusion of a wider range of individuals and hard to reach groups.</td>
</tr>
<tr>
<td>2 Reviewing services and gap analysis</td>
<td>Reviewing the services currently provided, and based on the identified needs, defining gaps.</td>
<td>Service user and carer involvement and perspectives are central in determining best current provision meets assessed local need.</td>
</tr>
<tr>
<td>3 Risk management</td>
<td>Understanding the key health and health care risks facing the CCG and deciding on a strategy to manage it.</td>
<td>Service users and carers are enabled to have more direct control over decisions relating to treatment, access to services and choice. This brings with it a degree of responsibility and accountability in terms of decisions made and any subsequent impact on services.</td>
</tr>
<tr>
<td>4 Deciding priorities</td>
<td>Given a list of desirable actions using available evidence of cost-effectiveness and based on a robust and defensible ethical framework, areas for purchase are prioritised. These will include national priorities and locally identified targets and priorities.</td>
<td>Priorities are based on the three equal criteria of user and carer perspective, clinical expertise, and evidence. The benefit of service user and carer involvement is potentially improved recognition of local community priorities and needs to balance national strategic targets.</td>
</tr>
<tr>
<td>5 Strategic options</td>
<td>Bring together all the available information into a single strategic commissioning plan that outlines how the CCG will deliver its core objectives (including those of NHS England) and identified outcomes. Strategic planning needs consideration of how to fund those services required to meet outcomes.</td>
<td>Commissioning infrastructures are based on VbC principles that actively include service users and carers as equal partners. Service users and carers are involved in developing and writing the strategic commissioning plan.</td>
</tr>
<tr>
<td>6 Contract implementation</td>
<td>Involves reviewing funding options, writing service specifications, writing pre-qualification questionnaires for potential service providers, writing an invitation to tender, and writing contracts.</td>
<td>Service users can review best funding options, contribute to writing service specifications and shape desired outcomes which reflect the personalisation agenda. Service users and carers can include quality statements and measures within the service specification element of the standard contract. Service users and carers can also evaluate bids or tenders and write contracts.</td>
</tr>
<tr>
<td>7 Provider development</td>
<td>Support provider improvements or introduce new providers to deliver the services required (including setting-up demand management systems and designing new care pathways). This includes supporting providers in decommissioning of services where appropriate.</td>
<td>Service users and carers become the first point of call for information about decisions relating to health care and treatment, and they work with clinicians and managers to develop services.</td>
</tr>
<tr>
<td>8 Managing service performance and outcomes</td>
<td>Monitor and manage the performance of providers against their contracts, especially against key performance indicators (KPIs).</td>
<td>This draws on all the above aspects, with service users and carers involved in developing a range of patient relevant performance and outcomes measures. The involvement of service users and carers will help refocus services on relevant outcomes from services (rather than a focus on process and targets).</td>
</tr>
</tbody>
</table>
Why is VbC important to commissioners?

There are four important concepts underpinning VbC:

1 expert experience
2 economic approach
3 a focus on outcomes
4 policy implementation.

1 EXPERT EXPERIENCE
- the perspective and opinion of patients, service users and their carers are the first source of intelligence or expert evidence informing a decision, alongside more formal research evidence and evaluation data.
- the success of VbC relies on a joint commitment by all stakeholders to the centrality of service users and carers in any decision-making. It does not negate evidence-based commissioning but rather complements and adds value to the commissioning process.
- in VbC, patients, service users and carers offer their knowledge, skills, experience and values at a strategic level, to achieve service improvement through a type of commissioning that better reflects what people are looking for from mental health services.

2 ECONOMIC APPROACH
- VbC is an effective model of commissioning to help commissioners achieve QIPP (Quality, Innovation, Productivity and Prevention) goals. QIPP is a large-scale transformation of the NHS to improve quality of care and make efficiency savings. ‘Right Care’ is one work-stream within this programme. The primary objectives of Right Care are to maximise (a) value that the service user derives from their own care and treatment and (b) the value that the whole population derives from the investment in healthcare.
- VbC encourages a close examination of local community needs and contributes to understanding how current and future spend is related to population health outcomes. Using the same process and familiarity with the local community, VbC can help in identifying and addressing unwarranted variation in outcomes and benchmarking spend and outcomes against other similar populations.
- in doing this, VbC promotes the integration of care across the pathway.

3 OUTCOMES BASED
- a number of current government policy documents and guidelines have recommended that commissioners should ensure that outcomes resonate with, are ‘owned’ by, and have support from professionals, providers, commissioners, service users and carers.
- one of the principles at the heart of VbC for mental health is that it offers an outcomes-based approach placing great weight and importance on the values and experiences of individuals using services, and, working with service users and carers, transforming these into patient relevant outcome measures.
- VbC also promotes a shared decision-making approach, involving service users to better understand individual and population groups’ mental health needs and desired outcomes, and work co-productively to develop locally appropriate integrated pathways with service user relevant outcomes.
Values-based commissioning in mental health

4 SUPPORTS EFFECTIVE IMPLEMENTATION OF POLICY

• service user involvement is key to VbC – this has been articulated in a number of policies.

• service user involvement in commissioning was a ‘competency’ described in World Class Commissioning (2007). Commissioning ‘competencies’ are the knowledge, skills, behaviours and characteristics that underpin effective commissioning. World Class Commissioning stated the importance of “continuous and meaningful engagement with people, service users and communities to shape services and improve health... good commissioners will want to ensure that they have it”.

• Equity and excellence: liberating the NHS (2010) emphasised the importance of service user involvement in a number of areas of the commissioning process: “GP consortia will have a duty of public and service user involvement, and will need to engage service users and the public in their neighbourhoods in the commissioning process”.

• No Health Without Mental Health promotes service user control and involvement in treatment: “putting individuals at the heart of services is a key driver of the Government’s Equity and Excellence: Liberating the NHS reforms. This means that people can, as far as possible, control and manage their own support so that it matches their needs and aspirations. People feel they are respected as equal partners, and know what choices are available to them and who to contact when they need help”.

• the NHS Mandate states that “local commissioners have the vital role of stimulating the development of innovative integrated provision – for example, across primary, secondary and social care, or for frail elderly patients. In responding to the barriers revealed by their work, further national action will be needed in a number of areas, including: better measurement of user experience of seamless care; better use of technology to share information; open and fair procurement practice; and new models of contracting and pricing which reward values-based, integrated care that keeps people as healthy and independent as possible”.

• Personal Health Budgets (PHB) are one part of the drive to personalise public services, specifically health services. By increasing individual patient and service user choice and control in the way money is spent on their health and social care, outcomes of better health and well-being are expected. Service users will take a more active role in shaping and ultimately commissioning their own services. In addition, service users acting as individual commissioners will work together with clinical commissioners planning for services for local populations. VbC addresses some of the concerns raised from evaluated pilots of PHB. These have shown that new commissioning models are required to release funding with a move away from block contracts and overcoming systemic cultural barriers, where the locus of commissioning control is shifted from ‘professional’ commissioners to individual service users as commissioners. Commissioners need to consider the impact that ‘micro-commissioning’ (as a result of people having personal health budgets) will have on historical commissioning decisions and traditional commissioning processes. Commissioners will need to reconcile decision-making at a strategic population level and more individual or personalised commissioning with shared decision-making.

What do we know about current practice in VbC?

VbC is an evolving field which is recognised within policy as having the potential to transform the outcomes of people with mental health problems, and where a number of services are already reporting positive experiences. Examples of these developments are given on page 10.
What would good values-based commissioning look like?

In this section, we describe specific recommendations for implementing VbC at:

• senior regional level/CCG Board level
• CCG executive/sub-committee level
• operational/commissioning level.

We also provide examples (from P15 onwards) of initiatives which have implemented VbC. These include:

1. the West Midlands Mental Health Commissioning Modelling Group
2. reverse commissioning (NHS BME Network)
3. the London mental health models of care project.
4. Northamptonshire Mental Health Service User Reference Group (SURG)
5. an evaluation of mental health service user involvement in the re-commissioning of day and vocational services
6. ‘the collaborative’: living well in Lambeth
7. the NSUN framework for VbC training.

SPECIFIC RECOMMENDATIONS FOR IMPLEMENTING VBC AT A SENIOR REGIONAL LEVEL AND CCG BOARD LEVEL

• **engage senior leadership** as the evidence suggests that leadership style and philosophy can influence change, particularly a style and philosophy that generates a commitment to a shared purpose through collaboration. The support of senior leaders within CCGs and other organisations is critical in implementing VbC. Leaders can develop a platform of commitment to changing the commissioning process, setting the conditions within the organisation, and creating a shared purpose for the change. They can role-model behaviours, skills and attributes necessary to implement VbC. They can engage and empower others to commit to action.

• **appoint a mental health lead at senior level** as recommended in the cross-government implementation framework for the mental health strategy. Whether CCGs focus on a small local area, or join-up with other CCGs across a wider area – such as a local authority or specialist mental health trust – a dedicated mental health lead can oversee mental health commissioning, advise the CCG Board on local population needs, ensure integration of primary and secondary mental health services, and make links with voluntary and community mental health organisations. The role of the mental health lead is to co-ordinate day-to-day activities and implement VbC.

• **organisational values, vision and mission** are crucial to setting a clear, understandable, and easily communicated direction and set of behaviours for an organisation and its members. Establishing the principles of VbC within these values and vision demonstrates that the organisation is aligned, congruent, and committed to VbC and co-commissioning. From an organisation’s values and vision, specific organisational goals and aims can be set and allocation of resources and policy development aligned with the values and vision.

• **communication**, at the corporate or strategic level, must ensure that the principles of VbC are enshrined within the communications strategy and that this shares information about VbC consistently, widely, and innovatively using more than one mode of delivery over a sustained timeframe. Within these communications ensure people have an opportunity to share concerns, ask questions, and offer ideas.

• **link into mental health lead peer networks and expertise** by establishing a sub-committee comprising mental health professionals and local voluntary mental health organisations. Membership of a larger network of peers can enable mental health leads to share intelligence and best practice, work through problems, and learn together. Such networks could also provide access to practical guidance and frameworks, or opportunities to hold workshops and training. The Primary Care Mental Health Leadership Development Programme was developed by NHS England in partnership with UCL Partners Academic Science Health Partnership and covers personal and strategic leadership development; epidemiology and strategic needs assessment; national and international best practice; the clinical evidence base on what works; value-based service improvement and change management; commissioning tools and techniques; contract levers, CQUINs and penalties, partnership and collaboration; performance and information management, user and carer engagement, and the new NHS and social care landscape.
**SPECIFIC RECOMMENDATIONS FOR IMPLEMENTING VBC AT A CCG EXECUTIVE OR SUB-COMMITTEE LEVEL**

- **set up a VbC panel** bringing together health, public health and social care commissioners, statutory and non-statutory providers, and mental health commissioning leads, to develop service user and patient involvement in commissioning – the West Midlands example is a useful model on page 13. The panel would need to meet regularly and with a range of patients, service users and carers. Service user and carer representatives could formally sit on this panel and in turn, co-chair a service user and carer advisory panel using the network model described on page 13. Their job role would include leadership at a strategic level and acting as a conduit between the panel and the wider community, to facilitate a two-way flow of information. Membership of this panel needs to be extended to a wide range of groups and organisations involved in mental health commissioning including local authorities, social care, housing, leisure, criminal justice and education.

- **establish a service user and carer advisory panel** including people from different backgrounds, with experience of different mental health problems and services. The panel should reflect the communities in the local population and will need to pay particular attention to recruiting people from marginalised groups. These may include travellers, vulnerable migrants, people from black and minority ethnic communities, people with other disabilities, young people, older people, veterans, and people with people with multiple exclusions such as homelessness, substance misuse and contact with the criminal justice system. The panel will need to use other means to engage a broader group, to prevent it becoming unrepresentative or insular.

- **use out-reach mechanisms to engage with the local population** as many people will be unable to participate in formal panels – due to their mental health condition, employment, family life, language or cultural barriers, lack of confidence – or may not wish to do so. VbC means engaging with people where they are, not expecting them to come to you. CCGs can tap into local networks such as user-led peer support groups, voluntary sector services and other community settings such as faith groups or children’s centres, to ensure they hear the voices of a wide range of people. Increasingly, use of online forums and social media will allow CCGs to reach people who do not engage with face-to-face or paper consultation techniques.

- **provide clear and accessible information** to ensure clarity of purpose, aims and objectives and skills needed for co-commissioning with service users and/or carers. Aim to have a clearly written policy, co-authored with service users and/or carers on how service users and/or carers will be reimbursed and rewarded. The concept of ‘commissioning’ needs to be demystified and explained. ‘Professional commissioners’ need to be sensitive to issues of language, power and cultural diversity. They should communicate clearly, explain acronyms and concepts, and not make assumptions with regard to levels of understanding. More specifically, awareness needs to be raised with regard to what ‘values-based commissioning’ actually is. It should be differentiated from other forms of commissioning through its emphasis on service user leadership, power sharing and co-production of services.

- **be open and transparent** about the level of involvement and influence service users will have. Be honest with service users about the potential for change, particularly if the options are initially limited. Part of the transformational organisational change needed for VbC is future commitment to VbC in strategic planning. This includes the provision of accessible information, which focuses on the context of the project, government policy guidance and other relevant material. A service user or carer involvement strategy should always underpin the process. They are after all the intended beneficiaries of change, and it is their views and opinions which should be shaping the service. Service user groups must be consulted on the detail of such a strategy and a review of its efficacy must be an integral aspect of any involvement plans.

- **provide formal support and capacity-building**, including training for panel members to support their general personal development and equip them with particular skills. There should be clear job roles and a Terms of Reference, which sets out responsibilities as well as the support that the CCG will provide, so people know what to expect. Recruitment to formal panels should be via a range of channels, including local community groups, to ensure seldom heard people have the opportunity to apply, coupled with skills workshops or buddy schemes to support people to gain the skills they need, so they can apply in the future.

- **promote skills development and training opportunities** for patient and service users to develop these skills early on in the project. Emphasis needs to be placed on the value of providing adequate support, appropriate training...
and sufficient time and resources to be able to carry out their role. Encourage a supportive ‘mentoring’ atmosphere. Leadership focused on, and promoting or championing the interests of service users, can create an environment where service user involvement flourishes. There is potential to create a role for a ‘Service User Co-ordinator’ who can provide practical and emotional support for patient and service user commissioners, identify training needs, and ensure that commissioners and service users are communicating effectively with each other. Training and development is also required for ‘professional’ commissioners in VbC principles.\(^\text{36}\)  

**SPECIFIC RECOMMENDATIONS FOR IMPLEMENTING VBC AT AN OPERATIONAL OR COMMISSIONING LEVEL**

- **use mechanisms to ensure services are also values-based** by including an organisation’s values base as a criterion in awarding contracts or funds and in the assessment of performance. Set clear standards, including values-base, in the procurement process and conduct regular, effective performance reviews including service user satisfaction measures. Set and monitor standards for providers based on the NICE quality standard on service user experience in adult mental health, such as for the use of joint-care planning, facilitating shared decision-making, using views to monitor and improve services, and conducting restraint safely and as a last resort.

- **focus on primary care and community mental health and wellbeing** to as great an extent as possible. Develop services and commissioning strategies that create a shift of resources to the ‘front-line’ and invest in public health opportunities and early intervention.\(^\text{2}\)

- **intelligently use available information** to achieve the change need for VbC. Commissioners need to collect more patient-relevant information which will require close working with service users and carers to explore what information is required and then how it is used. This includes information to understand local population, treatment inequalities, and access rates, and where to focus efforts. Accurate data is needed to understand risk, horizon scanning (planning services and future need) and to ensure the wider system isn’t destabilised by provider or service changes affecting other parts of the system. It will also be important to work closely with public health colleagues with this information. Currently most commissioning relies heavily on the National Minimum Dataset which provides information on the number of people using NHS mental health services, the rate of access to NHS mental health services by 100,000 population, the number of people detained in hospital, the number of people on the Care Programme Approach (CPA), information about how long people spend in hospital, information about the number of beds, patient admissions and discharges, number of contacts with different professional staff groups and information about the types of clinical teams coordinating patient care. It does not provide information about services for people with common mental health problems that are provided in primary care, nor specialist mental health services delivered by independent hospitals or through specialist services for children and adolescents.\(^\text{37}\)

- **be innovative** and consider involving people outside of the traditional format of meetings sitting round a table, by showing flexibility in the venue or format of meetings including ‘Question and Answer’, questionnaires, workshops, blogs, informal group activities, social gatherings and theatre and performance.\(^\text{38}\)

- **emphasise an outcomes based approach** (rather than process and target driven commissioning) – service users should be integral to the processes involved in measuring outcomes and their role will be central to evaluation and management in future. When approaching this, commissioners and senior managers need to be aware of three key issues. Firstly, the need to work across traditional service delivery boundaries to meet individual needs. Secondly, the relative unpredictability of costs when focusing on outcome rather than input (and the associated difficulties in setting fair pricing). Thirdly, the need to establish valid, reliable and repeatable indicators for measuring successful attainment of specified outcomes.

- **use commissioning levers** to build positive patient experience and involvement into services as a ‘mainstream’ concept so this becomes the ‘norm’ for services. Levers to improve patient experience and involvement in the commissioning process might include CQUINs (Commissioning for Quality and Innovation Payment). These were introduced to make a proportion of healthcare providers’ income conditional on demonstrating improvements in quality and innovation in specified areas of care agreed between the Trust and its commissioners. Service users can also be involved in developing CQUINs which are relevant to service users and carers. The QIPP (Quality, Innovation, Productivity and Prevention) programme was introduced to increase value (for money) and improve productivity whilst making financial savings for the health economy. QIPP areas, which would benefit from a VbC approach are redesigning clinical pathways, developing more integrated holistic services to address out-of-area placements and inappropriate use of services. The QIPP programme is now being redesigned by NHS England and may not continue in its current format.
Examples

1 THE WEST MIDLANDS MENTAL HEALTH COMMISSIONING MODELLING GROUP

In December 2010, NHS West Midlands convened a Mental Health Commissioning Modelling Group (CMG). The group met monthly until December 2011 and was formed with the intention of bringing together organisations and networks with an interest in mental health commissioning. The group included representatives from social care, Primary Care Trusts, public health and GP practices. A service user was also a member of the group. The CMG aimed to set out principles of best practice with regard to the concept and delivery of values-based commissioning. The shared purpose of the group was agreed as follows:

- to articulate ‘what good looks like’ for models of care and support across the major areas of provision and prevention within mental health and learning disabilities
- to model collaboration between a variety of ‘stakeholders’ to develop commissioning in the new NHS and reflect an extended role for local government
- to provide a platform for patient and carer leadership of collaborative commissioning
- to provide an evidence-base for VbC through an evaluation study.

Meetings were structured around presentations focusing on what good commissioning would look like in a number of different areas (e.g. dementia, compulsory treatment, liaison psychiatry). Participants agreed to raise the profile of the agreements made by the group through various networks, and bring issues back to the group on behalf of network membership. They also agreed to attend for at least a year in order for the aims of the CMG to be achieved.

As part of the evaluation of the West Midlands Mental Health Commissioning Modelling Group (CMG), the National Survivor User Network (NSUN) and NHS West Midlands wanted to explore the mechanics of VbC, particularly with regard to how mental health service users and carers could actively participate in, and ultimately take joint ownership of, mental health commissioning. This, in conjunction with an awareness of the issues outlined in a literature review, initiated the following research aims:

- to develop a model of best practice for VbC
- to find out how VbC can effectively work in practice.

Findings

- over the course of the project a significant number of people attended meetings, representing a wide range of statutory and voluntary organisations. As the project progressed, the numbers of those attending dropped gradually suggesting that although there was a breadth of support for the CMG, only a small group of people were able and willing to commit to the group and sustain meeting attendance.
- only one service user attended the CMG meetings, despite the fact that the group was set up to model ‘collaborative commissioning’. This limited involvement was seen to be tokenistic by some of the service users who participated in this project. However, the aim of the CMG was to develop a real-life practical model usable by commissioners and focused on developing into a ‘network’ model.
This meant that each person on the CMG was a representative of a larger organisation or group. They would feedback to their group who would in turn feedback into the larger CMG. This model was developed to provide a way of managing what could potentially be an unwieldy number of individuals sitting on the CMG, which could affect its ability to ‘function’. This is shown in figure 2.

- all participants identified the need to increase awareness of the concept of VbC and a greater understanding of how service users will be involved in the structures of clinician-led commissioning. This could be achieved through development of leadership training programmes for service users who are already involved in the commissioning process.
- a culture shift in attitude and approach is required whereby ‘professional commissioners’ have an increased sensitivity to issues of language and power, and are prepared to share the label of ‘expert’ with service users. For VbC to become established and the ‘norm’, there must be support from senior individuals within the health and social care sector. These senior individuals need to (a) support VbC and (b) allow their organisation to ‘go beyond’ traditional notions of user and carer involvement.
- to achieve change, front-line staff will need to be engaged themselves, both through clear explanations of what VbC is (and isn’t), and by outlining the benefits of VbC to practice and outcomes (in order to overcome reluctance and barriers).
- further empirical work is needed into the practicalities of co-production and service user involvement in mental health commissioning particularly focusing on the development of creative and inclusive ways to engage with service users who are marginalised.
- if a VbC panel was convened in the future, there would need to be an emphasis upon regular and sustained commitment from all those involved. This potentially has implications on employing organisations that would be required to release individuals to allow for meeting attendance.
- there was also a need to ‘formalise’ the communication processes involved. The reporting processes within and between organisations and the CMG needed strengthening (and a greater commitment from some CMG participants). Communication could have been enhanced by (a) the documentation of roles and responsibilities involved in the feedback process, (b) enhancing ownership and involvement in the process by senior organisational involvement and (c) senior recognition of the CMG which ‘validated’ individuals’ participation in the project.
2 REVERSE COMMISSIONING (NHS BME NETWORK)

- Evidence exists to show many health institutions have failed to adequately engage BME communities often describing them as ‘hard to reach’.
- Reverse Commissioning works by using existing data and evidence to identify the needs of BME communities AND empowering BME communities to engage with health professionals. Reverse commissioning recognises there is a need to establish lasting partnerships between health professionals and BME service users to effect change in the commissioning process and hence in health inequalities.
- Information gained from these partnerships can be used to inform and influence commissioning by CCGs.
- Reverse Commissioning uses a 4Es model. Using the 4Es model partnership development will occur when health professionals are:

  1. better informed regarding how best to **engage** BME service users
  2. better **educated** about BME service users/BME service users and their needs
  3. enlightened and able to utilise their knowledge to **enhance** and/or improve the service delivered to BME people.

- The 4Es model also recognises that BME service users need to be:
  1. better informed to become **enabled**
  2. better informed to be **empowered**
  3. encouraged to use their knowledge as **expert** service users to **enhance** their experience of the NHS.

For more information contact Dr Vivienne Lyfar-Cissé, Chair NHS BME Network: www.nhsbmenetwork.org.uk

---

3 THE LONDON MENTAL HEALTH MODELS OF CARE PROJECT

- This project was established after a widespread consultation on mental health services. It was led by the mental health team at London Health Programmes (LHP).
- Commissioners had identified a mismatch between spend on mental health and measured provider activity. The aim of the project was to strategically plan and redesign mental health services in London using the principles of right place, right time, right person, right assessment, first time.
- The ‘models’ of care were led by expert advisory ‘panels’ whose members included commissioners, providers, clinicians and other workers, academics, those using services and their family, friends and carers. Specific panels for people using services and their families, friends and carers, were also convened recognising the importance of their experiences and views.
- Following consultation of the advisory ‘panels,’ it was decided to initiate a mental health project to develop new models of care prioritising services for those in crisis and those with a long-term mental health condition. Existing services were mapped using the combined experiences and skills of panel members.
- Outcomes included increasing the quantity and quality of the knowledge available to inform commissioning of crisis services. This identified that prevention and early intervention were key areas and that a wider range of non-traditional service models needed commissioning to provide people with choice. Service users and carers, through their involvement in the advisory panels, directly influenced assessment and the
What would a good values-based commissioning service look like? (continued)

collection of information about current services, development and consideration of new models of care for people in crisis, and implementation of these different models

- NHS London supported implementation of the models of care, and endorsed the ongoing involvement of the service user panel in the implementation and review of services.

- Panel members also communicated with local services and groups to champion broader models of care.

- Panel members commented on how participating in the panel had been: beneficial, had given them a sense of contributing to improvements in services and improved their overall sense of wellbeing. Some of the members have gone on to be active in other ways (including finding paid work). Particular aspects of the panel, which worked well, included a diverse group of service users working together, having clear roles, functions and outputs of the group and having democratically elected leadership.

For more information:
www.londonhp.nhs.uk/services/mental-health/mental-health-project/

4 NORTHAMPTONSHIRE MENTAL HEALTH SERVICE USER REFERENCE GROUP (SURG)

- As part of a procurement exercise, commissioners in Northamptonshire worked with local service users to develop co-commissioning. The local service user reference group (SURG) was approached and invited to co-commission the mental health service user involvement contract and a core decision team was formed.

- A project group was established, which included the core decision team and representatives from services who had an interest in the service, but would not be tendering for them. Following training provided by the procurement officer, an event followed where the core decision team presented what they wanted from the contracted service, bids were evaluated and a final decision was made.

- The team concluded that the exercise had been successful. Service users had been involved as co-commissioners from the earliest discussions and crucially, the team had made decisions jointly throughout the process. The support, training, and technical advice had increased confidence, and the service users had been able to support and share ideas with each other, which was felt to be important considering the confidential and new nature of the work. Overall, the exercise has generated knowledge regarding what was possible in the area of co-commissioning, and provided increased expertise and capacity within service users for future procurement and commissioning exercises.

- “I think the success of this process was due largely to the commissioners’ commitment to service user participation in spirit and not just tokenistic. I appreciated the respect the commissioner and the commissioning team demonstrated for our input, which was the true incentive to participate. This can be identified as the core underpinning value of future service user participation.” (Service user co-commissioner)

- key areas identified by service users in an evaluation of the project were that information needed to be made accessible and available in a timely fashion for service user commissioners, service user commissioners should be remunerated fairly for time and work undertaken, and service user commissioners often were able to identify low cost, high volume commissioning options and more flexible innovative ways of working. Service users prioritised certain areas differently to ‘professional’ commissioners such as pathways into employment and mental wellbeing. They did report, however, that they encountered some resistance at times to the idea of service user commissioners as experts.

- service user involvement in re-developing mental health services extended to co-ordinating and involvement in a needs analysis, contributing to contract and service specification development, provider management, and monitoring or contract implementation.

For more information:
During 2007, a consortium of health and social care commissioners in England embarked on a process of modernising the day and vocational services that they commissioned for people with mental health problems. Their aim was to provide evidence-based services that promoted social inclusion, independence and recovery, reflected national good practice, and represented good value for money.

The consortium established a service user group with a key principle of service user involvement to inform the planning of new services. Eight service user members took an active part in the review process in a working group and were supported by an experienced service user consultant. Service users as part of the working group undertook a needs analysis and gap analysis. Service users also established priorities for service redevelopment. The service users in the working group’s remit included contributing to the design of the review, conducting research (visiting existing day/vocational services and carrying out one-to-one interviews with other service users about their views on services to perform a needs analysis) and contributing to decisions on service redesign in the light of review findings.

Three members from the working group volunteered to take a more active role and joined the Project Steering Group that also included representatives from the commissioners and the external consultants overseeing the review. They had a more involved role including input into development of service specifications and tender documents for the new service configuration and participating in selecting future providers through the tendering process.

An evaluation of this work highlighted the importance of practical arrangements. These included: the accessibility of meetings, reimbursement of expenses, inclusive meetings (with a minimal use of jargon), and a one page ‘working agreement’ (setting out the core group principles and objectives, and signed by all group members). Most working group members felt their involvement had been worthwhile even though they initially each knew little about the (re)-commissioning process. Some service users felt there was evidence of some personal learning and development from the process leading to further commissioning involvement.

There were a number of areas, which worked less well. Whilst most ‘professional’ commissioners were perceived to be committed to the process, there were some gaps and omissions including poor attendance at working group meetings, and not prioritising the role of the service user consultant as a support and supervisor for the group.

The service users on the steering group also felt that they were not offered sufficient support for the interviewing and tender selection process.

The working group failed to become an independent self-supporting group due to internal tensions, geographical distances between group members and tensions arising from being a member of the service user working group and a service user – such as issues of confidentiality about decision-making processes, perceived access to privileged information which set them apart from other service users, and imposed lines of accountability which all resulted in some service users reporting feeling isolated from their peers.

The evaluation concluded that more thorough planning at the front end of the project, in particular around the clarity of purpose of the group, their remit, aims and objectives and required skills would have been helpful. In addition, informing service users of potential areas of conflict they may face, what support, supervision and training they can expect, and how they would be reimbursed and rewarded would have facilitated the project. Service users identified that greater attention to detail (i.e. background contextual information, including government policy guidance, provided in easy to understand language), was very important and ‘professional’ commissioner ‘openness’ about the potential implications of change, future roles and working was necessary.

For further information: [www.centreformentalhealth.org.uk/pdfs/service_user_involvement_in_recommissioning.pdf](http://www.centreformentalhealth.org.uk/pdfs/service_user_involvement_in_recommissioning.pdf)
What would a good values-based commissioning service look like? (continued)

6 ‘THE COLLABORATIVE’: LIVING WELL IN LAMBETH

• ‘The Collaborative’, established in June 2010, is a partnership comprising users and carers, professionals from secondary mental healthcare, primary care, community and voluntary organisations, public health and commissioners coming together to co-produce an operating framework for the commissioning and delivery of services. Membership is shown in Figure 3.

• The Collaborative’s ‘mission statement’ is “to come together to radically improve the outcomes experienced by people with mental health problems” using co-production and a collaborative commissioning approach.

• The Collaborative defines commissioning as “about enabling an effective dynamic with communities and individuals to understand their needs, their assets and their aspirations, in order to fund and guarantee effective, meaningful and efficient support”.

• The Collaborative commissioning process is characterised by assessing needs, aspirations and adopting an assets-based approach (which emphasises that people are not passive recipients of services and have assets and expertise which can help improve services). It assumes that collaboration is the default position, creating positive competition to drive collaboration towards achieving better outcomes and meeting targets. It also promotes actively shaping markets to develop a range of better quality providers, writing iterative specifications which change over time to best meet the needs and assets of the local community which are identified, and sharing the learning and building upon this to develop commissioning expertise.

• The Collaborative supports system-wide workforce training and development, recognising that this is key to achieving organisation culture and behaviour change to support co-production.

For further information: http://lambethcollaborative.org.uk

Figure 3: Membership of the Collaborative
Session 3 – The bigger picture

Aims of the session:
- to provide a context for commissioning knowledge by locating it within the history and current policy and practice of mental health care
- to identify useful resources for the group to draw on (e.g. JCP-MH resources)
- to develop group work skills – trust, co-operation and mutual support.

Session 4 – How to be a values-based commissioner (1)

Aims of the session:
- to identify the skills needed to be a values-based commissioner
- to consider diversity issues
- to practice specific skills such as listening and being assertive
- to identify personal skills and areas for development.

Session 5 – How to be a values-based commissioner (2)

Aims of the session:
- to identify the skills needed for participating in a meeting, and chairing a meeting
- to practice the skills needed for reading and interpreting financial information (e.g. tables, graphs and charts)
- to practice being in a meeting situation through role play
- to evaluate the training programme.
Supporting the delivery of the mental health strategy

**HOW DOES VbC SUPPORT THE DELIVERY OF THE MENTAL HEALTH STRATEGY?**

The JCP-MH believes values-based commissioning will support the delivery of the strategy *No Health Without Mental Health* (2011) and its implementation framework in a number of ways.

**Shared objective 1:**
More people will have good mental health.

This is about promoting wellbeing and preventing ill health. VbC emphasises universal strategies for whole populations and targeted interventions for at-risk groups by capturing the viewpoints of local communities and people, and focuses on commissioning for public mental health and well being.

**Shared objective 2:**
More people with mental health problems will recover.

VbC gives equal status to service user and carer input, clinical expertise and formal evidence and should lead to services that better reflect people’s needs and therefore are more likely to help them recover.

**Shared objective 3:**
More people with mental health problems will have good physical health.

The clinician leadership in the process of VbC will ensure arrangements are made for the detection and management of physical health issues that so often accompany or complicate mental health problems.

**Shared objective 4:**
More people will have a positive experience of care and support.

The input of service users and carers into the setting of quality standards and clinical outcome measures will ensure services better meet people’s needs and learn from previous poor experiences, and increase satisfaction.

**Shared objective 5:**
Fewer people will suffer avoidable harm.

The emphasis on local government, clinicians and service users is likely to improve commissioning and feature in a large number of community services. This will mean better services out of hospital and therefore less exposure to the risks sometimes associated with being in hospital.

**Shared objective 6:**
Fewer people will experience stigma and discrimination.

Involving a new and wider range of individuals in the commissioning process offers a range of innovative alternatives to current medical models of healthcare. Involving service users as equal partners with valid expertise will also dispel myths and stigma that commissioners or health professionals may hold. The presence of local government and consequent emphasis on universal strategies to raise awareness will help reduce discrimination.
References and resources

7. Joint Commissioning Panel for Mental Health (2012) Guidance for commissioners of mental health services for young people making the transition from child and adolescent to adult services. London: JCP-MH.
22. Rose P. and Gidman J (2010) Evidence-Based Practice within Values-Based Care in McCarthy J and Rose P. Values-Based Health and Social Care: Beyond Evidence-Based Practice. London: Sage.


31 Royal College of Psychiatrists and ADASS. *The integration of personal budgets in social care and personal health budgets in the NHS*.

32 RCGP Clinical Commissioning Competences Framework (2011)

33 Centre for Mental Health, Department of Health, Mind, NHS Confederation Mental Health Network, Rethink Mental Illness, Turning Point (2012). *No Health Without Mental Health: Implementation Framework*.


