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# Mental health commissioning

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# Mental health commissioning: master or subject of change?

## Purpose

To explore change within the commissioning of third sector mental health services in England.

## Methodology

A case study methodology based on survey and interview data of a sample of third sector organisations and commissioners within an English conurbation.

## Findings

Normative commissioning models based on sequential cycles were not fully implemented with the main focus being on the procurement and contracting elements. There were examples of the process being an enabler of service improvement but overall commissioners seemed limited in their ability to bring about whole system change. Barriers included commissioners' capacity and competence, ineffectual systems within their organisations, and fragmentation in commissioning processes between user groups, organisations and sectors.

## Research limitations

The case study conurbation may not represent practice in all urban areas of England and there may be particular issues of difference within rural localities. The view of private and public sector providers and those working in Commissioning Support Units were not sought

## Practical implications

To lead whole system change   the commissioning function needs to be adequately resourced and skilled with better integration across public sector functions and organisations. Greater emphasis needs to be placed on implementing the full commissioning cycle, including the engagement of relevant stakeholders throughout the process and the practical application of outcomes.

## Originality

This research adds to the limited body of empirical work regarding commissioning in mental health.

## Key words

Mental health, commissioning, change, third sector, integration, outcomes.

Introduction

Successive governments in England have promoted commissioning as the process through which public sector services will be planned and overseen. Whilst no one definition or model of commissioning dominates, they are commonly based around a 'cycle of assessing the needs of people in an area, designing and then securing an appropriate service' (Cabinet Office, 2006, p 4; Bovaird *et al.,* 2012). Different sectors have developed their own approaches, and the recommended models within sectors have been subject to change over time. For example, in health care there was a progressive move to separate organisations responsible for the purchasing function from the delivery of services (DH, 2009) whereas local authorities have been able to retain both functions in principle, even if the majority of their direct services have been outsourced in practice. Across all sectors there has been a move towards greater diversity of provision in which public, private and third sector organisations (TSOs[i]) compete either *for* or *in* the market (Gash and Roos, 2012). Policy then portrays commissioners as the strategic overseers of a mixed economy of welfare, using their purchasing and influencing power to ensure that the publicly funded system is shaped to achieve the required outcomes within the resources available. It is worth noting that other governments have different interpretations of the commissioning cycle –for example the Scottish Government (2012) emphasises that securing the supply should be based on 'partnership' rather than 'procurement'.

This commissioning-led approach to strategic change has been promoted in mental health. The lead role for commissioning of clinical health services has been taken by various local and regional bodies within the national health service (NHS), for social care by local authorities, and for public health by the NHS and now local authorities.. Mental health commissioners are charged with leading the fight locally for parity with other patient and user groups, facilitating the move to a 'well-being' rather than 'disease focused model', and to ensure that care planning and population led strategies are co-produced with individual and their communities (DH, 2012a, b). They are expected to act as leaders who use both 'hard' (in the form of tenders, contracts and financial incentives) and 'soft' (in the form of lobbying, inspiring and influencing) approaches to steer and co-ordinate the action of the various players (NHS England, 2014). This includes partnership working with those agencies outside of the mental health or indeed health or social care sector, with increasing recognition of the vital role played by statutory and community agencies working in housing, employment and criminal justice in providing more integrated care (Seymour, 2010, DH, 2011). The market of clinical services over which commissioners preside has largely been retained by the public sector through NHS mental health trusts and now mental health NHS foundation trusts. Private and third sector providers have significant involvement in particular aspects of delivery such as residential, specialist treatment, home

support and advocacy services (Mental Health Strategies, 2012), and successive governments have been keen to enhance this diversity through attempts to introduce competitive procurement, payment systems and individually held budgets. TSOs are also seen as important partners for the wider commissioning process, through their community networks and understanding of specialist needs (DH, 2006, DH, 2012a).

This article seeks to consider three key questions in relation to change and commissioning from the perspectives of TSOs who work in mental health and commissioners of health and social care services, with the overall aim of understanding the extent to which commissioning has been able to act as a catalyst for change –

*How has commissioning changed the strategic planning and purchasing of mental health services?*

*How has commissioning changed the way in which the mental health system operates?*

*What has limited the ability of commissioning to achieve the changes expected within national policy?*

The article begins with an overview of mental health commissioning in England and finishes with a discussion informed by change management theory.

Commissioning in mental health

Mental health services have been subject to the various restructures of commissioning that have befallen the wider health and social care system. Primary Care Groups and then Trusts were given lead responsibility for commissioning both clinical and public health services in the 2000's, with commissioning of specialist services such as forensic services being retained by Strategic Health Authorities. Following the election of the coalition government in 2010 the majority of local clinical services are now purchased by Clinical Commissioning Groups (CCG) led by GPs, specialist health services by the national body NHS England, and public mental health services by Local Authorities. Commissioning Support Units (CSUs) have been created to provide support to CCGs in particular with a range of commissioning related activities, including communication, engagement, procurement and contract management. CCGs are not required though to purchase this support from their local or indeed any CSUs, and from 2016 they will operate as autonomous businesses within a commissioning support market. A number of concerns have been raised regarding these collective changes, including the ability of GPs to take on these new and very different responsibilities, the potential for fragmentation due to a new set of boundaries and inter-organisational relationships, and the danger that local authorities will divert the public health funding to other priorities (APPG, 2012). Whilst it was called by a different name, local authorities were effectively required to adopt a commissioning approach to social care mental health services through the community care reforms of the 1990's, and have retained this responsibility throughout the various NHS changes. In many local areas a proportion of

social care commissioning responsibility has been delegated to the NHS through the use of Health Act flexibilities, with in 2007/8 £1.4 billion (out of a total spend of £10.3 billion across health and social care) being administered through pooled funds (Audit Commission, 2009). Direct payments, in which the person accessing services effectively takes responsibility for 'micro-commissioning' their own care package, has had a slower uptake in mental health than in other service areas (Fernandez et al, 2007). It continues to be promoted though, and has been extended to personal health budgets through a national pilot in which the people accessing mental health services were found to benefit in particular (Jones *et al*, 2013).

National guidance regarding the commissioning of mental health services has largely been targeted towards health, or health and social commissioners (e.g. Bennett *et al*, 2012, NMHDU, 2009, NICE, 2011). The proposed cycles are variants of those outlined above, with an expectation that they will operate at different levels – the individual person, the GP practice, and for whole populations. In comparison to other models there is a more explicit emphasis on managing risk and putting people who receive services at the centre of the process. The latter has been described as a vital component due to statutory and regulatory requirements, greater likelihood that people will receive a service that is value to them, and previous evidence that it results in essential improvements being achieved (NMHDU, 2011). 'Values based' approaches emphasise the importance of explicitly stating the values as well as evidence base that lie behind decision making (Carter *et al*, 2011). These are seen to support a 'move away from the dominance of clinician experience and scientific evidence that has been prioritised over service user values and experience in traditional commissioning processes' (Perry *et al*, 2013, p6). Values are also part of the rationale behind the 'mental wellbeing' commissioning model promoted by Heginbotham and Newbigging (2014). This seeks to take a whole life approach which 'strengthens protective factors and reduces risk factors' (p6) by building individual resilience and support networks from childhood (and therefore has a strong correlation with 'asset based approaches' e.g. IDEA, 2010). Finally, whilst not mental health specific, it is worth also mentioning 'intelligent' and 'outcomes based' commissioning as they have been influential in this sector. The former arose out of work by the Audit Commission (2007) regarding engagement of the third sector in the commissioning process and identifies key opportunities and challenges for this to occur at different stages in the cycle. Outcome based commissioning is a generic term that has been deployed by a number of commentators, think tanks and public bodies to imply that commissioners should be focused on the impacts not the process or mechanisms of delivery (see e.g. Bovaird and Davies, 2011).

Methodology

The research was based in a case study conurbation which incorporated three local authorities and five clinical commissioning groups (Yin, 2009). An online survey was completed of TSOs involved in the mental health field, with potential respondents being

identified through lists or databases of mental health organisations held by local infrastructure bodies, discussions with local TSO representative bodies and mental health commissioners, and through searches via the internet. Building on the survey responses a purposive sample was developed which reflected the range of mental health services provided by third sector organisations in the conurbation. These services were primarily – advocacy and representation, social care (including domiciliary care, residential care and day activities), supported housing, employment, advice, and support for carers. Semi-structured interviews were conducted with a sample of 23 TSOs in mid-late 2013. Through the interviews and general research process, six individual commissioners were identified and agreed to be interviewed. These commissioners worked in local authorities or CCGs, and included those from a social care, supporting people and general practice background. Interviews were conducted in a similar manner, and in the same period, using a revised semi-structured interview schedule. All interviews were recorded, transcribed and key data entered into a spread sheet matrix organised according to identified themes (Robson, 2011). Ethical approval was granted through the University of Birmingham. The principle limitations of the study were that the case study conurbation may not represent practice in all areas of England and there may be particular issues of difference within rural localities. The view of private and public sector providers and those working in Commissioning Support Units were not sought. TSO (rather than public or private sector) perspectives were focused on due to the emphasis in national mental health and commissioning policies on their engagement throughout the process. Furthermore many of the individuals leading the TSOs had worked in the locality since before commissioning was formally introduced in national policy and could therefore provide comment on how it has shaped - or not - public sector behaviour.

Findings

*How has commissioning changed the strategic planning and purchasing of mental health services?*

Few respondents, including those who worked as commissioners, reported that the expected cyclical model had been achieved in practice, and most highlighted that commissioning in the real world is much messier than the neat normative models would suggest. The general consensus was that there had been some improvement in needs analysis and in the public sector being more aware of how its resources were actually being used, but that overall commissioners were far from achieving the managed process that is envisaged in national guidance summarised earlier. GP commissioners highlighted that it was still early days in their tenure, and recognised that other stakeholders may not have seen any difference as yet

> I would fully understand if the third sector organisations didn't think it had felt any different at this stage, because like any commissioning cycle, we've got to go through the first bits before we can get round to redesign. (CCG Lead)

The aspect of the cycle that was seen to have changed the most was procurement and contracting. Indeed many TSO participants effectively saw commissioning as being limited to this activity and struggled to respond with any depth to questions regarding other aspects of the cycle. It became clear that for them the term 'commissioning' was commonly used to denote the purchasing process rather than its broader considerations – in other words 'to be commissioned' rather than 'a commissioning cycle'. Financial arrangements in the pre-commissioning era were described as being much looser, with grants (which had relatively few conditions) being the predominant funding mechanism. Under commissioning the financial relationship was more formal and based on contractual agreements with accompanying specifications and more thorough (and therefor onerous) monitoring requirements. Competitive tendering was also more common (although not as ubiquitous as expected), with TSOs having to compete for funding alongside private and NHS providers.

Previous research (e.g. McMillan, 2010) has suggested that third sector organisations often have a negative view of a competitive funding process, and this was mirrored in the views of some participants

> They could develop partnerships and frameworks where they're constantly working to evolve and grow the quality of the services that are delivered.  But they would rather spend millions of pounds going through a procurement exercise than actually saying "No, let's do a framework and let's work with a select number of providers to deliver our services for the future." (TSO)

Overall though, the formalisation of the new procurement arrangements was welcomed. TSOs felt clearer about what was expected of them and how they were expected to demonstrate impact and contractual agreements were seen as more binding than yearly grant arrangements. Competitive tendering could be challenging and time-consuming process, particularly for smaller organisations, however it also meant that there was an opportunity for innovation and organisational growth. Commissioners saw procurement as a component rather than the whole of the commissioning process. They recognised the tension between giving providers sufficient certainty that they could deliver new service models whilst also periodically giving other providers the opportunity to propose new approaches. The impression was of a dynamic and messy process, in which there were multiple procurement cycles being undertaken at any one time.

### _How has commissioning changed the way in which the mental health system operates?_

Commissioning was largely seen to have encouraged the public sector to be more aware of how its resources were being used and to have facilitated, or at the very least not prevented, improvement of individual services. However participants were less convinced that commissioning had had been able to improve the mental health system as a whole, and was seen as some as being more of a hindrance than a help

But I look back, and over the last four years, as far as I can see, there has been no new service type…. The creativity has gone. (TSO)

Whilst not always seen to be exemplary in partnership working in their own practice (see below) commissioners were described as being supporters for integration in the services purchased. In one locality the commissioner had developed a hub that facilitated joint working between different TSOs, and in other was described as being an individual champion for better integration. It was thought that GPs' connection with patients would enable them to recognise the importance of inter-agency co-ordination, and such a view was summarised by one GP commissioner as follows

You pull together the builder, the architect and the plumber into an alliance to put up your house. In health we have this particular resistance to pulling people together and to holding them to account as a group. And actually I think without a doubt in my mind, it is the way forward. (CCG Lead)

Whilst commissioners were clear about the need to better integrate frontline services and were personally committed to achieving it, they were realistic about the progress that had actually been made due to the previous fragmented approaches to the planning and delivery of services. This was echoed by a number of the TSO participants, both in relation to the integration within specialist mental health services and between mental health and other service areas. In relation to the latter, there were concerns that those with needs that were more complex and somewhat different to the general users of mental health services were particularly poorly served.

There were though also examples of services successfully co-ordinating their responses, and in particular between TSOs and NHS providers. Larger TSOs also recognised that they had at times developed their own service silos, and were seeking to address these in future as a means to make their own offer more efficient.

The language of outcomes appeared to be being adopted by commissioners, however for most participants it was yet to be practically translated into commissioning processes and this to considerable frustration for TSOs. In addition, many TSOs believed that they were better able to understand the outcomes that would be would be appropriate for their beneficiaries and how to incorporate these into their practice. Others argued that all parties find it difficult to define, operationalize and measure outcomes, and it is a struggle to achieve such an approach in reality. Another issue was that care managers had the key role in specifying the outcomes required from individual packages, and they were not always as engaged with this agenda as their commissioners

On the ground the service orders come through saying get this person out of bed, get them fed, get them washed, rather than saying to the supplier, well what you're looking to do is get this person independent. (TSO)

Many TSOs, including obviously those who were involved in its delivery, noted that the commissioning of Improving Access to Psychological Therapy services had a strong focus on outcomes, and the nationally developed performance framework sought to capture clinical recovery alongside access and throughput measurements. There were also examples of existing services being redesigned to have a greater focus on outcomes. For example, an inward focused sheltered employment scheme had become more focused on encouraging people into mainstream and sustainable employment.

*What has limited the ability of commissioning to achieve the changes expected within national policy?*

There are a range of different 'softer' influencing strategies that commissioners can deploy when trying to influence change – for example they can develop a normative vision that inspires, use their networks to link together relevant individuals and services, and draw upon the credibility arising from personal experience and professional expertise (NHS England 2014). All of these were reported to some degree by the TSO participants, however the main change approaches highlighted were those based on the allocation of funding and contracting process.  This reflects the market-based logic that underpins the commissioning models in England in which the purchaser-provider split has been seen as sacrosanct in healthcare and local authorities have externalised much of their direct services (Gash & Roos 2012). However, simply having the funding that organisations rely upon for their survival does not by itself guarantee that a purchaser will be able to dictate how they operate. Commissioners are themselves accountable for a challenging set of deliverables, and rely on providers to achieve these on their behalf highlighting a strong degree of mutual dependency and arguably diluting the power of the purchasers (Lonsdale, 2012). Markets require sufficient diversity to bring competitive pressure, the opportunity for new entrants to bring innovation, and the sanction of expulsion for organisations or services that are not seen to be delivering (Le, Grand 2009). Participants in this study highlighted that NHS providers continue to dominate the local market place and from their perspectives this monopoly over many clinical services watered down the purchasing power.  Furthermore, managing this relationship soaked up much of the commissioners' time and  left them little energy or capacity to develop the areas of service that the TSOs were engaged in. TSOs also had different proportions of the market, with larger ones (including those with no historical connection with the locality) being seen as better able to participate in competitive tendering. This led to concerns regarding the demise of smaller TSOs who actually exhibited the features that commissioners favour, such as specialist knowledge, community engagement and holistic working.

The competence of the public sector to undertake commissioning was raised by most TSOs. Whilst some individuals were praised for their ability to make a positive change, there were also commissioners who were seen to be lacking and therefore had a negative influence. It was striking in this regard how much impact the individual commissioner's attitude and

approach was thought to make. Unsurprisingly perhaps commissioners did not flag up personal competence as an issue, although there was notable variation in what experience or knowledge they thought would be necessary for someone to take on a commissioning role. There was also considerable difference of opinion regarding what type of relationship they would expect to have with TSOs in comparison to other providers. Linked to this, a number of commissioners emphasised the importance of values in their work and the importance of this being a driver of commissioner behaviour. Alongside competence was the major issue of capacity, with commissioners and TSOs emphasising that demands placed on commissioners outweighed their available time. This meant that reviews of services or pathways were delayed as commissioners were not able to engage. Numerous complaints were also made regarding the competence of the organisation in which commissioners were based, particularly in relation to keeping to agreed deadlines for tenders, maintaining records, and paying bills. These perceived organisational failings appeared to tarnish the good work of individual commissioners -

> First they sent us a ridiculous letter saying we'd been awarded XX a year, the next day they emailed saying, "Oh, we've sent you the wrong letter". Then I couldn't get hold of anybody to find out what they meant, did they mean we hadn't been awarded anything? (TSO)

Commissioners were often described as being fragmented in their structures and practices. TSOs whose services were procured by more than one public sector body, or indeed more than one department within a single public sector body, had common experiences of this being dis-jointed. This appeared to result from commissioners having different outcomes frameworks, budgets and performance measurements and their personal interests and priorities. The inter-organisational fragmentation included the NHS, in which all the bodies are in principle part of the same overall 'family'. It was also replicated between commissioners in the same organisations who were responsible for planning and purchasing services for different user groups

> We've got an adult section, a young carers section and a young adult carers section, and we had a commissioner for the young carers section and then we had another commissioner for the adult section, which was ridiculous. (TSO)

This internal separation was observed by TSOs as leading to commissioners being in competition regarding funding – either to attract new streams or to transfer responsibility to other commissioners. This led to disputes between commissioners about who should pay for a contracted service and TSOs being passed between organisations and teams. TSOs also reported a lack of understanding or interest by commissioners in considering the public sector purse as a whole, with numerous examples of duplication in spending and initiatives that would reduce the costs to one commissioning budget whilst increasing the expenditure for another-

> They now don't have to spend this money, but of course, the Local Authority don't really care about that because it isn't their money that I'm preventing from being spent… (TSO)

> The Health Authority thought it was great because at that time they renegotiated their Section 75 money with the Council so they weren't paying anything.  So no wonder the mental health commissioner from the Trust thought it was wonderful, but it was costing more for less. Mad. (TSO)

The commissioners also recognised that their structures and processes were far from integrated. The most recent restructures had led in one area to health commissioners being now based within the Council, and it was hoped that the informal contacts that this would foster may lead to better joint working in practice. One TSO reported that the downsizing of the commissioning team may have addressed the previous fragmentation through replacing multiple commissioners with just one person, however the viability of such an arrangement in the long term could be questioned in light of the comments about capacity above.

Adding to these partnership difficulties were the periodic internal restructurings, organisational mergers and whole system changes within the public sector. This means that settlements that had been reached between the previous commissioners were often disregarded, and agreements regarding responsibility for funding and contracts had to be renegotiated between the new commissioners:

> I think that's being challenged now that Public Health have gone into Social Care, there's a row going on about who's doing the commissioning. (TSO)

The process of setting up new organisations, developing alternative commissioning structures and appointing individuals to commissioning roles caused uncertainty and delay. This meant that key decisions regarding funding were not being made during the period in which the research was carried out, and short-term agreements were being used to give the commissioners more time. This was unsettling for TSOs, and again meant that they could not proceed with service reviews and improvements. The churn within commissioning functions also disrupted established personal relationships, and this was made worse by a perceived lack of good information and contractual systems within the public sector. This meant that TSOs often had to repeatedly provide basic information on their services and what they had been commissioned to provide, and to educate new commissioners on the underlying thinking behind local strategies. Commissioners, many of whom had been subject to personal uncertainty regarding their employment and future careers, shared many of these concerns in relation to the continual change. However they were also largely optimistic that the new arrangements could be a positive change, for example through enabling greater engagement of clinicians in commissioning, local authorities to have a broader role in promoting mental wellbeing, and people accessing services to be more in control through their managing their own budgets.

Discussion

English mental health policy does not solely place responsibility for change on the heads of commissioners, and the implementation guidance emphasises that providers and other public sector functions must also play their part (DH, 2012a). However, commissioners are expected to play a key role in steering the direction of their local system by deciding on priorities for funding, selecting models and providers, and monitoring the outcomes (DH, 2011, NHS England, 2014). This study suggests that through transactional power based on their control of the financial flow and more transformational approaches based on visioning and trusting relationships, commissioners are able to exert influence over mental health services delivered by the third sector. Commissioning as a cyclical method of planning and purchasing services does not appear to be fully implemented, and there was no particular model of mental health commissioning that was consistently and explicitly preferred over another. From the perspectives of TSOs, commissioners' ability to achieve positive change was greatly limited by their capacity and competence, by ineffectual systems within their organisations, and fragmentation between commissioning processes for different sectors and user groups. Despite these restrictions, and the dominance of NHS providers in local market places, there were examples of commissioners and commissioning changing the services that were provided on the ground. Commissioners were not seen as being able to shape the system as a whole though, with the continual flux within their immediate and far environments being considerable barriers to sustained improvement (Emery and Tryst, 1965).

In many ways then, commissioners were the 'subjects' rather than the 'masters' of the change. This, and the limited impact that a small number of individuals can make on a complex system, is not unexpected despite the high expectations placed upon them in policy. Public sector change literature highlights difficulty of achieving change due to the multi-layering of governance arrangements, the influence of multiple stakeholder groups, and the uncertainty and expediency connected with democratic processes (Rushaw, 2007, Kuipers *et al*, 2013). The range of individuals who must participate in such change is considerable, all of whom (and indeed their teams, services and organisations) will have their own capacity and readiness to change (Kuipers *et al*, 2013). Furthermore it is clear from this study that the use of financial buying power is not by itself sufficient to overcome the inertia and active resistance to change that are currently preventing the achievement of the community based, well-being model of mental health care that is envisioned by higher-scale policy actors. Commissioning generated forces for change are not consistently able to overcome the forces opposing them (Lewin, 1951). As the closure of the asylums in the mid-20th century and move to more community-based teams in the 1990s demonstrate, this should not be taken to suggest that large scale change in mental health care is not achievable. A key lesson from these previous reforms is that there needs to be realism regarding what can be expected of a planning and purchasing process, and a sensitivity to

the danger that too great an emphasis on one approach (i.e. commissioning) will exclude other relevant and necessary sources of support (Gilburt and Peck, 2014).

Conclusion

This research could be taken as evidence that commissioning is not a satisfactory approach to achieving strategic change in mental health care, and that a new paradigm is required if we are to transform the lives of people with mental health problems. Clearly one major issue with such a proposition is what this alternative would be, as the arrangements pre-commissioning were also far from perfect. Such as debate is however outside the remit of this article, and instead we would like to consider what is required to enable commissioning to be a more effective facilitator of change within the environment in which it operates. Procurement theory and research also tell us that it is hard to achieve good purchasing without having a robust procurement function that is able to design a process that reflects the services being bought and the market that is likely to supply them, and which can assess and positively respond to the connected risks (Lonsdale, 2012). In relation to mental health services this suggests that we need more, rather than less commissioners, and that they be trained and supported to fulfil their responsibilities. This training should include working with colleagues in other agencies and sectors, being skilled in managing internal processes, and understanding some of the deeper academic and practice based understandings of the power and political dynamics to purchasing and contracting relationships (i.e. the risks of poor procurement practice), and understanding how to lead change. Within clinical commissioning, the capacity and competence of the mental health related staff within CSUs also needs to be considered. A multi-agency mental health commissioning group would seem a necessity, and this could potentially be a sub-committee of the health and well-being boards (which are responsible for health and social care commissioning as a whole).

Having shored up the commissioning function, there needs to be a greater emphasis on the commissioning cycle as a whole rather than just the purchasing element. All the models mentioned in the introduction to this article stress the benefits of engaging patients, family carers, community groups and providers of all sectors throughout the cycle, and this was echoed by the participants in the study. In relation to public sector change, this equates to taking a multi-stakeholder approach to cope with the inherent complexity of the process (Crosby and Bryan, 2005). Involving those affected is more likely to generate support and reduce resistance, as the process undertaken has been shown to contribute significantly to growing readiness for change. Commissioners in this research appeared to recognise and aspire to such engagement but were restricted through their capacity and the disruptions highlighted above. Providers of all sectors will clearly prefer to win rather than lose tendering opportunities, but the evidence of this and previous (e.g. Windle et al, 2009) studies is that transparency and a fair playing field will help to sustain trust beyond a loss of funding.

The promotion of greater diversity of providers and the market incentives that they imply is undoubtedly one of the most divisive aspects of the current reforms (Powell and Miller, 2013). Again taking a pragmatic approach that deals with the current state of play, the benefits of better market shaping would seem clear. At present there is a real danger that smaller TSOs, with their potential for engagement and innovation, will be lost, and that larger providers will dominate the market. Broader literature on supply chain management again emphasises that this is not a task to be underestimated, with a difficult balance to be struck by commissioners between guarding against opportunism through tight specifications and tight monitoring whilst ensuring that these do not destroy trust and the willingness to take shared risks (De Vries and Huijsman, 2011). One response currently being promoted to the demands of market diversity is for commissioners to give large contracts to 'lead' or 'prime' providers and expect them to manage the supply chain on the commissioner's behalf (Featherstone, 2012). Evidence from the Work Programme in England and this study suggests this is fraught with difficulty, and the basis on which it is assumed that providers will be able to manage a supply chain – and associated risks – better than a commissioner must be questioned (Rees *et al*, 2013).

Finally, transformative leadership theories underline the importance of vision to inspire others to commit to change (Alban-Metcalfe and Alimo-Metcalfe, 2010). There was a general consensus amongst those interviewed to an overall vision of a mental health system that was person centred, integrated, community based and focused on mental well-being. However the translation of this vision into meaningful descriptors and measurement of outcomes appeared to be lacking. This resulted in providers not being confident that commissioners valued what was important, and a sense that energy was spent gathering data on the wrong things. This issue is not specific to mental health (see e.g. Miller *et al,* 2013) but the answer for these services must surely lie within people who access mental health services and the expertise of the professionals that support them (Slade, 2006).

*To conclude then, whilst commissioners have some influence over their local mental health system this is substantially limited by pressures and powers out with their control. Going forward, English policy needs to decide if it will give them the tools, capacity and stability required to enable them to contribute to mastering rather than being subjected to the challenges that are currently faced.*

## Acknowledgments

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[i] For the purposes of this article the following definition is used of the 'third sector' – 'Organisations operating outside the formal state or public sphere that are not trading commercially for a profit in the market. This means charities and voluntary organisations, community groups, social enterprises, cooperatives and mutuals. Whilst these organisations are exceptionally diverse, they share a broad common theme of being value driven.' (Available at www.trsc.ac.uk (accessed 30 May 2014)