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Institute of Public Care

Transforming Care and Relationship-based Commissioning

July 2018

OXFORD BROOKES UNIVERSITY

http://ipc.brookes.ac.uk

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1 Introduction

People with learning disabilities and/or autism who display behaviour that challenges require a complex response from services to get their needs met. A complex response is a response that requires input from more than one service area (health, education, social care, housing). Furthermore, providers that have the skills to meet complex needs must also have the ability to work effectively with a complex system. The ability to work effectively with a complex system is dependent upon the values, attitudes and behaviours that both providers and commissioners across the system bring to the table. Relationship-based commissioning emphasises the need for commissioners and providers to have trusting, respectful relationships as only then will they be able to work proactively and flexibly with children, young people and adults with learning disabilities and/or autism, their families and the community to meet complex needs and achieve desired outcomes.

In 2015 NHS England, ADASS and LGA published the National Service Model as part of the National Transforming Care Plan[1]. The vision described in the model is one where there is a whole-system response to delivering high quality services and support for people. The National Service Model refers to the need for 'capable environments'[2] which are characterised by, among other things, positive social interactions and support to maintain relationships. These golden threads must transcend past service models to the commissioning and procurement of services if we are to achieve equal opportunities and quality of life outcomes for children, young people and adults who display behaviour that challenges. A quote from a commissioner sums this up:

> ***"The success in this lies not within systems and processes but within human connections, commitments, accountability and sustainable relationships that are non-adversarial."[3]***

IPC worked with Dimensions, Choice Support, MacIntyre, Avenues and United Response to identify good examples of commissioning from a provider perspective. By reflecting on the examples we identified a set of key principles. The providers and commissioners agree that relationship-based commissioning makes better use of finite resources; encourages innovation; allows safe places to share positive risk taking; creates greater flexibility and hence facilitates market shaping.

[1] NHSE, ADASS, LGA (2015) 'Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition. Service model for commissioners of health and social care services.
[2] See: http://www.kcl.ac.uk/sspp/policy-institute/scwru/news/2014/newsfolder/McGill-et-al-Capable-environments.pdf
[3] NHSE, ADASS, LGA (2015) 'Supporting people with a learning disability and/or autism who display behaviour that challenges, including those with a mental health condition. Service model for commissioners of health and social care services. Page 4

2 What is Relationship-based Commissioning

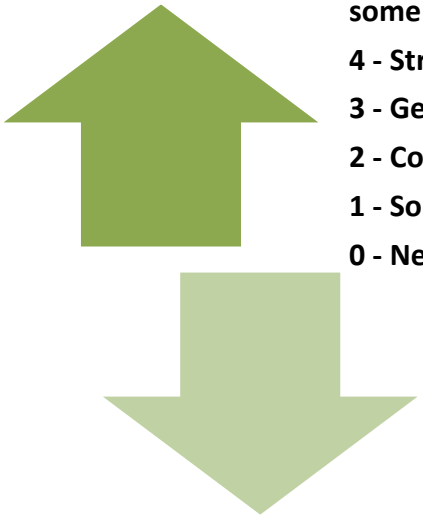
Relationship-based commissioning describes an approach to working in a collaborative way to provide complex responses to small numbers of people (and their families) with fluctuating needs. This requires commissioners to work with a small group of providers with specialist skills. To build trusting relationships with these providers to enable them to maximise flexibility to meet such fluctuating (at times even erratic) levels of need.

At the heart of relationship-based commissioning is the idea that we do our best work and hence achieve the best outcomes with people when we have good relationships. Good relationships are built on good rapport. We work best with people that we experience as warm, attentive and easy to relate to. Naturally no one experiences everyone they do business with as warm and attentive, but we do know that if you come across as warm and attentive you are more likely to build rapport and eventually trusting relationships.

Some people are able to build rapport naturally, while for others it is a skill they choose to develop. Either way, building rapport with providers is important but, a bureaucratic, complex or challenging system can erode rapport and hence we must be mindful about the processes and procedures we use in our business relationships. The usual way of doing things in the context of commissioning and procurement has not always resulted in good, respectful and hence effective relationships between commissioners and providers. This is due in part because commissioners and providers often see themselves as different, whereas rapport builds on features of sameness. Where there is a high degree of sameness we build rapport more easily.

Relationship-based commissioning aims to support providers/other partners and commissioners to find common ground and from it to build rapport moving them to relationships of support and trust which in turn enables them to provide complex responses in challenging contexts.

Rapport Building Scale[4] (Starr, 2011)



5 - Support, trust, sense of being positively 'connected' in some way.

4 - Strong sense of knowing, the familiar.

3 - Genuine warmth, kinship.

2 - Comfortable, familiar.

1 - Some warmth.

0 - Neutral.

1 - Hesitation, trepidation.

2 - Some discomfort, detachment.

3 - Awareness of dislike, disassociation.

4 - Genuine aversion, antipathy, real dislike.

5 - Stronger, hostile feelings, even loathing.

[4] Starr, J. (2011) 'The Coaching Manual' Pearson Education Limited: Edinburgh. p55

3 Top tips from providers

The top tips below describe what good commissioners do from the perspective of providers.

Do test the market and use us to shape your specification.	**Don't** just write a specification and tell us it's what you want.

Good Practice

- Describe the strategic needs of the cohort you are focusing on.
- Write an outline proposal of how to meet those needs.
- Send the proposal to providers for comment.
- Use the feedback to write the specification.
- Invite providers to meet face to face to discuss the specification, identify barriers and agree solutions.
- Finalise specification and design tender process that reflects feedback.

Do boundary out cost and procure quality	**Don't** procure on price.

Good Practice

- As part of the market testing activities work with providers to agree what it costs to support the cohort you are focusing on.
- Take price out of the selection criteria but give some boundaries by agreeing floor and ceiling rates with providers.
- Don't base your decisions just on written bids. Once you have a short-list of providers arrange site visits that include speaking to frontline staff, people living in/ using the services and families.

Do empower us to get on with the doing.	**Don't** constantly make us compete against each other.

Good Practice

- Once you have procured your framework forget the scattergun approach to referrals.
- Agree the assessment methodology with providers and work with them to share the 'burden' of assessment as it is costly and time consuming. Don't make providers compete by getting them all to do an assessment not least because it is intrusive for the person with learning disabilities.
- There is enough work to go around and providers often work together, sharing ideas, matching people, matching staff. Build on this by creating a process where completed assessments are brought back to the framework and discussions held about which provider or collaboration of providers are best placed to work with the individual (being mindful that people with learning disabilities and their families always have the right to choose).

Do be realistic about the long lead in time.	**Don't** expect us to be able to set up a new service immediately.

Good Practice

- Good providers are not sat ready and waiting with voids to fill and staff teams twiddling their thumbs. They deliver person centred services and these take time to design and staff teams take time to recruit. Therefore, be realistic about timescales. It takes 6 to 9 months at least to set up a new service and even longer if housing needs to be found too.
- Involve providers in review and planning meetings as early as possible – they will help you solve some of the challenges.
- Work with the provider to write a shared development plan, with actions and timescales that all parties sign up to and progress is monitored against. Don't expect providers to be able to complete their actions on time if commissioners and/or other stakeholders have not completed theirs.

Do share the risks with us.	**Don't** expect us to shoulder all the risks on our own.

Good Practice

- Understand that it costs a provider approximately £50,000 to setup a new service in a geographical area where they do not currently have any services and these costs must be covered.
- With complex packages there are higher risks of things going wrong and sometimes people being admitted back to hospital. There needs to be shared protocols around decision making, admission procedures and financial agreements around paying the staff team so that it is possible to discharge the person quickly again.
- Providers and commissioners should agree contingency plans for fluctuations in need. This may include a contingency budget for any increase in support needed for a crisis or to maintain a placement. If the budget is not used, it is repayable to the commissioner.

Do think flexibly about homes.	**Don't** just think supported living or residential homes.

Good Practice

- Involve a housing provider(s) with experience of developing bespoke, high spec housing that addresses sensory sensitivity, physical access, smart technology, etc.
- Understand that many people will be better placed in bespoke, ordinary housing rather than supported living complexes.
- Understand maintenance and service costs.
- Support families to make adaptations to their houses or even move house to enable them to continue to care for their children at home.
- Support families to buy houses for their young adult children in the same community.