Commissioning Plan – Advocacy and HealthWatch Services

Section A

A.1 Purpose of this Document

The purpose of this document is to set out a Commissioning Strategy for recommissioning Advocacy services and HealthWatch Bristol. This includes our progress towards commissioning HealthWatch in partnership with neighbouring authorities, and how we seek to maximise the available funding.

It seeks to determine Bristol City Councils (BCC) requirements and expectations of advocacy providers relating to this commissioning process. This document will equip providers with the information they need to prepare for these changes and input into the consultation. The audience for this paper includes stakeholders, and potential bidders to deliver the service. An easy-read version of this document will be produced on request.

A.2 Context

Advocacy is described as taking action to help people say what they want, secure their rights, represent their interests and obtain services they need. Advocates and advocacy providers work in partnership with the people they support and take their side. Advocacy promotes social inclusion, equality and social justice (Advocacy Charter: Revised edition 2014).

Advocacy services are currently commissioned within Bristol City Council across different directorates including Adult Care & Support, Children's Services and the Bristol Clinical Commissioning Group (CCG). Local HealthWatch and NHS Complaints Procedure Advocacy are being procured alongside advocacy services to make a strategic procurement of our "family" of services. HealthWatch may be possible to procure jointly with South Gloucestershire Council and North Somerset Council subject to their public consultation, to be concluded by end of summer 2018. Social Care Complaints Advocacy is included within our larger NHS Complaints Advocacy.

This 'family' of services incudes:

- Local HealthWatch
- NHS and Social Care & Complaints Procedure Advocacy (IHCCAS)
- Independent Mental Health Advocacy (IMHA)
- Independent Mental Capacity Advocacy (IMCA)
- Independent Care Act Advocacy (ICAA)
- Care Management Advocacy Project (CMAP)
- BME Advocacy
- Outreach Advocacy
- In-patient Advocacy

Historically, these services have been commissioned separately. This leaves the potential for double funding, gaps in provision which could leave vulnerable adults without the appropriate support and inconsistent contract monitoring between related services. In addition, we are seeking to maximise funding for HealthWatch by collaboration with other authorities, in order to try to maintain the level of investment at the same, or greater than its predecessor LINK.

There have been significant changes over the past few years that have impacted on these services including the increase in use of services as a result of changes in Deprivation of Liberty Standards (DOLS legislation and additional statutory requirements introduced in the Care Act 2014.

The advocacy services that are commissioned by Care and Support Adults are under contracts which that expire on 31 March 2019. Some of these services are funded via pooled funds with the CCG. The total value of these contracts is £755,021 per year. Collectively, the Advocacy services included in the scope of this document support approximately 1800 individuals a year.

Financial pressures on local authority budgets across the country have meant that many councils have ceased to fund 'non-statutory' services. It will be important, to demonstrate the additional value that non-statutory advocacy services contribute within a whole-system approach by aligning the offer with the Councils 'Three Tier Model' and promoting 'self-advocacy', where appropriate.

Existing services are Voluntary Community Sector (VCS) and Small & Medium Enterprises (SME). Early engagement has taken place with them as industry experts alongside input from Voscur, the support and development agency for Bristol's Voluntary, Community and Social Enterprise sector (VCSE) to ensure that BCC as lead commissioner procures services in a way that can measure social responsibility, economic value, and environmental impact.

Section B: Drivers for Change

B.1 Principles underpinning this Commissioning process

B1.1 BCC have adopted an approach to Advocacy that considers the "family" of advocacy services. This has meant the provisional inclusion of HealthWatch Bristol within the scope of advocacy procurement, due to its "collective advocacy" on behalf of health and care users. We will seek to align these contracts, where possible to those in the Bristol, North Somerset and South Gloucestershire BNSSG footprint to facilitate strategic commissioning.

B1.2 To apply the vision and themes of BCC's three tier model as outlined in the Adult Social Care Market Position Statement[1] and the Adults Strategic Plan 2016-2020[2]; People can get the right level and type of support, at the right time to help prevent, reduce or delay the need for ongoing support, and to maximise people's independence.

B1.3 Aim to develop a strategic approach to aligning related services in Bristol.

[1] https://www.bristol.gov.uk/documents/20182/2678414/Market+Position+Statement/bdd21e05-0a76-94ae-4094-246ad9eb5739

[2] https://www.bristol.gov.uk/documents/20182/305531/Adult+Social+Care+Strategic+Plan+December+2016/2f87741f-a4eb-4a49-a70c-c24b77704380

B1.4 Scope medium term potential (post 2024) for contracting advocacy within a sub-regional area.

B1.5 Examine value for money from current services and question how to lever the greatest health and wellbeing benefit from advocacy investment. This approach reflects the value of the impact of these services within the health and care system more proportionately than may appear by judging them solely on their contractual monetary value.

B1.6 Examine key legislative changes, BCCs responses and progress towards meeting its statutory responsibilities. Elements of the Care Act (2014) have highlighted the duty on the Local Authority to develop a more transparent social care offer. This will include prevention and early intervention; provision of information and advice to enable people to make good decisions about Care and Support; and to have a range of provision of high quality appropriate service to choose form.

B1.7 Demonstrate our continuing commitment to valuing and developing the provider community, which includes the Voluntary Community and Social Enterprise (VCSE) sector, and Small and Medium Enterprises (SMEs). We will ensure compliance with our local VCSE Compact. https://www.voscur.org/content/voscur-and-compact

B1.8 Examine the coherence of current service provision from all stakeholders perspective.

B.2 Priorities in the commissioning of Advocacy services

B2.1 To conduct a full commissioning and re-procurement process to include all in-scope services. This process will include a needs analysis that will inform the development of an approach that considers separate advocacy contracts within a set of related services.

B2.2 Determine the range and level of future commitments from investment partners (i.e. CCG).

B2.3 Develop a more consistent approach to Contract Management. This will include (1) ensuring that performance indicators collected are limited to those with a defined purpose or use; inclusion of Advocacy Services within BCC Quality Assessment Framework. The use of a generic monitoring workbook for all advocacy services for use commencing with new contracts. Explore the use of Collaborative Quality Management Systems - Peer Review and Monitoring.

B2.4 Align contract lengths of Advocacy services, and ensure the “whole service family” encourages wider collaboration, and enables future sub regional opportunities to be considered.

B2.5 Procure services in a strategic way to allow market shaping activity and developing inter agency collaboration that results in a clear and accessible offer to service users.

B2.6 Understand where and how advocacy services fit with regard to BCC’s Market Position statement, the Social Care three tier model, and wider plans around Information, Advice and Guidance.

B2.7 Consider planning for future needs in regard of market diversity and capacity to ensure adequate future supply of advocacy services.

B2.8 Ensuring services promote self-advocacy and equity of access where possible and a strengths-based approach that supports an individual's independence, resilience, ability to make choices and wellbeing, where appropriate.

B.3 Services in scope for recommissioning

Bristol has a range of formal and informal Advocacy services delivered across the city. The Council fulfils its statutory duty to provide professional advocacy under current contracts, these contracts are for the following services: Independent Care Act Advocacy (ICAA), Independent Mental Health Advocacy (IMHA), Independent Mental Capacity Advocacy (IMCA), NHS Complaints advocacy and HealthWatch.

Historically, Bristol City Council has commissioned 'non-statutory' advocacy services to address identified gaps or barriers to access provision. These services are intended to complement the provision of statutory provision and provide an 'early intervention' approach. The provision focuses on three groups: Disabled adults, Adults with Mental Health as a primary need and Adults from a Black or Minority Ethnic group.

Advocacy and HealthWatch services are currently commissioned with five providers: Bristol MIND, WECIL, Your Say, SEAP and the Care Forum.

B3.1 **Independent Mental Capacity Advocate – Deprivation of Liberty Safeguards (IMCA DoLS)**

This service is currently delivered by Bristol MIND. The Mental Capacity Act 2005 introduced the role of the independent mental capacity advocate (IMCA). IMCAs are a legal safeguard for people who lack the capacity to make specific important decisions: including making decisions about where they live and about serious medical treatment options. IMCAs are mainly instructed to represent people where there is no one independent of services, such as a family member or friend, who is able to represent the person. The Deprivation of Liberty Safeguards (DoLS) introduced a number of new roles for IMCAs. These are known as 39A, 39C and 39D and refer to the sections of the Mental Capacity Act 2005 in which these new roles are described.

B3.2 **Paid representatives (RPPR)**

Relevant Person's Paid Representatives (RPPR) are qualified advocates who have specialist knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DoLS) legislation. RPPR's are required by the Act to be independent from the care home or hospital where a person is being deprived of their liberty, as well as the Local Authority and Supervisory Body/DoLS team whom are depriving the person of their liberty.

The role of the person's representative is set out in Paragraph 140 of Schedule A1 of the amended MCA, and described in the DoLS Code of Practice (Paragraph 7.2) as:

- 'To maintain contact with the relevant person, and

- 'To represent and support the relevant person in all matters relating to the deprivation of liberty safeguards, including, if appropriate, triggering a review, using an organisation's complaints procedures on the person's behalf or making an application to the Court of Protection.'

B3.3 **Independent Care Act Advocacy (ICAA)**

Independent Care Act Advocacy is currently provided by 'Your Say'. The Care Act 2014 places a duty on Local Authorities to provide Independent Advocacy provision to eligible people engages in one of the following processes:

- Assessment
- Review
- Support Planning
- Safeguarding

Like the Mental Capacity Act 2005, the Care Act 2014 focusses on person-centred care, making it the responsibility of the local authority to involve people in their care and support assessment, planning, review and safeguarding processes. The statutory requirement for the provision of independent advocacy under the Care Act is to support that involvement where the person would otherwise have 'substantial difficulty' being involved and has no one appropriate to support them.

The 'substantial difficulty' requirement means that people who have capacity but still struggle to actively engage in their care planning can have the support of an advocate.

B3.4 **Independent Mental Health Advocate (IMHA)**

This service is currently delivered by Bristol MIND. The right to an IMHA was introduced in 2007 under amendments to the 1983 Mental Health Act.

Access to an IMHA is a statutory right for people detained under most sections of the Mental Health Act, subject to Guardianship or on a community treatment order (CTO). When someone is detained in hospital or on a CTO it can be a very confusing and distressing experience. IMHAs are independent of mental health services and can help people get their opinions heard and make sure they know their rights under the law. IMHA can make a big difference to people's experience of detention and are highly valued by people who use services[3]

B3.5 **In-Patient Advocacy**

This service is currently delivered by Bristol MIND. The service is available to people in in-patient units who are not under the mental health act, and to people who are under the act, but whose issues fall outside the remit of the IMHA role. All advocates working in in-patient units provide this service including IMHA's.

All advocates working in in-patient units provide this service including IMHA's. The advocate visit wards at Callington Road and Southmead on a weekly basis.

[3] https://www.scie.org.uk/independent-mental-health-advocacy/

B3.6 **Outreach Advocacy**

This service is currently delivered by Bristol MIND. It is a one-to-one advocacy service for people with Mental health issues living in the community. This service is being provided through two weekly drop-ins; one at Bristol Mind's Old Market Street offices; and one at Windmill Hill city farm. There are sixteen active volunteers. All volunteers complete the Bristol Mind Advocacy Volunteer training course which includes the completion of written assignments.

The service signposts and refers people to other services: support groups, Talking Money and various Advice Centres; solicitors for legal advice including Avon and Bristol Law Centre; PALS, and the Care Forum for Social Services related complaints etc.

B3.7 **Black and/or Minority Ethnic (BME) Advocacy**

This service is currently delivered by Bristol MIND. The Bristol Mind BME Advocacy Service provides inpatient and community based advocacy to people from Black and/or Minority Ethnic communities. The service is specifically aimed at people from BME communities who are experiencing severe and enduring mental/emotional distress.

The general aim of the service is to provide culturally appropriate high quality, issue based, outcome focused advocacy. Specific to secondary care mental health, the service will provide advocacy to people in psychiatric hospital (inpatients) across Bristol, this includes people placed in Fromeside (medium secure unit) and Wickham (low secure unit). The service also receives requests for information/ advice from people who have family members with significant mental health issues, but are not engaging with services

B3.8 **Care Management Advocacy Project (CMAP)**

This service is currently delivered by WECIL. The aim of this service is to provide Advocacy to adults from a disability equality perspective, working in an anti-discriminatory way incorporating all equality principles and enabling service users to make informed choices and decisions about support planning process. Its aim is to increase Service User understanding of the Care Management process and signpost the service user towards community resources and other specialist agencies/organisations that may meet needs that fall below the Critical / Substantial level of the 'Eligibility Guidelines for Social Care'.

B3.9 **Local HealthWatch**

Local HealthWatch succeeded its predecessor "Local Involvement Network" service, with additional new responsibilities for Information and Signposting to services. It operates in each English Local Authority and forms a collective led by HealthWatch England, the independent national champion for people who use health and social care services, and provides advocacy for greater public involvement in health and care services.

It has eight statutory functions as follows:

- Increasing public involvement in the commissioning, provision and scrutiny of local care services.
- Enabling local people to monitor the standard of provision of local care services and whether and how local care services could be improved

- Obtaining the views of local people regarding their needs for, and experiences of, local care services and importantly to make these views known
- Making reports and recommendations about how local care services could or ought to be improved. These should be directed to commissioners and providers of care services, and people responsible for managing or scrutinising local care services and shared with HealthWatch England.
- Providing advice and information about access to local care services so choices can be made about local care services.
- Formulating views on the standard of provision and whether and how the local care services could and ought to be improved; and sharing these views with HealthWatch England.
- Making recommendations to HealthWatch England to advise the Care Quality Commission to conduct special reviews or investigations (or, where the circumstances justify doing so, making such recommendations direct to the CQC); and to make recommendations to HealthWatch England to publish reports about particular issues).
- Providing HealthWatch England with the intelligence and insight it needs to enable it to perform effectively.

Discussions with partner authorities are being pursued to see whether Local HealthWatch could be recommissioned collaboratively between Bristol, North Somerset, and South Gloucestershire for services commencing April 2019.

B3.91 **Independent Health and Care Complaints Advocacy Service (IHCCAS)**
These services were previously commissioned in a combined procurement with Local HealthWatch in 2013. The outcome produced a partnership between SEAP (providing a paid advocacy specialism for NHS Complaints processes), and The Care Forum (providing Social Care Complaints Advocacy through volunteer advocates). This enables some flexibility to develop volunteer advocate caseloads and ensure that specialist advocacy support could be accessed for more complex social care complaints. The services were commissioned in a partnership with Local HealthWatch recognising its role in gathering user's views of service quality; its contribution to safeguarding boards; and its participation in Quality Surveillance Groups.
The purpose of these services is to enable people to participate in complaints processes who might otherwise be unable to do so. This can be achieved through direct advocacy on a service user's behalf, promoting self-advocacy wherever possible with a range of support materials.

B.4 Needs Analysis by Service and Profile of Users

A full needs analysis has been undertaken for these services, which included quantitative and qualitative evidence as indicated below:

- Statistical evidence has been gathered through a through desktop review of available reports and data sets including Provider monitoring, Liquidlogic Adults' Social Care System (LAS), Office of National Statistics (ONS), Joint Strategic Needs Assessment (JNSA), Projecting Older People Population Information System (POPPI) and other sources.
- Online questionnaires generated by BCC and commissioned services.

- Interviews have been carried out with staff, local experts and key partners in the CCG.
- Stakeholder workshops with internal experts and current providers.

IMCA service: Dementia was the primary need for individuals accessing the service (42%), Learning Disability then Mental Health, artificial nutrition and hydration were the main issues where a Serious Medical Treatment (SMT) decision was required, however a significant number of treatment decisions were not recorded.

IMHA service: The primary need of service users for this service is Mental Health support, secondary needs are not captured. Most individuals accessing this service were female and were in the 35-44yrs age group. The main issues dealt with by IMHA's to relate to: patients treatment while in hospital, information about the mental health act, appeals against detention, medication, access to leave, discharge and aftercare, and ward/hospital-related issues.

Inpatient advocacy: Criminal justice proceedings, Referrals of complaints to Patient Advice and Liaison Service (PALS), Probate and land registry; personal property issues, dealing with housing issues, referrals for legal assistance, discharge planning meetings, and in discussions concerning other aspects of their care and treatment.

Outpatient advocacy: Access to community psychiatric services, benefits, legal issues, general information, accommodation and safeguarding (fig. 1).

BME advocacy: Primary needs for BME advocacy service users are around hospital issues, complaints, legal issues, IMHA rights issues and IMHA treatment issues.

Care Act advocacy: Main referral reasons are around Assessment, Review, Support Planning and Safeguarding

CMAP advocacy: Referrals for the advocacy service are around care or financial assessments

IHCCAS advocacy: Support and advocacy to access and participate in a complaint involving any NHS service or statutory social care service.

HealthWatch – Collective advocacy for health and care users, providing information and advice on access to services. Retains the power of "Enter and View" to inspect and report on registered premises.

Demographic findings

Ethnicity: White/UK individuals were most likely to have accessed Advocacy services. In comparison with wider ethnicity demographics of Bristol – Black or Black Caribbean & Black British African Somalian individuals are over-represented. The exception to this is Care Act Advocacy, which is broadly representative of the Bristol population and the Care Management Advocacy Project which has a higher proportion of Pakistani individuals supported due to a high level of referrals from an organisation that supports this specific group.

Age: The IMCA service typically sees a referral age of 80+, followed by 66-79yrs which would correlate with the main primary need of service users being Dementia. The IMHA service & Inpatient Advocacy has a lower age demographic of 33-45 being the most prevalent age group.

Individuals receiving Care Act advocacy are typically in the 65+age group followed by 55-64yrs, which is a similar range to the Care Management Advocacy service.

Religion: The most common religion recorded was Christian, followed by Muslim

Disability: All services reported that individuals accessing services had a disability, where this was not the case this was often because the person receiving support was a Carer. The primary Disability type for referrals to IMCA & Care Act Advocacy services were Learning Disability support, Mental Health support and Physical Disability.

Gender: IMHA & IMCA services received slightly more referrals for females that for males. There was a 50/50 split for Care Act advocacy. The CMAP service received significantly more referrals for women than for men.

Transgender: There were few referrals for individuals who were Transgender, typically 1 or 2 per service over a 12 month period. There was a significant number of no response/data not recorded.

Sexual orientation: Most individuals stated that they were Heterosexual; however there were a significant amount of no responses/data not recorded. LGBT were under-represented as a group in comparison with the Bristol demographic.

Liquidlogic Adults' Social Care System (LAS) data findings

LAS data suggested that the primary reason for an individual needing an IMCA service was a broad three-way split between Mental Health, Physical Disability and Learning Disability.

It also gave a useful indication of the growing number of family members acting as an advocate for individuals whose primary need was Physical Health or Learning Disability, however relatively few family members were supporting someone who required Mental Health support. Where an advocate has not been instructed due to there being appropriate support provided by the family, the numbers of individuals supported by a family member has doubled in the last 3 years

Summary of points from Advocacy and HealthWatch Needs Analysis

- The population is projected to increase 10.4% to 488,500 by 2024 due to an inward migration and an ageing population.
- The proportion of older people is lower than nationally but is now rising, mainly in the North &West (inner). Projected to be 7,700 additional people 65 & over by 2024, a 13.1% rise.
- The proportion of the population who live with learning disabilities and physical disabilities will rise as more people with disabilities live longer.
- The number of people detained under the Mental Health Act increased by 47% (between 2005-2015) and has continued to increase.[1]
- Black or Black British groups (including Caribbean, African and Any Other Black ethnic categories) showed higher rates of access to hospital services than any other groups.
- Excess mortality rate in adults with serious mental illness is higher in Bristol than nationally.

- Mental health disorders are up to three times more prevalent in women than men however known detention rates were higher for males (83.2 per 100,000 population) than females (76.1 per 100,000 population).
- There is a continued presence of areas of high concentration of deprivation.
- Carers - there are over 40,100 carers in Bristol (all ages), which is just under 1 in 10 of the population (9.4%), which is growing as the population rises.
- There are no known gaps in statutory Advocacy services. Long-term, sustainable funding levels for local HealthWatch are being identified. There is a perceived gap for particular interest groups for non-statutory advocacy which will be evidenced through the Equality Impact Assessment (EqIA).

B.5 Outcomes from engagement with Providers

There have been two provider workshops with existing providers of Advocacy and HealthWatch services focussing on; the expertise in the Local offer (current services), performance monitoring, peer support & peer review, self-advocacy toolkits and understanding the skills, experience and quality marks relevant to these services.

B5.1 The outcome from engagement with providers has been:

- A better understanding of the local offer: A mixed and diverse provision containing individual specialisms/expertise.
- To better understand the additional social value delivered by SME/VCS provision through integration within a community of related Tier 1 and Tier 2 services. Providing early signposting and re-directing inappropriate referrals.
- A focus on self-advocacy: Working towards people becoming less dependent on services by increasing confidence in self-advocacy.
- To identify the potential to improve contract monitoring: Setting core outcomes & outputs that allow organisations to work effectively within complex services, consistently applied across services.
- To scope the potential for inter-agency collaboration (an advocacy provider forum) and horizontal accountability (systems for peer challenge/peer-review) as part of a collaborative quality management system.
- To understand the proactive and reactive response to an advocacy need: A failure to support an individual in a timely way has direct links to the duration/cost of a subsequent intervention. Community advocacy represents the tip of the complaints iceberg - many do not escalate to formal statutory complaints.
- The identification of training needs appropriate for each Advocacy role, core competencies/any specialisms and quality indicators.
- To identify how service users could best be consulted and develop a plan for service user involvement throughout the commissioning cycle.

B.6 SWOT analysis

Strengths	• There are no known gaps in statutory Advocacy services. • The council currently fulfils its duty to provide statutory Advocacy and HealthWatch services. • There is a thriving VCSE/SME Advocacy sector offering specialist advocacy provision in Bristol City Council that supports the aim to spend 25% of the Councils total procurement budget with 'priority organisations' which includes micro, small and medium sized enterprises and organisations, black, minority ethnic owned enterprises, those with majority ownership/leadership from a group protected by legislation and voluntary and community sector organisations. • Positive Social Value outcomes are added through Advocacy services integration with community groups, use of volunteers and a cohesive relationship between Advocacy providers
Weaknesses	• There is a perceived gap for particular interest groups for non-statutory advocacy which will be evidenced through the Equality Impact Assessment (EqIA) and further engagement with stakeholders. • There are gaps in the communication and signposting between non-statutory and statutory advocacy services.
Opportunities	• Bristol City Council will welcome bids from organisations who would like to work together in the form of a consortium. Consortia are groups of organisations who may come together for a specific project or purpose and may be either formal – for example, Prime contracting, Alliance contracting - or informal associations, for example, a number of organisations who work together supported just by a memorandum of understanding. • To develop a more consistent approach to Contract Management. This will include ensuring that performance indicators collected are limited to those with a defined purpose or use; inclusion of Advocacy Services • Explore the use of collaborative Quality management systems, peer review and monitoring. • Building capacity through partnership working, including exploring opportunities to apply jointly for additional funding.
Threats	• Long-term, sustainable funding levels for local HealthWatch are still being identified. • An increase in need for statutory advocacy services • An increase in need for 'Help to help yourself' preventative services may put pressure on non-statutory advocacy services to work outside contractual boundaries.

B.7 Demand for services

Key impacts on demand will be:

- The introduction of Universal Credit, the increase in the number of people being sanctioned for failing to meet conditions for continued receipt of employment related benefits and the roll out of revised assessment arrangements for disability benefits.
- Older people living for longer and likelihood of being diagnosed with Dementia.
- The impact of growing population.
- The increased prevalence of adults with mental health issues over national trends.
- Historical performance of services over the last 3 year period demonstrates an increase in the number of referrals to advocacy services alongside a decrease in inappropriate referrals.
- There is a backlog of DoLs assessments, which is a national issue. The duty to complete these assessments falls on the Council. The capacity of the Council to process assessments will correlate to the demand for IMCA DoLs.
- Impact of legislative changes for DoLS following the Department of Health's response to the Law Commission's consultation on mental capacity and deprivation of liberty[4]

Demographic data and referral trends have been used to forecast demand; these projections are not a guarantee of the level of service to be provided and are offered as a guide only.

Service	Forecast				
	2018/19	2019/2020	2020/2021	2021/2022	2022/2023
IMCA	197	201	205	209	213
IMCA DoLs*	139	N/A	N/A	N/A	N/A
Paid Representatives	155	N/A	N/A	N/A	N/A
IMHA	332	339	345	352	359
Care Act	122 (1050hrs)	123 (1060hrs)	124 (1071hrs)	125 (1081hrs)	126 (1091 hrs)
Inpatient Advocacy	84	86	87	89	91
Outreach Community Advocacy	383 (93 sessions)	385 (93 sessions)	387 (93 sessions)	389 (93 sessions)	391 (93 sessions)
CMAP	64	67	68	69	70
BME Advocacy	164	167	170	174	177
Independent Health and Care Complaints Cases (Health)	166	175	180	185	190
Independent Health and Care Complaints Cases (Care)	30	32	33	34	36

*unable to forecast

[4] https://www.scie.org.uk/mca/dols/practice/lips

B.8 Strategic Drivers

There are clear local strategic drivers and values that underpin the recommissioning of this family of services. They are:

1. **The BCC Market Position Statement for Adult Social Care**:
   The MPS outlines the strategic vision for meeting the demand for care and support in Bristol, acting as a steer for discussions between BCC and service/ support providers, in particular voluntary and community sector organisations, small and medium sized enterprises (SMEs), and entrepreneurs.

2. **BCC Corporate Strategy 2018-23**
   Bristol City Council's Corporate Strategy 2018-23 lays out the vision, values and key themes to make sure that BCC plays its full part in creating a city that is successful for everyone. All these themes are relevant to the recommissioning of services outlined in this commissioning plan as stated below:

   - Empowering and Caring: Working with partners to empower communities and individuals, increase independence and support those who need it. Give children the best possible start in life.
   - Fair and Inclusive: Improve economic and social equality, pursuing economic growth which includes everyone and making sure people have access to good quality learning, decent jobs and homes they can afford.
   - Well Connected: Take bold and innovative steps to make Bristol a joined up city, linking up people with jobs and with each other.
   - Wellbeing: Create healthier and more resilient communities where life expectancy is not determined by wealth or background.

3. **Mayor's Vision**: To ensure life chances and health are not determined by wealth and background.

4. **Better Lives programme**: Maintain quality services with people at the heart of what we do and make cost savings whilst holding our ambition to improve outcomes.

5. **Adults Social Care Strategic Plan 2016-2020**: To meet our obligations within the Care Act 2014 we have developed a three tiered model of care and support. It is designed to ensure that people can get the right level and type of support, at the right time to help prevent, reduce or delay the need for ongoing support, and to maximise people's independence.

6. **BNSSG** – The transition of Clinical Commissioning Groups to a larger footprint has prompted Bristol, South Glos and North Somerset to explore longer term collaboration for provision of Local HealthWatch to make best use of available resources.

B.9 Other influences on this commissioning exercise.

Interdependencies with other commissioning projects

Interdependency	Details
IAG	Align advocacy service development with IAG re commissioning project to ensure a consistent approach. Wellaware has a specific inter-dependency with HealthWatch
Carers services	Carers services are key signposting agencies to advocacy services and offer collective advocacy for the role and needs of carers.

It will be necessary to work closely with interdependent commissioning projects. At the time this analysis is being prepared, the contracts for Carers and IAG are entering the analysis phase of re-commissioning.

We have looked for potential to work over a wider area than just Bristol, in different combinations of authorities such as West Of England Combined Authority (WECA), and North Somerset and South Gloucestershire to mirror changes in the Clinical Commissioning Group (CCG).

Section C: Future Commissioning Model

C.1 Service Standards & Specifications

This will be informed by engagement with stakeholders within the consultation phase

C.2 Contract Approach

This will be informed by engagement with stakeholders within the consultation phase

C.3 Equalities Impact Assessment

Available on request

Section D: Tender Process

D.1 Procurement approach

An options appraisal has been completed, which has suggested that an open tender will provide the best process for procurement.

1) This option would allow for the project objectives to be achieved through the development of the specification and key performance indicators.
2) Tendering allows for competition to be stimulated.
3) Corporate objectives can be achieved through the tender process
4) There is a requirement for a category specialist and commissioning manager as well as a contract manager to be involved in the tendering process.

5) The risk of procurement challenge from the market is reduced
6) Inclusion of performance indicators to ensure services is delivered in line with the specification.
7) Rationalisation – can take place in terms of the numbers of contracts that the Council currently has to provide these services.
8) This approach will ensure a sustainable advocacy provision across the city.

D.2 Service User Involvement

We are planning to offer a service user involvement process which will:

- Encourage participation with previous and potential users of these services throughout the consultation period.
- Consider all views and seek to update or amend the commissioning plan based on what have learned through consultation.
- Involve individuals or groups who can demonstrate lived experience of advocacy in the devising and scoring of a tender question.
- Afford travel expenses, tender evaluation training and certificate of completion to service users who score tender questions.
- Gather feedback from Service users involved in participation and produce a 'You said, we did' document.

D.3 Transition and Mobilisation of Services

A clear process will be outlined at the point of tender for service user transitions to the newly tendered service. This transition will include appropriate sharing of information and communicating with all professionals. The transition process will be informed by provider's responses to tender questions.

A lead-in for new services will be based on having the least disruptive approach for service users which may mean that some longer-term case work will be transferred or clients who wish to continue towards closing their support in the first quarter may be allowed to remain with their current provider. This will require a charge-back arrangement.

We anticipate that there will be a three month transitionary period where there is a change in provider.

Outcomes from Public Consultation on Draft Strategy

To be completed when Consultation has concluded

Outcomes from ongoing engagement with providers

To be completed when Consultation has concluded