
# Advocacy & HealthWatch Consultation Report December 2018

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# Section A: Background of the Consultation

## Introduction

Bristol City Councils Adult Commissioning Team undertook a consultation exercise between 27 Aug 2018 and 19 Nov 2018. The purpose of this consultation was to gather views from stakeholders on the Draft Advocacy and HealthWatch commissioning plan.

This document analyses the feedback from this consultation. This analysis informs the 'You Said, We Will' document which informs stakeholders of what we plan to do with the feedback and how it informs the final Commissioning plan and subsequent specification for services.

The Draft commissioning plan can be viewed here[1]

Feedback was gathered via:

- Online consultation
- Emails
- Four consultation sessions (3 open events and one session dedicated to Adult Carers).
- Telephone interviews
- Interviews with service users
- Group sessions with service users

[1] https://files.smartsurvey.io/2/0/7QCTTY3C/Commissioning_Plan_LHW_and_Advocacy_v8_Final.pdf

Consultation events were based in the North and the South of the city with large and small venues offered to encourage participation. An 'Easy-read' version of the draft commissioning plan and the consultation questions was produced and shared on request and at consultation events.

## What we were looking to commission

The specific services included in this round of recommissioning are:

- Local HealthWatch
- NHS and Social Care Complaints Procedure Advocacy
- 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

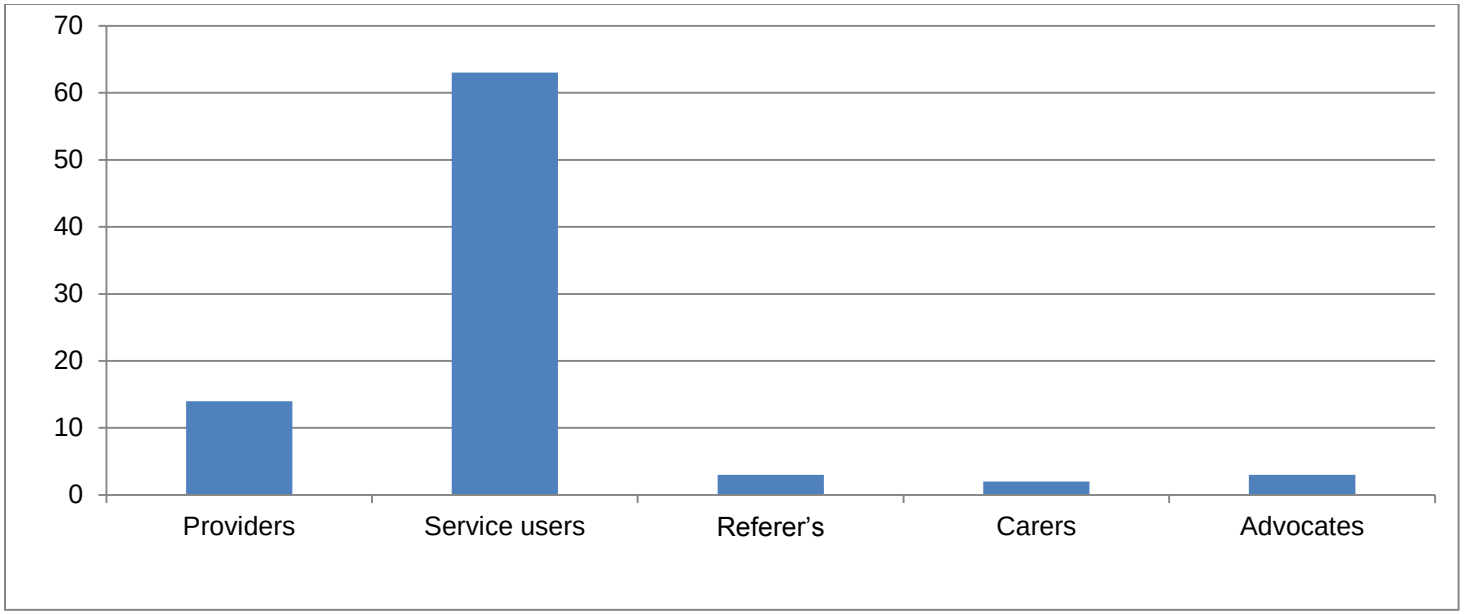
## What we asked

The commissioning intentions were laid out to the providers and public and as a part of the consultation five questions were asked within it. An open question was asked to allow for an opportunity to demonstrate and concern or agreement that may not have previously been captured. The consultation focused on collecting feedback on these questions. Feedback was analysed using the following methods.

1. Consultation questionnaire – the questionnaire asked for peoples comments' on the questions within the strategy. To view the consultation questionnaire, see Appendix A.
2. Consultation events- the events asked for people's responses to the consultation questions.
3. Emails from providers who have expressed an interest in tendering for this provision
4. 1:1 Interviews and Group sessions with people of lived experience of advocacy

## Who engaged with the consultation process?

A total of 65 responses were received in relation to the consultation.



## Service user engagement

Individuals who have had experience of using Advocacy and HealthWatch services have a unique and valuable perspective to offer throughout the commissioning cycle.

Service user engagement was via a group setting or 1-1 interview within unstructured interviews. 1-1 interviews were conducted in person and via phone and two group sessions took place. Where issues were identified, service users identified solutions. This feedback will inform the final commissioning plan and service specifications.

Table 1.Themes from service user engagement

| Theme | Detail | What could be different |
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| Things that are going well | • Those spoken to had positive experiences of working with their advocate such as feeling listened too, empathy of worker, knowledge, professionalism and a commitment to working to better outcomes.<br>• Awareness raising activity by advocacy services<br>• Opportunities to develop self-advocacy skills and a route to work towards becoming an advocate.<br>• Being told about other relevant services<br>'They move as one person and they see as one person, they have 'Mind Eyes' (talking about Bristol MIND staff). | • Increase awareness raising activity<br>• Increase opportunities for people to develop self-advocacy skills and recognise the value brought by individuals with lived experience.<br>• Increase Signpost onto relevant services<br>• Referrers should signpost earlier to advocacy services to prevent crisis |

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| Positive outcomes from having an advocate | • Employment, Volunteering, Taking part in activities<br>• Engaging with community, No-recall to hospital,<br>• Children being returned to their care,<br>• Stable medication,<br>• Having a support plan that better met needs.<br>• Safeguarding<br>• Increased confidence<br>'Since leaving hospital I have not had a relapse, I have seen my GP and he is now supporting me get my driving license reinstated. I am now planning to start working locally, stocking shelves and I have already had an offer of work' | • Encourage the use of Volunteers as peer advocates and link to community.<br>• Develop a befriending service to support resilience and widen the offer. |
| Engaging with the Council | • People were unable to navigate complex systems (internet based and multiple option phone systems).<br>• Negative previous contact with Social services, housing, benefits, environmental health.<br>'If the housing worker had responded to the ASB of my neighbour I would not of needed my advocate. Without this I think I would of got into trouble with my neighbours' | • The council should have a 'filter' to identify individuals who find council systems a barrier to accessing services they are entitled to. This would enable easier access to services by talking directly to someone with sufficient knowledge to support or signpost them onto the appropriate service i.e. a community navigator<br>• Training for 'front door' professionals to recognise that people are their own expert (i.e. what medication may prevent a relapse)<br>• Having timely access to representation |

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| Stigma | • People not having their opinions /knowledge valued due to the label of Mental Health. Resulting in the allocation of an Advocate.<br>• People with Mental Health conditions being perceived as a danger.<br><br>'If I had been listened to by my mental health team at the start, I would not of needed my advocate. Without my advocate, I would of relapsed' | • Training for Mental Health professionals to recognise that people are their own expert (i.e. what medication may prevent a relapse) |
| Communication, Information and the environment | • People not understanding why they were in hospital or why they were being detained. This is linked with people observing that Mental Health wards were understaffed, staff not having the time to talk to patients.<br>• Services (Social care, Health, Housing) not providing Translators or Interpreters on request. Resulting in referral to an Advocate.<br><br>'I am not very good on the internet – I need to be able to have a phone number that I can call and talk to someone' | • All Health and Social care services should give people to clear information in a form that is accessible to them to explain where they are, why they are there and next steps.<br>• The provision of appropriate translation or interpreting service in a timely way.<br>• Staff training, Psychologically informed environment.<br>• Key qualities of all professionals should be that they are knowledgeable (understands the changing local system 'navigation'), empathic and consistent. |

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| Service promotion | • Not knowing about Advocacy services<br><br>'My community leader told me about the advocacy service, otherwise I wouldn't of known about it. My daughter did not have the right care plan and I wasn't listened too. If I had received this support earlier, my daughter would have had the right care and I would have been in receipt of the right benefits from the start' | • Ensure leaflets are available and promotion of services happens at a community level.<br>• Have leaflets on services, for professionals to be aware of services, for services to be accessible by phone, for services to be able to meet the service user at their home. To have a presence on Google and up to date information on Well-aware<br>• GP's should be aware of the local Advocacy offer |
| Qualities of an advocate | • Knowledgeable: understands the changing local system 'navigator', understand the relevant legal framework, empathic, consistent, honest, good communication skills, to be able to create a 'safe' space, ability to minimise risk. To represent people assertively. Record keeping. Understanding the benefits system<br>• For some people it is important that they feel represented by someone that can identify with the challenges that they face, particularly when in an environment of predominantly white professionals<br>• Having continuity of worker was felt to be valued by service users, where that doesn't create a delay in accessing a service.<br>• For some people, it does not make a difference to some people as to whether the Advocate is from a BME background if they have the right professional qualities. | • Sufficient training for Advocate to keep up to date with changes in the wider systems.<br>• To have the ability to match an advocate to an individual based on ethnicity, recognising that Black African and Black Caribbean people are over-represented in the mental health system. |

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| Access to Advocacy | • Important that there was a quick response to a referral and that a referral can be made over the phone.<br>• Referral being responded to within a week.<br>• Services being based in Bristol allowed access through drop-ins and increased awareness of services (such as outreach advocacy based in city farms)<br>'If the adaptations team had fitted the walk-in shower I would not of needed to contact my advocate. If the change had not been made, I may of fallen'. | • Understand the value of a buildings based offer in communities.<br>• Timely and monitored waiting list with triage<br>• Encourage people will access mainstream services first to be heard before referring for an Advocate<br>• Ensure provision has a community buildings base and/ or presence. |
| Personal Independence Payments (PIP) | PIP reviews cause anxiety. People have had bad experiences when attending reviews and feel unable to attend (feeling unsafe). This can result in an Advocate being allocated. | PIP reviews should be conducted in a way that people feel safe, by people that have sufficient training and are able to communicate with individuals who have a range of needs |
| What might of happened if you had not had an advocate? | • Homelessness<br>• Debt, Hospitalisation<br>• Delay to leaving hospital<br>• Harm to self/ Safeguarding risk<br>• Poor quality of life<br>'I spent 14 years on the wrong dosage of medication before getting an advocate. If I had known about advocacy earlier I would of got the right support and got on with my life (without the side-effects I now have)' | • Ensure services are promoted.<br>• Early referrals<br>• Ensure there is an advocacy offer below the threshold of statutory services.<br>• Recognition that Advocacy has saved the Housing, Health and Social care system money. |

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| Other places for support | • Citizens Advice Bureau (CAB), family, friends (although some people cannot call on family or friends for support).<br>• Avon Law centre<br>• Family<br>Where I am an advocate for my son/daughter/loved one/friend – I need advice, I would like to be able to talk to someone who can give me advice, access training and talk to other Carers who advocate for their loved ones' | CAB to have a consistent worker, sufficient knowledge around mental health needs or the health and social care system. |
| Reduction in council funded services | People felt, and had experience of a decreasing level of support and that support plans and financial contributions are being cut | Reducing support or spend in one area may then lead to an increase in other costs (Homelessness, debt, Hospital admission, Prison) |
| Multiple advocates | People were prompted as to whether they had more than one advocate at any one time. None had.<br>Some people who accessed IMHA services had complaints against the NHS | People should be made aware of other types of advocacy to include Care Act Advocacy, Care Management Advocacy, Complaints Advocacy and Outreach Advocacy |

## Section B: You Said, We Did

This section is formed from the feedback to the consultation questions which have been submitted via email, e-survey, consultation events and interviews. Feedback has been collated separately to form a table of responses, with the Councils response.

Stakeholders chose different methods of engaging with the council, with the majority of professional stakeholders completing surveys, and attending consultation events. Email responses were from existing providers and referrers. Service users engaged with the Council through group-work, 1-1 interviews and telephone calls.

The feedback from professional stakeholders was not differentiated by role, and for this reason it has not been separated out into thematic response by profession.

| **Question 1: Family of Services**<br>Bristol City Council has 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) area to facilitate strategic commissioning. Do you agree with this principle underpinning the commissioning process? | |
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| **Responses via email:**<br>'My view is that it would be a mistake to join commissioning of HealthWatch (collective advocacy) services with individual advocacy. They are not the same things. A different skill set and qualifications are needed for these different roles. Additionally, and very importantly, inclusion of this in the advocacy tender brief would clearly advantage organisations that have a track record in | Separate out the lots for HealthWatch and Complaints Advocacy from other Advocacy services |

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| the delivery of HealthWatch services and disadvantage those that do not.<br>(Advocate/Advocacy consultant)<br><br>'We believe that HealthWatch should be tendered separately from the one to one advocacy services. HealthWatch is a form of advocacy connected to broad policy and changes in local health care, while individual advocacy promotes the interests of particular individuals by acting on their behalf to resolve specific issues'<br>(Provider of Advocacy services)<br><br>WECIL agrees with the approach of commissioning a family of advocacy services as this is a step towards having advocacy services that are commissioned across whole BNSSG area and prevents postcode eligibility. Bringing the collective knowledge and expertise together and ensuring a more seamless advocacy experience for the individual would also be hugely beneficial. In regards to the addition of HealthWatch, we are not entirely sure this aligns with the family of advocacy services. As a feedback forum rather than an advocacy provider HealthWatch does not seem to fit with the advocacy model. Also, this could be seen as a conflict for referrers who may see all advocacy services as a feedback forum or route for an individual who is unhappy with the service they are/aren't receiving rather than a network of independent advocates<br>(Provider of Advocacy services)<br><br>**Responses via Online Consultation:**<br>There were 35 responses to this question. 40% of those answering the question selected Neither Agree nor Disagree while around 35% either disagreed (20%) or Strongly Disagreed (14%).<br><br>Of those that Disagree or Strongly Disagreed, there was a concern that a larger organisation commissioned to cover multiple areas may not understand the needs of the area. There were | so they are tendered separately.<br><br>Explore opportunities for providers to share thematic learning appropriately between individual and collective advocacy services.<br><br>We understand services that represent specific |

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| concerns that it may lead to a provider lacking area specific knowledge and risk and uneven service distribution.<br><br>Feedback has suggested that the opinion on whether services could be effectively commissioned over a wider area depends on which services were in scope. The risks and opportunities of this approach vary in relation to each advocacy service.<br><br>**Responses via Engagement Events:**<br>Provider feedback demonstrated that while HealthWatch could be commissioned with Advocacy it would be beneficial to be included in a separate lot (unless combined with Complaints Advocacy) and therefore not necessarily the same provider. | local needs need to be commissioned at a local level.<br><br>NHS complaints Advocacy and HealthWatch offer the greatest opportunity to be delivered on a sub-regional basis.<br><br>We will maintain sharing and analysis of anonymised complaints advocacy outcomes data with HealthWatch who will continue to promote access to the service) |

## Question 2: Promoting self-advocacy/ self-representation

The proposed commissioning plan describes the following as a priority in the commissioning of advocacy services: Ensuring services promote self-advocacy and equity of access where possible and a strengths-based approach that supports an individual's independence, resilience, and ability to make choices and wellbeing where appropriate. Do you agree with this priority in the commissioning of Advocacy services?

### Responses via email

'Agree with the intention – promotion of self-advocacy ought to be promoted by all, utilising peer support advocacy in the future, where possible. Our experience is that a lot of clients would not be able to self-advocate due to their health, fluctuating disabilities or home circumstances. Self-advocacy could certainly be encouraged but should not be an expected outcome. The use of volunteer advocates who have experience in successfully navigating the system could be an effective way to promote self-advocacy and peer support.
We must be careful not to prevent those that cannot self-advocate from being able to access the system. Some critical eligibility on whether family members, carers etc. might have a conflict of interest in advocating for a family member would be required.

'We strongly agree with working in a person-centred way which is standard for us as is providing equity of access. Being experts in access for disabled people we are well placed when it comes to providing a fully accessible service for disabled people. Having advocates with a lived experience of disability enhances the knowledge and expertise of the service.'
(Provider of Advocacy services)

### Responses via Online Consultation

In relation to the online survey and the proposed priorities for recommissioning advocacy and

Services will operate in a strengths based, recovery oriented approach (and provide tools to support this).

Ensure that contract monitoring does not set arbitrary performance indicators for self-advocacy

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| HealthWatch 74% agreed of which 29% strongly agreed.<br><br>"I think the key priority of independent advocacy has to be the promotion of rights of vulnerable people in their situation, and the support for people to get the services they want and need. The promotion of self-advocacy should be an aim of all advocacy services; however the rationale for introducing advocacy services initially was in part due to the recognition of the power imbalances in certain systems, and of the difficulty some people have in having their voices heard. Self- advocacy is best viewed as a continuum that people move along in either direction depending upon their mental and emotional health and the complexity of the situation/ issue at hand. The promotion of self-advocacy should not be seen a leading to a reduction on the need for advocates."<br><br>**Responses via Consultation Events:**<br>Feedback from consultation events was Self-advocacy was recognised to build resilience. Concerns were raised in direct relation to KPI's associated with self-advocacy and KPI's would need to reflect the individual's situation. If self-advocacy is pushed it could force users to feel isolated from the service they are relying on.<br><br>Generic' advocacy supports a step-up/step-down approach to advocacy. This could be supported by agency specific advocacy champions<br><br>**Responses from service users (interview):**<br>Service users stated the value of increased self-advocacy skills and the value brought by individuals with lived experience as peer advocates and volunteers.<br><br>Increased confidence and knowledge can lead to an increased sense of being able to self-advocate - the potential to be a volunteer, peer or offer befriending support for those people who have benefited from advocacy can help support individual confidence and resilience. | Identify clear routes into volunteering, peer advocacy and befriending<br><br>Incorporate volunteer models and peer support into the specifications for advocacy services (as appropriate). |

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## Question 3: Cost & Quality

Do you agree that cost and quality should be equally valued as criteria for selecting future provision?

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| **Responses via email:**<br>'We believe that quality should be the key defining element in the successful bids; these are all services for some of the most vulnerable people within our community', ' A stronger focus on simple cost is likely to lead to a reduction in service for the most vulnerable as these people are often the hardest to provide effective services to, and as such are 'more expensive' to provide services to, as they may require more time (staffing costs will form the bulk of any tender budget' ' Based on knowledge of recommissioning in other local areas, we are concerned that lower costs can make it harder to maintain standards; while potentially delivering some cost savings to the contract it may lead to higher costs in other areas of local health and social care and poorer value overall for money. E.g for the IMCA services, a cheaper, lower quality provider is likely to cause increased costs elsewhere - delayed hospital discharges, re-scheduled medical appointments, increasing the work for Best interests assessors, doctors and social workers'.<br>(Advocacy provider)<br><br>'Vehemently disagree!!!!!!! The quality should be the focus. If the funding envelope has been agreed by BCC then why allocate so much weighting to price? This means big organisations can go for this and run as a loss leader effectively edging those smaller local charities with expertise and relationships out of the market. Smaller charities won't be able to compete in the same way as bigger organisations. Besides, awarding on price means perhaps the bid with lower cost will get awarded over one with better quality.<br>Ultimately focusing on cost at this stage of commissioning (rather than quality) is highly likely to result in further costs later down the line. If people do not access effective services and support they are likely to end up in crisis at some point leaning more on statutory services and budgets.<br>(Advocacy provider)<br><br>**Sub-Question** | Consideration will be given to feedback on quality and cost ratios |

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| If not, what importance do you think should be given to cost and quality? (The total should be 100%)e.g. 25% cost and 75% quality would mean quality would be scored as 3 times more important than cost;<br><br>Response 1<br>'We would suggest to award on; 5% on cost, 65% on quality, 10% question marked by beneficiaries, 20% added social value<br><br>Response 2<br>'We welcome the stated intention for 20% fo tender assessment to be allocated to social value. Further we recommend that the overall approach to the tenders has an emphasis on quality, with a Quality:Cost ratio of a minimum of 80:20'<br><br>**Responses via Online Consultation:**<br>Through the online consultation the question of cost and quality was debated somewhat. Around 60% of the overall response disagreed with the statement that they should be equally rated of which the remaining 40% was split with 20% Agreeing and 20% having no preference. The average split on the ration given was 30% to be weighted to cost and 70% to quality.<br><br>**Responses via Engagement Events:**<br>The overall response from the consultation events towards cost and quality was that quality should be weighted higher than cost. Balancing the remaining 80% (Excluding mandatory 20% social value) Suppliers felt that this would reflect the overall long term reduction in advocacy access in a front loading approach " pay more now, pay less later" using the model of creating sustainable community change in the field of service referral and self-advocacy. | |

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| **Responses via service user (interview)**<br>Feedback from service users suggested that quality should be the most important factor when investing in advocacy services | |
| **Question 4: Tender Approach**<br>Do you agree with the proposed open tender approach for the procurement of Advocacy? | |
| **Responses via email:**<br><br><u>Response 1</u><br>'WECIL agree with open tender however to give protection to the advocacy sector we would suggest commissioning more than one Lot for reasons we have already stated and warn against consolidating all or several of the services into 1 or 2 lots. This would decrease competition from large (profit driven) organisations looking to take over all advocacy services and would encourage bids from VCO's and specialist organisations with years of expertise.<br>It is imperative that service beneficiaries are involved in writing and scoring one of the quality questions so that we are putting them are the centre of the commissioning process.<br>(Advocacy provider) | The Council will involve individuals of lived experience of Advocacy in the setting and scoring of a Tender question |

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| Response 2<br>Lot 1. Independent Mental Health Advocacy (IMHA), BME, Inpatient and Community Advocacy<br>Lot 2. Independent Mental Capacity Advocacy (IMCA), Deprivation of Liberty Safeguards (DOLS) including relevant Persons Representative (RPR)<br>Lot 3. Care Act Advocacy and Care Management Advocacy<br>Lot 4. Independent Health and Care Complaints advocacy<br><br>We therefore recommend that the above approach to lot management would be beneficial to service users and is a practical solution that Bristol VCSE organisations could deliver.<br>(Advocacy provider)<br><br>**Responses via Online Consultation:**<br>The response to the tender approach via the online consultation tended to agree with the proposed plan for a collective procurement plan with lots. 45% of respondents agreed with the approach and 25% disagreed.<br><br>**Responses via Engagement Events:**<br>Concerns were raised that the separation of advocacy services into separate lots could increase the risk service users falling between the gaps of provision. Mitigation for this risk could be strong inter-agency collaboration, with clear signposting and communication between related services.<br><br>Providers were asked how BCC might rationalise multiple contracts. Lotting identified there could be a potential of three lots.<br><br>1. Independent Mental Health Advocacy (IMHA) + Black and Minority Ethnic Advocacy (BME Advocacy)<br>2. Complaints Procedure Advocacy (CPA) and Social care Complaints ( If Healthwatch were to be reintegrated lot 2 would be the most applicable.)<br>3. Independent Mental Capacity Advocacy (IMCA) , IMCA DoLS (Deprivation of Liberty | We will consider the lotting approaches fed back through the consultation |

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| Safeguards) + Care management advocacy (Direct Payments) Independent Care Act Advocacy (ICAA)<br><br>This approach allows for independent advocacy to remain separate from collective advocacy protecting individual outcomes. | |
| **Question 5: Working within the BNSSG**<br>Do you agree with the aspiration to commission advocacy and HealthWatch services in Bristol, North Somerset and South Gloucestershire? | |
| **Responses via email:**<br><br>There was a limited response to this question via email, those that did reference this question agreed that HealthWatch could be commissioned on a regional basis and any approach that minimized a 'post-code lottery' would be of benefit. This needed to be balanced against the need for a service that understands the local area and need.<br><br>**Responses via Online Consultation:**<br>The overall response to cross boundary working is split. With most disagreeing (46%) followed closely with 37% agreeing. The overarching theme to be identified within this is that the respondents have concerns in relation to the ability to deliver a service over such a large geographic area.<br><br>Within this section a differentiation was highlighted that HealthWatch should sit at the heart of communities so that they can accurately reflect the needs of the people. By broadening the | Advocacy will not be recommissioned on a sub-regional basis at this point in time. This will be revisited in the next round of recommissioning.<br><br>Any available opportunities to develop a collaborative HealthWatch |

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| representative area there is a potential of misrepresentation or gaps appearing. Further to this as previously highlighted there is concern's that services commissioned for advocacy could be done but a local presence must be key for it to succeed otherwise there is a risk communities could be missed or service users cherry picked for hotspot locations.<br><br>"I have already indicated that in my opinion advocacy services can be commissioned over a wider area as long as they are accessible for everyone equally"<br><br>"Advocacy should be independent to 'HealthWatch', HealthWatch is specifically tasked to look at health and social care issues. Advocacy covers a wider range of issues which are person-centered and not all related to health and social care eg education, financial. Also for advocacy to truly work it requires to be independent from vested interested parties." | partnership between BNSSG authorities will be given priority. A core value of any partnership will be to retain the local identity of each service.<br><br>The Care Act 2014 requires the Council must have an independent advocacy service. |

# You Said, We did Summary

| Question | You Said | We Did |
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| 1. Family of Services<br>Bristol City Council has 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. | 40% of those answering the question selected Neither Agree nor Disagree while around 35% either disagreed (20%) or Strongly Disagreed (14%).<br><br>HealthWatch should be tendered separately from the one to one advocacy services. | • Separate out the lots for HealthWatch and Advocacy services so they are tendered separately.<br>• Explore opportunities for providers to share thematic learning appropriately between individual and collective advocacy services. |
| 2. Promoting self-advocacy/ self-representation | 74% agreed of which 29% strongly agreed.<br><br>Self-advocacy should encouraged but should not be an expected outcome | • Services will operate in a strengths based, recovery oriented approach (and provide tools to support this).<br>• Ensure that contract monitoring does not set arbitrary performance indicators for self-advocacy<br>• Consider how service users can be signposted to services that match their needs.<br>• Identify clear routes into volunteering, peer advocacy and befriending |
| 3. Cost & Quality<br><br>Do you agree that cost and | Quality should be the key defining element in the successful bids | • Consideration will be given to feedback on quality and cost ratios |

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| quality should be equally valued as criteria for selecting future provision? | | |
| 4. Tender Approach<br><br>Do you agree with the proposed open tender approach for the procurement of Advocacy? | 45% of respondents agreeing with the approach 25% disagreeing.<br><br>Concern that too many lots could create gaps, or duplication of services.<br><br>Concern that limited lotting, or a single lot will limit the number of organisations able to submit a tender application and subsequent loss VCS provision<br><br>Service beneficiaries should be involved in scoring one of the quality questions. | ● We will consider the lotting approaches fed back through the consultation<br>● The Council will involve individuals of lived experience of Advocacy in the setting and scoring of a Tender question<br>● Any available opportunities to develop a collaborative HealthWatch partnership between BNSSG authorities will be given priority. A core value of any partnership will be to retain the local identity of each service.<br>● The Care Act 2014 requires the Council must have an independent advocacy service. |
| 5. Do you agree with the aspiration to commission advocacy and HealthWatch services in Bristol, North Somerset and South Gloucestershire? | 46% disagreed, 37% agreeing | ● Advocacy will not be recommissioned on a sub-regional basis at this point in time. This will be revisited in the next round of recommissioning. |

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| | | • We will prioritise any opportunities to develop a HealthWatch partnership within the BNSSG area, whilst maintaining separate service identities. |

## Next Stages

**Stage 1**

Publish the final Advocacy and HealthWatch Commissioning plan. This will set out the new model for commissioning services.

**Stage 2**

Launch the formal tender process. It is envisaged this will be in Quarter 1 2019.