	**Adults and Safeguarding Committee** **7th March 2022**
Title	**Advocacy Services – a single provider approach**
Report of	Chairman of the Adults and Safeguarding Committee
Wards	All
Status	Public
Urgent	No
Key	No
Enclosures	None
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Summary

The London Borough of Barnet is currently in a tri-borough contracting arrangement with the neighbouring boroughs of Enfield and Haringey for the provision of Independent Mental Capacity Advocacy (IMHA) and Independent Mental Health Advocacy (IMHA). The council also holds separate, borough specific contracts for Independent Health Complaints Advocacy Service (IHCAS) and Care Act Advocacy (CAA), which are solely for the use of Barnet residents.

This report summarises the rationale for the recommendation to re-procure all advocacy services under a single tri-borough contract with a lead provider from 1st November 2022. The lead provider would be expected to subcontract to smaller specialist organisations, where beneficial, to reach diverse communities and meet a full range of accessibility needs.

Officers Recommendations

1. That the Adults and Safeguarding Committee approve the proposed approach to proceed with the planned re-procurement of the tri-borough advocacy contract, under a single provider approach, to include all statutory and community advocacy functions, namely Independent Mental Capacity Advocacy (IMHA), Independent

Mental Health Advocacy (IMHA), Independent Health Complaints Advocacy Service (IHCAS) and Care Act Advocacy (CAA).

2. That the Adults and Safeguarding Committee note the early termination of the Care Act Advocacy contract, in order that it be coterminous with the tri-borough and IHCAS contracts to facilitate tendering as proposed under recommendation 1.

1. Why this report is needed

1.1 The London Borough of Barnet is currently in a tri-borough contracting arrangement with the London Boroughs of Enfield and Haringey for the provision of Independent Mental Capacity Advocacy (IMCA) and Independent Mental Health Advocacy (IMHA). This contract ends on 31st October 2022.

1.2 On 9th December 2021, the Policy and Resources Committee approved the Annual Procurement Forward Plan as a record of activity for 2022/23 – 2024/25. This authorised the re-procurement of this contract and Barnet are the designated lead authority for this contract cycle.

1.3 The council currently has separate contracts in place for the provision of Barnet-only Independent Health Complaints Advocacy Service (IHCAS), ending 31st October 2022 and Care Act Advocacy (CAA), due to end 31st March 2024. The CAA contract delivers statutory advocacy in relation to social care needs.

1.4 Following extensive research and engagement with neighbouring boroughs, officers' recommendation is to procure a single provider to lead the delivery of advocacy services across the tri-borough footprint, covering IMHA, IMCA, IHCAS, CAA, from 1st November 2022. The report will set out our rationale for this approach and the benefits we expect it to deliver for residents.

2. Context: advocacy services

2.1 Advocacy services fulfil important statutory functions on behalf of local authorities as required under the Care Act (2014), the Mental Capacity Act (2005) and the Mental Health Act (1983, as amended in 2007). They provide independent support to residents to ensure their voices are heard; empower people to exercise their rights and to be involved in decisions that affect their lives.

2.2 The provider market for advocacy services is relatively small nationally, with a handful of providers holding a majority of the market share and the necessary skills and expertise to deliver at scale. There are a number of smaller, specialist providers working with particular cohorts, for example people with learning disabilities and different ethnic and faith groups. These providers often work at borough-level and tend not to bid for large contracts that reach outside of their area of specialism.

In Barnet we are currently working with two of the large national providers across our three advocacy contracts. We do not have any formal advocacy arrangements with any of the smaller providers in the borough.

2.3 Our new contract arrangements will need to account for several upcoming changes to legislation and codes of practice that are likely to require changes to ways of working and increase demand for advocacy services:

- The Mental Capacity (Amendment) Act (2019), which will replace the Deprivation of Liberty Safeguards (DoLS) with Liberty Protection Safeguards (LPS).
- The introduction of a revised Mental Capacity Act Code of Practice to support the implementation of LPS.
- Proposed legislative reforms to the Mental Health Act (1983, as amended in 2007) expected to included clearer, stronger detention criteria and give patients more substantive rights to challenge detention.

Timescales for these changes are not yet known nationally, but it is envisaged that some funding will flow to support implementation.

3. Reasons for recommendations and alternative options considered

3.1 Monitoring information demonstrates that Barnet's current advocacy services are effective and provide good outcomes for residents. However, people accessing the services have shared feedback that their case can be passed between organisations or has needed to be dealt with by two organisations if pertinent to health and social care, which requires them to tell their story multiple times. This feedback prompted officers to appraise the benefits and drawbacks of procuring via a single provider approach:

Approach	Advantages	Drawbacks	Mitigations
Single provider	• Residents need only to tell their story once • Ability to refer internally to meet a range of needs • One front door = no wrong door • Efficiency gains associated with a single referral system • Streamlined contract monitoring and KPI tracking • Reduced failure demand • Scope for economies of scale, particularly at a management level maximising budget for service delivery	• Potential loss of small organisation specialisms who are not able to act as the lead provider • Risks attached to contracting with one provider, if they were to fail to deliver • Potential to lose the individual within a large organisation approach	• Using market warming and engagement and the tender process to actively encourage / require subcontracting / consortium arrangements, with a particular focus on reaching diverse communities and meeting a full range of accessibility needs • Ensure the tender process includes thorough evaluation of the lead provider's ability to deliver
Separate lots for each type of advocacy	• Potential to have a specialist / more experienced provider for each advocacy service • More accessible for smaller providers to deliver an entire lot themselves	• Less cost effective due to fewer economies of scale • More protracted procurement process • Greater demands on performance management for each service/provider • Multiple points of entry and referral systems increase potential for failure demand and delayed responses to resident needs • Inability to refer internally to meet a range of needs	• Undertake robust financial assessment in the tender process to ensure maximum cost effectiveness • Commissioning role to ensure providers delivering separate lots work well together to reduce failure demand / poor resident experience

3.1 Working with a single provider for advocacy services would align Barnet with the majority of other London boroughs who commission their services in this way. Statutory Care Act guidance also encourages local authorities to consider merging advocacy services in order to improve continuity for those that access them (Care and Support Statutory Guidance (2014), Chapter 7, Section 7.57).

3.2 Following the review of guidance, benchmarking, Strength, Weakness, Opportunity, and Threat (SWOT) Analysis and considering the feedback received, it is proposed that the advantages of the single provider approach outweigh the drawbacks, particularly when considered alongside the mitigations officers can implement. The Committee is asked to endorse this approach.

4. Post decision implementation

4.1 A competitive procurement process for the tri-borough contract was already scheduled for Spring 2022. We intend to maintain this schedule, with amended tender documentation aligned to seeking a single lead provider. The commissioning team will work with colleagues in Enfield and Haringey to design a process that will suitably test providers' ability to deliver the full suite of services and achieve best value for money, as well as their plans to collaborate with other local organisations and ensure that the needs of diverse communities are met.

4.2 Service specifications will be co-designed with residents to ensure they fully reflect their feedback and expectations. Resident representatives will also be involved in the evaluation process.

4.3 The terms of Barnet's existing CAA contract include provision for early termination with three months' written notice.

5. Implications of decision

5.1 Corporate Priorities and Performance

5.1.1 The Barnet Corporate Plan sets out our ambitions to work "in a strengths-based way, recognising people's goals and aspirations" and ensuring residents "have greater choice and control over the care they receive". Advocacy services play a valuable role in empowering residents to articulate their goals and aspirations, to be involved in decisions that affect their lives and to challenge us when health and care services do not deliver the high quality of service that we expect. Advocacy services also play a vital role in supporting residents to challenge inequalities in the access to, and delivery of, services.

5.1.2 Commissioning a single lead provider for advocacy, creating one front door, and encouraging collaboration with smaller local organisations, will further support corporate priorities by making services easier to access (a top 3 priority for Barnet residents), strengthening partnership working between organisations and acknowledging the value of local community-based support.

5.2 Resources (Finance & Value for Money, Procurement, Staffing, IT, Property, Sustainability)

5.2.1 The planned procurement will remain within the financial limits within the Forward Plan

agreements for all affected contracts, £493,291 per annum, be met by the existing Adult social care budget.

5.2.2 Barnet's contributions to existing contracts up until the proposed end dates of 31st October 2022 are as follows:

6.	Contract Term	Annual contribution	Global contribution for contract term
IMCA and IMHA (Tri-borough contract)	01/11/18 - 31/10/22	£111,021	£ 444,084
IHCAS	01/04/21 – 31/10/22	£59,088	£93,556
CAA	06/04/21 – 31/10/22	£122,161	£193,422
Totals		**£292,270**	**£731,062**

The proposed new contract will be funded from within the prevention cost centre in the adult social care budget, which is – currently £7.887m in 2021/22.

6.1 Legal and Constitutional References

6.1.1 Article 7 of the Council's Constitution sets out the terms of reference of the Adults and Safeguarding Committee which includes the following responsibilities:

(1) Responsibility for all matters relating to vulnerable adults, adult social care and leisure services.

(2) Work with partners on the Health and Well Being Board to ensure that social care, interventions are effectively and seamlessly joined up with public health and healthcare and promote the Health and Well Being Strategy and its associated sub strategies

6.1.2 Legal advice has been sought in relation to early termination of the contract for CAA. Early termination with three months' written notice is within the contract terms and is therefore legally permissible.

6.1.3 The duties to provide advocacy services are found as below:

6.1.4 Independent Mental Capacity Advocate is found at s35 of the Mental Capacity Act 2005.

6.1.5 Independent Mental Health Advocate duty arises in s130 A of the Mental Health Act 1983, as amended by the Mental Health Act 2007.

6.1.6 The Care Act advocacy duty is at sections 67/68 of the Care Act 2014 and in the Care and Support (Advocacy) Regulations 2014.

6.1.7 The Independent Health Complaints Advocacy Service duty is found in the Local Government and Public Involvement in Health Act 2007, as amended by the Health and Social Care Act 2012.

6.2 Insight

6.2.1 Although monitoring data demonstrates the positive outcomes being achieved by advocacy services, research on alternative models and feedback from residents has given us sufficient evidence to support the recommendations made in this report. The commissioning team will work with care quality colleagues to establish new monitoring and reporting requirements that are aligned to the new contract.

6.3 Social Value

6.3.1 Providers will be tested on their ability to offer social value through this contract in the tender process at 10% weighting. Collaboration with smaller local organisations will also contribute to social value outcomes.

6.4 Risk Management

6.4.1 There are limited risks associated with the recommendation to procure advocacy services from a single lead provider. There are some risks associated with early termination of the contract for CAA, although these will be mitigated through our positive working relationship with the provider. Risks and mitigations are outlined below, and further references are made under section 3.1

Risk	Mitigations
• Damage to relationship with provider • Viability of provider • Impact on current service delivery and performance	• Early engagement with provider • Market analysis and assessment of impact – council contract is not material to provider viability • Robust contract and relationship management

6.5 Equalities and Diversity

6.5.1 Procuring a lead provider model with expectations around subcontracting with smaller local specialist organisations will strengthen capacity to reach diverse communities and meet a full range of accessibility needs.

6.6 Corporate Parenting

6.6.1 Advocacy services work with all adults 18+, including those for whom Barnet hold corporate parenting responsibility and those who are care experienced.

6.7 Consultation and Engagement

6.7.1 We will be co-designing the service specifications with residents to ensure we fully reflect their feedback and expectations and involving residents in the evaluation process.

6.8 Environmental Impact

6.8.1 The environmental impact of this service is minimal; however, we will be expecting the successful provider to consider this as part of their social value contributions. This may

include offering a blended online and face-to-face service, thus minimising travel requirements.

7. Background papers

7.1 N/A