AGENDA ITEM 5

BRISTOL CITY COUNCIL
Health and Well Being Board
16th December 2015

Recommissioning of Children's Community Health Services

Bristol Wide All Wards

Strategic Director: **Alison Comley/John Readman**

Report author: **Anne Colquhoun/ Rebecca Cross**

Contact telephone no. **0117 9223696**
& e-mail address: **anne.colquhoun@bristol.gov.uk**
Rebecca.cross@bristol.gov.uk

1. Purpose of the report:

To update the Health and Wellbeing Board on changes that have been made to the proposed service model following feedback received from the consultation on the proposed values, outcomes and service model for Children's Community Health Services.

For the Mayor to approve the procedure to be adopted for the commissioning of the new services in conjunction with partner agencies, including the delegating authority to the Programme Board.

2. RECOMMENDATION for the Mayor's approval:

The Health and Wellbeing Board are asked to agree;

- to the proposed joint working arrangements (and enter into a formal agreement to record these),
- to the CCG acting as lead in connection with the procurement, and
- to the delegation of powers to the Programme Board regarding all aspects of the proposed procurement process, (including determining the appropriate procurement procedure, finalising the service specification, selection and contract award).
- Delegate to the Director of Public Health and Service Director Strategic Commissioning People Directorate, authority to conclude all necessary contracts.

3. Executive Summary

The contract for children's community health services will be renewed from April 2017. Since 2014, commissioners from 6 different organisations across Bristol, North Somerset and South Gloucestershire have been working together to develop the new contract. There has been thorough and extensive public and professional engagement on the values, outcome and service model underpinning the contract. The feedback has been written into a report (this will be available for the Board, but is currently being refined)) and taken into account when finalising the service specifications ready to go

out for tender in January 2016. All commissioning organisations are individually receiving this report and through their own governance arrangements being asked to confirm agreement to proceed to tender.

4. Background

Community children's health services and child and adolescent mental health services (CAMHS) were re-commissioned by Bristol and South Gloucestershire PCTs in 2008-9. A contract for an integrated service covering the Bristol and South Gloucestershire areas was procured through a competitive tender process and the contract was awarded to the Community Children's Health Partnership (North Bristol NHS Trust and Barnardos) for five years with a two year extension option. This contract period will come to an end in March 2016.

In May 2015 NBT announced that they would not extend the contract beyond March 2016 and they would not bid for the 2017 contract. An interim provider has been secured for April 2016 until March 2017 and this is not covered in this paper.

5. Bristol CCG is the lead commissioner for the interim and substantive contracts. This was agreed through a joint commissioning arrangement by the Programme Board in 2014.

6. The commissioning responsibility for children's services sits with commissioners as follows:

- Bristol CCG (Community Paediatrics, Therapies and CAMHS)
- South Gloucestershire CCG (Community Paediatrics, Therapies and CAMHS)
- Bristol City Council ,Public Health, (School Nursing, Health visiting, Family Nurse Partnership, Young People's Substance Misuse Treatment Services)
- Bristol City Council, People (CAMHS, Therapies, Early Years Key workers, Children Looked After Nursing)
- South Gloucestershire Council ,Public Health (School Nursing , Health Visiting, Family Nurse Partnership)
- NHS England (Immunisation Services)

7. The timetable for the procurement is below

Activity	**Date**
Engagement	April – July 2014
Engagement Feedback	3 Nov- 8 Dec 2014
Feedback analysis and service model development	Nov 2014 – May 2015
Write draft service specifications	Nov 2014 – May 2015
Governing Body approval processes	June/July 2015
Consultation period	Sept - Nov 2015

Revise service model and specification	Mid-Nov to Dec 2015
CCHS Procurement Programme Board sign off final service model, specification, tender evaluation process and approval to start tender process	Jan 2016
Advert	Jan 2016
Procurement phase	Jan to Sept 2016
Contract award	Sept 2016
Service transition phase	Oct 2016 – Mar 2017
New service start date	April 2017

8. Consultation

From April 2014 the commissioning organisations have worked together to seek the views of children, young people, parents, carers and health, education and social care professionals on the current children's community health services and how we can use this opportunity of re-commissioning to make improvements to the services. This phase was known as the engagement phase and the results of this work can be found on the Bristol CCG website at

https://www.bristolccg.nhs.uk/media/medialibrary/2014/11/childrens_chs_involvement_1.pdf

9. In September 2014 it was agreed that there needed to be further involvement to allow for co-design and co-production of the service model and service specifications with patients, public and health and social care professionals. A revised procurement timetable was developed to enable a full 12 weeks of final consultation to be conducted before the tender process commences in January 2016.

10. The 12 weeks consultation period commenced on 3rd September and ended on 25th November 2015. In order to ensure as much engagement as possible several methods were used;

- Interactive consultation web-pages that described the key aspects of the service and asked the key consultation questions. The option to request a printed version of the web pages was possible. The web site was introduced by an animation developed and voiced by members of the Young People's Reference Group
- Many organisations invited commissioners to present the consultation web pages at their meetings and gain feedback
- A professional engagement event was held where health, social and educational professionals were invited to discuss the consultation issues.
- The web site also held copies of the individual service specifications on which comments were requested
- Analysis during the consultation period of who was responding with extra effort to engage groups that were not responding

11. The feedback from consultation highlighted these main areas;

Public and professional feedback indicated agreement with the proposed model, values and outcomes, but thought there were too many and they should be simplified.

1. We need to manage expectations as the proposed service models are ambitious

2. There was a need to better understand the links to health and social care and education and how pathways will be developed

3. The importance of service integration

4. How communication is key to everything

A full report is attached at Appendix 1 (will be added)

12. Bristol City Council Specific Consultation and scrutiny input:
The recommissioning has been discussed at the following meetings:

Cabinet agenda conference November 2015
Neighbourhoods and People joint Scrutiny meeting September 2015
Presented to health and Well Being Board in June 2015 for information on procurement process and progress to date
Discussed with Assistant Mayors May 2015
Discussed with Mayor, May 2015
NLT/PLT May 2015 and November 2015

Discussed at SLT April 2015 and November 2015
Discussed at Children and Families Board March 2015 and November 2015

13. Specifications
In December following the consultation phase the service specifications will be revised to incorporate the feedback, these revisions will be agreed by the Programme Board in January.

1**4.** All of the engagement, involvement and co-production work has informed the service specifications to date. There is an overarching specification, individual service specifications and a quality standards document. The latter sets out the outcomes to be achieved which have arisen directly from the feedback received during engagement are available on request. The project team have taken the points identified as important to service users and set them under seven main headings with some examples of outcomes;

1. Service user experience
   person centred where they feel listened to and can get the care they need, increased independence, resilience and quality of life.
2. Early identification, intervention and service access
   helped sooner through shorter waiting times and earlier intervention
   find services are more accessible as they receive flexible integrated services.
3. Communication
   improved communication between families and professionals
   improved co-ordination of care through a key worker model
   feel better involved and informed about their care.
4 Integration of Services
   help will be available out of hours and responsive in a crisis receive co-ordinated, seamless services centred upon personal choices through integrated pathways and the voluntary sector.
5 Delivery of safe, high quality, evidence based services
   service users will receive safe services at the right time and place by a properly planned, educated and trained workforce.
   receive services that are Young People Friendly accredited
6 Workforce Requirements
   service users will be seen by workers who are culturally aware, passionate and skilled in engaging and working with children and young people.
7 Moving into adulthood
   service users will experience a good transition to adult services when necessary.

15. Measures will be further developed during competitive dialogue with the provider to ensure that we achieve the main high level outcomes.

16. Procurement process

The procurement process is described in appendix 2 including the pre procurement design and planning. There were two well attended market warming events held at the beginning of the process to ensure wide engagement and test the market. Procurement will commence on 1st February 2016, led by the South West Commissioning unit as

part of the CCG recommissioning project team. Commissioners form Bristol City Council will be members of the Procurement Board to work with other commissioners to ensure the best possible service providers are secured.

17. Governance

A collaborative commissioning agreement has been in place since 2014

18. There is a robust governance structure being overseen by the Children's Community Health Services (CCHS) Recommissioning Programme Board.

19. The purpose of the CCHS Recommissioning Programme Board is to direct the procurement of an agreed model of children's community health services and oversee the development of the related service specifications and contract documentation. The Programme Board will decide on the procurement process lot formations and make recommendations for contract award by the CCG.

20. The Programme Board is chaired by Bristol CCG Operations Director, Judith Brown and includes representatives from all CCGs, Local Authorities including the Directors of Public Health and South West Commissioning Support Unit who provide advice on procurement. Becky Pollard (Director of Public Health and Netta Meadows Service Director Strategic Commissioning (People) sit on this Board.

21. There is a Children's CHS project risk register which is reviewed at the Programme Board. Risks of 12 or above are raised to the Bristol CCG Governing Body and entered onto the Bristol CCG corporate risk register.

22 . The re-commissioning is managed by a project group which co-ordinate the work of the following work streams

- Patient and Public Involvement
- Professional Engagement
- Quality/Clinical Reference
- Communications
- Estates
- Information Management &Technology
- Finance

The reporting structures for the recommissioning are available on request.

23. Other options considered:

Due to procurement legislation the current contracts funded by Bristol City Council had to go out to tender.

Bristol City Council could have undertaken a reprocurement process as a single commissioner, but many services are integrated or joint across Local Authorities and CCG's which would have left services isolated and disjointed. Sharing the procurement will save costs both in procurement, but also in service provision by sharing management arrangements, building costs etc.

24. Some thought was given to bringing services in-house to be employed by Bristol City Council but due to the clinical nature of the majority of the posts, remaining as part of a larger service with shared clinical supervision and management made this option

less viable.

25. Risk management / assessment:

RISK Threat to achievement of the key objectives of the report	INHERENT RISK Before controls		CONTROL MEASURES Mitigation (ie controls) and Evaluation (ie effectiveness of mitigation).	CURRENT RISK After controls		RISK OWNER
	Impact	Probability		Impact	Probability	
By delegating to the Programme Board the endorsement of the recommendation to award contract, the council is not fully sighted in the decision making process.	High	Medium	Bristol City Council People and Neighbourhoods Directorates are represented at the programme Board and on the evaluation panel to ensure that the services commissioned by Bristol City Council are commissioned with the highest integrity for the best outcomes	High	Low	The Mayor
Lack of funding to sustain current service levels due to cuts to local authority funding both Public Health and other areas.	High	High	In discussion with preferred bidder/service provider, reductions in service provision will be agreed aiming to have minimal impact on service delivery	High	Medium	Becky Pollard

RISK Threat to achievement of the key objectives of the report	INHERENT RISK Before controls		RISK CONTROL MEASURES Mitigation (ie controls) and Evaluation (ie effectiveness of mitigation).	CURRENT RISK After controls		RISK OWNER
	Impact	Probability		Impact	Probability	
If BCC do not agree to proceed to tender in January other commissioners will proceed without BCC services resulting in no service provider in place to deliver services on behalf of BCC in April 2017.	High	Medium	The health and Wellbeing board is well briefed and informed of the robust processes in place to have confidence to agree to proceed to tender with partners.	High	Low	Becky Pollard

26. Public Sector Equality Duty 2011

The Commissioners have to ensure compliance with their obligations under the Equality Act. The main Public Sector Equality Duty (PSED) is comprised of three limbs (more commonly referred to as areas/ sections), set out in section 149(1) of the Equality Act 2010 ("the Act"):

The commissioners, in the exercise of their functions, have had due regard to the need to:

- eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under this Act;
- advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it;
- foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

The statute does not give us much information about what constitutes 'due regard', other than in very general terms in section 149(3). Therefore in order to approximate the definition of the term, courts take into account case law when interpreting section 149.

One of the leading cases in this context is the "Post Office closures case". This established six principles, known as the "Brown Principles":

- decision-makers must be made aware of their duty to have due regard to the identified needs;
- the Duty must be fulfilled both before and during consideration of a particular policy, and involves a "conscious approach and state of mind";
- it is not a question of ticking boxes, the Duty must be approached in substance, with rigour and with an open mind, and a failure to refer expressly to the Duty whilst exercising a public function will not be determinative of whether due regard has been had;
- the Duty is non-delegable;
- the Duty is continuing;
- it is good practice for an authority to keep a record showing that it has considered the identified needs.

The commissioners will ensure that the creation of a formal equality impact assessment is undertaken and that equalities have been considered at all times through the professional advice and guidance of the Programme's equality lead – the Equality & Diversity Programme Manager for Bristol CCG.

27. The Programme's Equality lead is a member of the Programme Board. An equalities impact assessment has been undertaken and is available on request.

28. Public Services (Social Value) Act 2012

The Act states that the CCG should consider (in a proportionate manner and only with regard to the specific services under discussion) how what is proposed might improve the economic, social and environmental well-being of the relevant area.

29. Eco impact assessment

There are no significant environmental issues arising from this proposal

30. Resource and legal implications:

31. Summary of Financial Arrangements

32. Bristol Local Authority will be a co-commissioner in the new re-commissioned service.
33. The contracts will be awarded for a period of "five plus two" financial years from 2017/18.
34. It is recognised that due to potential changes in budgets before and over the period of the contract, negotiations may have to take place with the provider before and during the life of the contract.
35. We are seeking Programme Board agreement to include in the particulars a clause that states any additional periodic rights (6 months) to review the scope or value of the services that we would require.
36. The table below indicates the draft current totals of funding streams identified by each commissioner for the contract from 2017 onwards.

Bristol CCG	South Glos CCG	Bristol LA	South Glos LA	North Somerset CCG	NHS England	17-18 available funding
£11,320,236	**£5,293,584**	**£11,471,629**	**£4,017,174**	**£3,073,015**	**£116,813**	**£35,292,451**

37. We will review the financial contribution to the 2017 substantive contract from Bristol City Council as a result of the funding cuts to public health budgets. This may result in changes to service provision.

38. The financial breakdown of the funding stream by BCC commissioned services is below.

Service	Funding Stream	Service Description/Notes
Public Health Funded Services		
Health visiting and Family Nurse Partnership	£7,902,282	Universal specialist service supporting under 5's to ensure children have best start in life. Includes specialist gypsy traveller post. FNP works intensively with 100 young parents under 19. Deliver healthy child programme
School Nursing	£1,302,894	Specialist nurses supporting young people to access help early and improve health. Deliver the healthy child programme.
Young Peoples Drug treatment service	£399,247	Specialist treatment service as part of CAMHS working with young people with problematic substance misuse.
Total Public Health Spend	**£9,604,423**	
People Directorate funded services		
Therapy Provision	£507,132	Primarily Speech and Language therapy for SEN children, Early Years Speech and Language Prevention and Early Intervention

CAMHS/ Learning disability	£965,224	CAMHS in schools, Early Help, with Looked after children, positive behaviour support to avoid placement or home breakdown and Be Safe for sexually harmful children
Early Years Key workers	£41,250	Working with children with SEN and their families.
Looked after children Nursing Team	£48,588	Provide LAC health assessments and provision.
Residential Short break nursing	£305,012	Part of pooled budget that funds nursing support
Total People Spend	**£1,867,206**	
Total BCC Spend	**£11,471,629**	

a. Financial (revenue) implications:
Commissioners have set out their view of funding streams that will be available for the contract from April 2017 based on analysis of existing funding arrangements. The funding streams will need to be reviewed as a result of the 6% reduction to the public health grant (effective from this financial year 2015/2016). This will lead to either a reduction in the funding streams for the re-commissioning or reductions in funding for other services within the Public Health.
In addition, the changes to schools funding indicated in the recent comprehensive spending review will need to be reviewed as more details emerge to identify any implications for the funding streams from the People directorate.
Advice given by **Robin Poole Finance Business Partner**
Date **26 November 2015**

b. Financial (capital) implications:
There are no capital implications
Advice given by **Robin Poole Finance Business Partner**
Date **26 November 2015**

c. Legal implications:
Notwithstanding the proposed delegations to the CCG and the Programme Board regarding the procurement process, any contract in respect of Council services will need to comply with the Public Contracts Regulation 2015. The procurement strategy set out in Appendix 2 indicates a recognition of the need to comply with EU requirements.
Advice given by **Eric Andrews, Senior Solicitor, Legal and Democratic Services**
Date **27/11/15**

The Council is required to make fair and reasonable decisions. To ensure a decision is fair, consultation should be undertaken with those affected. The council has jointly funded the CCG to undertake consultation in this case.
Principles of proper consultation have been developed through case law and can be summarised as follows:

- it must consider carefully who should be consulted and how (linked to those who are potentially affected by the decision and should include those who are likely to support the proposals as well as those who are likely to object);

- consultation must be at a time when proposals are still at a formative stage;
- sufficient reasons must be given for any proposal to enable intelligent consideration and response,
- adequate time must be given for consideration and response;
- the product of consultation must be conscientiously taken into account in finalising any proposals.

A report will be presented to the meeting to set out in detail how this has been complied with.

Advice given by Nancy Rollason, service manager and interim deputy monitoring officer
Legal services
Date 8th December 2015

d. Land / property implications:
All costs of buildings and premises are included in the allocated costs from each commissioner and will be managed by the service provider.

e. Human resources implications:
TUPE legislation will apply as a result of recommissioning however there are no impacted staff currently employed by Bristol City Council. As this work develops HR will review for potential workforce implications and provide the necessary advice to ensure any TUPE is effectively managed.

Advice given by
Richard Billingham/ Service Director HR
26/11/15

Appendices:
Appendix 1 – Consultation Report
Appendix 2 - Procurement Route

In partnership with Bristol North Somerset and South Gloucestershire Clinical Commissioning Group and NHS England

Recommissioning of Children's Community Health Services Consultation Report

December 2015

Contents

Consultation report

1. Introduction

Bristol, North Somerset and South Gloucestershire (BNSSG), as part of the commissioning process, aim to improve Children's Community Health Services (CCHS) for this area. This report describes the process and outcomes from the consultation undertaken as part of the re-commissioning of these services. It captures how the Clinical Commissioning Groups (CCG), Local Authorities (LA) and NHS England (NHSE) have engaged with the public, professional groups and the voluntary sector; the consultation process, the feedback received and the next steps to be taken.

A 12 week consultation was held between the 3rd September and 25th November 2015 and involved an online consultation and range of community meetings and events to proactively seek the views of stakeholders within Bristol, South Gloucestershire and North Somerset.

Before the consultation, the commissioners undertook an extensive engagement and involvement phase which began in March 2014 and ran until July 2015 where people were asked what we should do to improve services. We used this feedback to develop the model, value and outcomes as well as the service specifications.

This consultation sought to hear the views of stakeholders about the proposed set of values, new model and outcomes for the future CCHS. It gave us the opportunity to check that we heard people correctly during the engagement phase.

Services are changing because of the changing demographic needs and size of our local population. In Bristol the number of children under the age of five has risen by 22% in the last five years. The fastest increase has been in the most diverse inner city and eastern areas. In South Gloucestershire there was a 10.2% increase in children under the age of four in the five years leading up to 2012. In 2008 there were a total of 47,000 children and young people aged 0 – 19 living in North Somerset, about 23% of the total population along with a 17% increase in births since 1999. Our final commissioned service needs to make the most effective use of the resources which are available both in health and other services to meet the needs of children and young people; and be better coordinated and integrated.

This report describes our approach to consultation and the methods used to capture the emerging themes from the feedback. It presents the overall findings from the consultation process, captures what we heard and reports on key recurring themes arising in the feedback. Although all the feedback has been considered, it does not report on every comment received. It focuses on the key themes in a colourful summary form. It is suggested that this report should be read in conjunction with proposed changes to the care pathways contained in the consultation document available at www.yourhealthyfuture.org

The report is specifically written in a manner so that young people will be able to read and understand the conclusions drawn.

2. Background: the story so far

The services that fall within CCHS include: health visiting, school nursing, child and adolescent mental health services (CAMHS), speech and language therapy (SALT), occupational therapy and physiotherapy, community paediatricians, and a range of dedicated services for vulnerable children including children in care, children with learning disabilities, children with life limiting conditions and children with drug and alcohol problems.

During the engagement phase we heard extensive feedback from children, young people, parents and carers, voluntary community service groups and professional groups. Engagement with groups was facilitated in a number of ways. There were also opportunities for the public to fill out a survey, write in, telephone or be a part of a focus group.

An important concept for the CCHS re-commissioning is to ensure that equality and inclusion is integrated into all phases of the project to enable us to meet our public sector equality duty. Therefore the focus for the activity for the engagement phase was to ensure, as far as possible, that the engagement activity mirrored the local demographics of Bristol, South Gloucestershire and North Somerset and that our approach was and continues to be inclusive.

Commissioners heard a variety of feedback during the engagement phase, some positive but also a number of concerns expressed from both adults and young people. A summary of that feedback can be found in Appendix 1.

From the outset, we have developed our proposals for improving these services in partnership with parents, carers, young people and the professionals who support them. For example, the discussions we had in the initial period of public engagement helped us to develop a series of draft service specifications. In addition, the clear aspirations for these services from parents, carers and young people helped us to identify the values that should underpin the services, as well as the model of care.

Throughout this extensive process of engagement we have always tried to listen and learn to make sure that we do understand what people are telling us, and that we are reaching out to hear a range of views.

This public consultation, which was held for 12 weeks from the 3rd September to the 25th November 2015, on the re-commissioning of CCHS has been our final, public checkpoint in the development of a new approach to the commissioning of these services. It has given people the opportunity to check whether their views have been understood and taken into account in the development of the values, model and outcomes.

3. Methodology

Listening to the feedback we heard in the engagement phase and especially in relation to services needing to have a bigger online presence, the Commissioners decided, with the assistance of the Young People's Reference Group (YPRG), to

develop an online consultation in the form of a new website www.yourhealthyfuture.org which was a “first” for the Commissioners.

We were consulting on the values, the models and the outcomes. However, for openness we included the draft service specifications and allowed users to provide feedback to these if they wished. Although this was not part of the formal consultation any comments received will be reviewed by the Commissioners

There were different ways for the public and professional groups to feedback; they could respond by email, write, attend a focus group or telephone and there was printout option of the consultation questions to post back for those who preferred it.

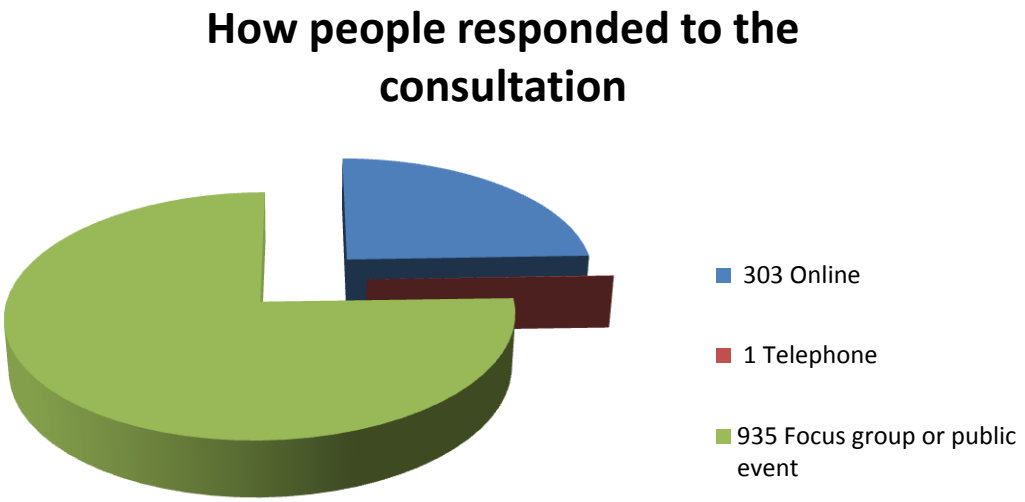
The content of the online consultation was written for young people. The website led the user through a journey from how we developed the values, models and outcomes, the questions we wanted answered and then how we would use the information received.

An advantage of being online was that changes to the wording could be altered right up to the moment that the website went live and also during the consultation. This allowed us to respond to feedback from those trying to navigate the website and make it easier for future users.

From the outset, the design of the consultation has taken into account the diverse needs of the populations it is aimed at. During the engagement phase, we had learnt that our communities access information (and therefore the consultation) differently, and as a result we needed to design a consultation process that would accommodate these diverse needs and by doing so engage with as many people as possible in this process.

Deciding to do an online consultation has allowed it to be more interactive for users with different needs, for example there was an audio browse aloud option (this reads the text aloud for users) , a translation bar that translates the text into other languages, which can then be listened to, a British Sign Language introduction as well as an easy read introduction. Therefore the consultation was more inclusive and accessible to more people than the usual paper based consultation.

In total 303 people responded to the online consultation. In addition to the online consultation 81 face to face events or focus groups were held across BNSSG with 935 people attending. A full calendar of events can be found in Appendix 3. In total there were 1240 people contributing to the responses and the chart below shows the breakdown of these:



3.1 How did we select the current methods for consultation?

The ongoing Equality Impact Assessment (EIA) for the re-commissioning of CCHS informed the design and approach to the consultation. Out of the variety of consultation methods/tools (Table 1) open to us, we selected the following approaches which we anticipated would address the areas of improvement identified and feedback received during the engagement phase.

Table 1: Outline of the tools/ methods used in the consultation

Method/ Tool	Comments
Web based consultation: Your Healthy Future.	The "Your Healthy Future" website has been designed with the following features: • Young person's involvement in the development of the website through the Young People's Reference Group, which has been expertly facilitated by the CCHS PPI lead. • Built in accessibility and usability testing, with a specific focus on the accessibility of the consultation site by people that are visually impaired. • A specifically commissioned sign language introduction to the consultation process. • The use of Google translate and browse aloud (whilst acknowledging their limitation, it can still assist in breaking down language barriers) • A design that is compatible with a variety of screen readers to offers access for visually

	impaired users. • Accessible design which is engaging and aims at presenting key concepts in a simplistic fashion to encourage more people to offer their views on the values, model and both the single & multiple needs pathways.
Focus groups	Focus groups have been set up to accommodate the needs of individuals and/or groups where a web based consultation is not suited.
A facility to request alternative formats (easy read, paper based documents etc.).	The Communications team have organised a range of publicity events (interviews, postcards and posters etc) to ensure that our communities are aware of the consultation time frame, and whilst initially directing people to the "Your Healthy Future" website, a telephone number to receive and respond to queries for alternative formats.

Throughout the engagement and consultation process it has been important for us to ensure that we were hearing a diverse range of views from all sectors of the community. Importantly, the online survey allowed us to include equality monitoring questions. Whilst the completion of these questions was optional, this data where provided, was vital to help us ensure that we understood the needs of our communities and to check that we were reaching out to all sectors of the local population.

There was a mid-point review during the consultation to evaluate the current number of responses and for a more in-depth look at the community members who were responding. This allowed us to identify any potential gaps in the reach of the consultation and to renew effort in reaching these groups.

From this mid-point analysis identified that we had a lower response rate than we might wish from men and the lesbian, gay, bisexual and transgender communities. In order to attempt to address this gap, South Gloucestershire contacted Barnardo's and asked them to publicise the consultation with Fathers' Groups which they engage with. We also contacted Off the Record to ask them to promote the consultation with the Freedom Project which works with LGBTQ young people, including those from South Gloucestershire. We also made contact with the Diversity Trust who posted the link to the consultation on their Twitter feed (1300 followers) and Facebook pages (500 reach) including two pages aimed at LGBTQ young people.

For Bristol this mid–point review identified that we had a lower response rate than we might wish from the black and ethnic minority communities (BME) and young people under the age of 15. Therefore the Bristol CCG contacted and identified further organisations, such at the BME forum and youth clubs that work with BME and also younger community members. The YPRG then had a second attempt in their schools and local areas targeting younger people and local youth groups.

For North Somerset from the mid-point review we identified that we needed to target the Gypsy, Roma, Traveller (GRT) Community in North Somerset and the Lesbian, Gay, Bisexual and Trans (LGBT) young people. We developed our relationships with professionals and community groups such as the North Somerset Corporate GRT Group and the North Somerset LGBT Forum and HERO a voluntary organisation working within in Churchill Academy.

4. Who have we worked with and involved in the consultation

We know that listening to people helps us to design better services. Both the Local Authorities and the CCGs have a duty to involve patients, carers and the public (including children and young people) in the development of commissioning plans to change and develop local health services. Whenever decisions are made about improving or changing services, we need to be confident the decision is properly informed by public opinion. It therefore makes sense to recognise the value of involving young people and children themselves in decisions about the services they use. Research shows that the effectiveness of any changes to services young people use is greatly enhanced by involving young people in discussion and consultation. During our consultation we aimed to reach and involve not only children and young people, but parents, carers and professionals across Bristol, North Somerset and South Gloucestershire. In order to allow as many people to be consulted with as possible, we contacted a vast number of organisations explaining how to access the online consultation through the website, and the offer of face to face engagement. We also contacted all, and revisited most, of the previous participants involved in the engagement phase.

4.1 How have young people been involved?

Young people have consistently worked with us and been involved throughout the whole recommissioning process of CCHS.

We have engaged with a variety of young people in many different ways. Alongside the 46 young people, aged 11- 24, who replied online, we consulted with 292 young people face to face.

One group who we worked with particularly closely was the Young People's Reference Group (YPRG).

4.1.1. How the Young People's Reference Group (Young Healthwatch) worked with us to co create the consultation - this section has been jointly written by the members of the YPRG

The YPRG are a group of volunteers, between the ages of 13 - 25, which began in April 2014 as a way for young people to be consistently involved in decisions about the future of CCHS. Some young people in this group wanted to get involved as "they have had first-hand experience of the services being recommissioned or have an interest in improving these services". This group gave a voice to the young people from all backgrounds to collaborate together and express there feeling about community health services and what they would like to see improved or changed. Many members of this group have a great interest in finding out more about how the NHS functions and what goes on behind closed doors in one of the world best healthcare service.

The YPRG have met once every six weeks, to discuss all aspects of the recommissioning process. The group is run jointly by Bristol CCG and Healthwatch Bristol but has members from North Somerset and South Gloucestershire. This group has been influential throughout the recommissioning process so far for example during the engagement phase, not only did the group contribute and gather feedback on services, they helped to co-created the new pathway (model) that was consulted on. The new pathway took into consideration the feedback from the public in Bristol, North Somerset and South Gloucestershire as well as professional groups. As a group they discussed their key priorities and values "that they would like to achieve from this new pathway and then implemented them". The YPRG expressed that they were proud their "pathway model was a part of the online consultation".

Following the decision by the commissioners to use an on line consultation, the YPRG voted for this, rather than a typical paper based consultation as they believe it to be more accessible for young people. The group believed that allowing young people to view the consultation online or on their phones in a format that was accessible, quick, easy and anonymous, would result in a higher response rate. The group helped design the website "by constantly bouncing ideas off of one another to see what would look best and what language would encourage others to comment. The group suggested that the best way to promote this consultation and reach young people would be to make a short, funny quick animation. Some of the group members featured as characters in the animation and their voices were used". The group then acted at ambassadors in their local areas and schools to promote the consultation with the postcards they helped design. They promoted it through organising and delivering school assemblies and sharing the web links through social media.

“We chose to do an animation because it’s would be easier and more interesting for young people to understand. Also with many young people accessing the internet today, they can see it and share it on their news feed, on their social media websites, and it is the first thing they see when they visit the ‘your healthy future’ website. The process began when we came up with a script for the animation. We had to make the script so that we clarified all of the main points to cover, as well as making sure that the animation could go smoothly, and so it was not too long for the audience. Young viewers can get bored easily but also we didn’t want it to be too short for the audience to not understand. After we had finished with the script, we then booked a recording studio so we could voice and record our characters. We then got to see drafts of the animation to make sure it was perfect for everyone. We finally got to see the updated version of the animation on the website which we shared on our social media and promoted around our schools”

The YPRG believe the online consultation to have been “an incredibly useful platform to allow young people to share their views about the draft reforms regarding the children’s community health service. The online consultation has allowed young people in the local area to provide feedback, in a more accessible way and remain completely anonymous at the same time. This has been of utmost importance as it has removed possible barriers, such as embarrassment, that often prevent young people from having the confidence to share their views”.

"The online consultation has been a great success due to the internet's ability to attract a huge audience of young people, enabling the collection of feedback. This feedback will play a fundamental role in ensuring that the new reforms to children's community health services will provide the most effective, high quality care to Bristol's young people"

"Involving young people in the consultation has been an extremely important part of the process. Young people have very specific needs and services, especially community health services, need to be tailored around them. Community health services are a huge part of a young person's experience with the healthcare system. Having young people involved enables them to truly represent their age group, so their point of view can be heard. Without the involvement of young people, decisions are made based on factual, or numerical, evidence rather than on the opinions of the service users. This consultation has been an example of where young people have truly managed to change the way their services are run. For this reason, the involvement of young people has been meaningful, rather than tokenistic. This has been seen throughout this consultation process through the involvement of the Young People's Reference Group. The group has allowed young people, of various ages and backgrounds, to give feedback on existing services and suggestions as to how they could be improved upon. It has played a vital role in allowing young people's voices to be heard"

The YPRG has merged to be called Young Healthwatch, and as the recommissioning changes focus the volunteers will continue on to work with Healthwatch. The Young People's Reference Group is a an exciting and innovative example of involving young people in the commissioning of their own services and demonstrates how powerful a consultation can be in reaching young people when they are also involved in its design.

4.2 How have we worked with parents?

During the recommissioning of CCHS we have understood that effective and meaningful consultation will depend on good involvement with parents and carers.

The Commissioners continued, throughout the consultation, to build on the dialogue with parents/carers started during the engagement phase. We have met with Bristol and South Gloucestershire Parent/Carers and The National Autistic Society Parent representatives and ensured that there has been parent and carer involvement throughout the recommissioning process. Not only has their input directly informed our draft specifications, but they have also helped us in the design of the online consultation.

Furthermore many parent carer organisations around BNSSG were contacted at the beginning of the consultation and sent an email to raise awareness of the consultation with a direct link to the webpage, plus an offer of face to face meeting to discuss the consultation. Details of those groups we met with are included in Appendix 2. We will continue to work with and involve parent and carers during the next steps of the tendering process for CCHS.

4.3 How have we worked with professionals?

A successful consultation will ensure that all stakeholders are given the opportunity to give feedback. We recognise the importance of involving not only parents, carers and young people, but also the need to involve the professionals delivering the current services who will have views on how these services should be delivered in the future.

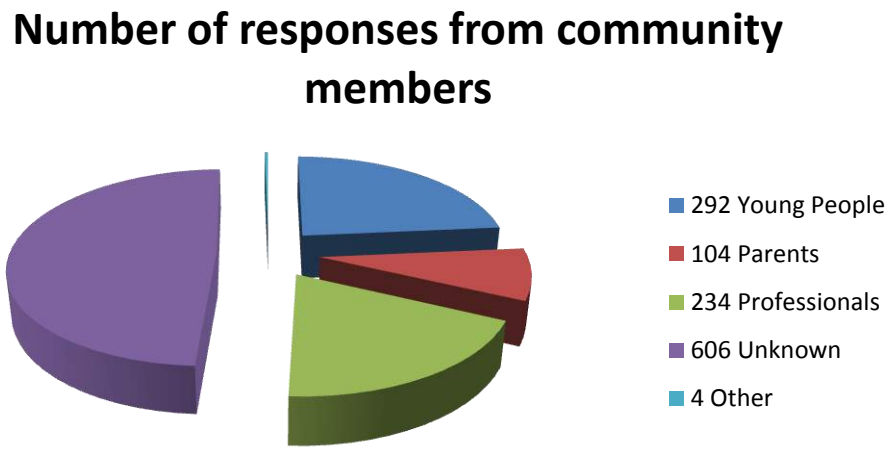
An event was held at the beginning of October to which professionals from across BNSSG were invited. Professionals were invited from health, social care and special schools to provide feedback on the consultation. The event was attended by 49

people across BNSSG. The professionals, in facilitated group workshops, gave their views on the values, model and outcomes and were also encouraged to give individual feedback on the website. The session also covered the proposal to tender the services in lots. A number of health care professionals have provided feedback on the service specifications and these will be considered by the Commissioners and reflected in the draft specifications were appropriate.

Further opportunity for face to face consultation was offered at this event and accepted by some professionals. Other professionals from this event requested further consultation promotional material (the postcards) to help them publicise the consultation further.

5. Who have we heard from?

Throughout the consultation we have had an inclusive approach, which we have built on from the engagement phase. This has resulted in 1240 people involved in forming the responses to the consultation. An overall breakdown of those responses follows:



To see a further breakdown of who has responded to this consultation and analysis of community members by equality please see Appendix 4.

From the 303 online responses 193 chose to complete their equality monitoring questions; 46 of these were young people. Therefore 15% of the overall responses online were from young people. It is important to note that during face to face consultation it was not always possible to gather monitoring information. In total, we heard from a known 292 young people, which is 23% of the responses to the consultation. The online monitoring data suggests that the percentage of respondents who were aged 24 and under is not as high as we might have expected, given that this consultation was designed together with young people and aimed to directly meet their needs.

However, there are several possible explanations for this. Firstly, we have anecdotal evidence that in at least one case a group of young people discussed the

consultation together and then having reached consensus completed only one online consultation form. In this case this meant that instead of having twelve responses, we received one. If this had happened in even two or three cases, this could significantly alter the data we have.

Secondly, it is possible that young people are simply less likely to complete equalities monitoring information. For example when meeting a youth group called Mentality in Bristol, members there, stated they did not like to be “put in boxes” or fill out monitoring information. They also mentioned they felt this made things feel less confidential.

Thirdly, it is possible that parents and carers have communicated with young people and then completed the consultation on their behalf.

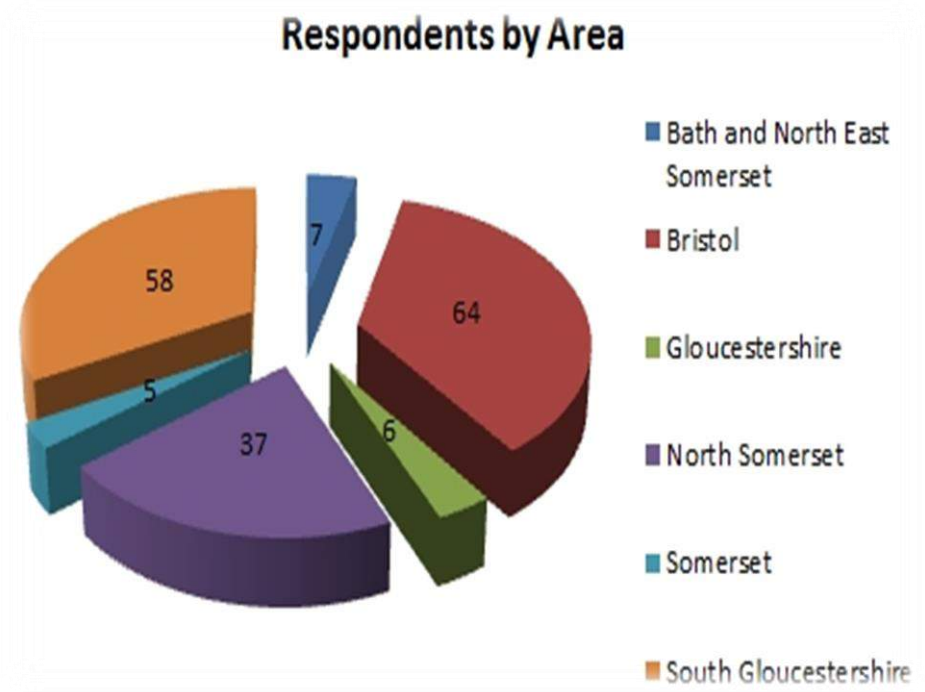
Fourthly, it is possible that young people went online, viewed the consultation information, looked around the webpage, agreed with what they saw and didn’t feel the need to comment any further. When showing the consultation webpage to a school class, the group navigated around the webpage, looked at the values, model and outcomes. They told to the facilitator that everything looked agreeable, when the facilitator asked if they had completed the survey they said no. They explained they didn’t feel the need to because everything looked okay and what they and said in the engagement phase had been heard.

From the data pulled from the online consultation we can see that 2,716 people visited the home page of online consultation and 939 of those went on to view the draft proposals. Appendix 5 shows further analysis on the general activity and number of visits or hits the website has had.

6. Consultation Feedback

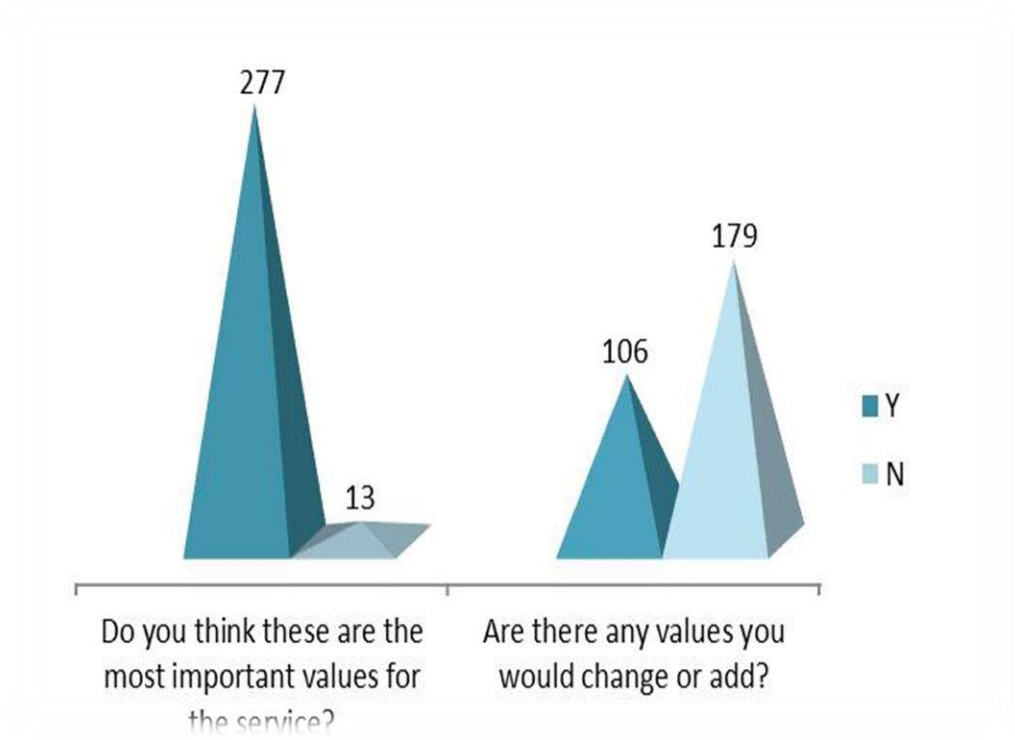
From the various methods of consultation offered, consistent feedback has been heard from many different sectors of the community. In total we heard the views of (either through focus groups or online) 1240 people on our service proposals.

The chart below demonstrates the number of online responses to the consultation received by geographical area. The chart reflects a representative response from across BNSSG. A detailed map of responses by postcode and area can be found in Appendix 6

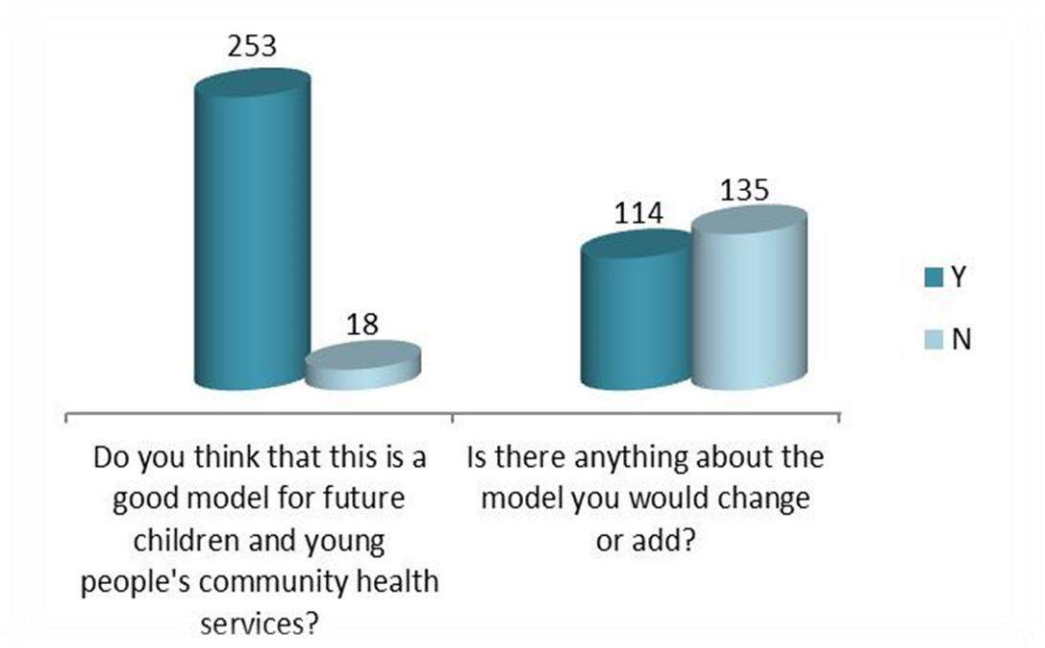


The feedback from the consultation is one of a positive message that the public are in favour of the proposed values, model and outcomes

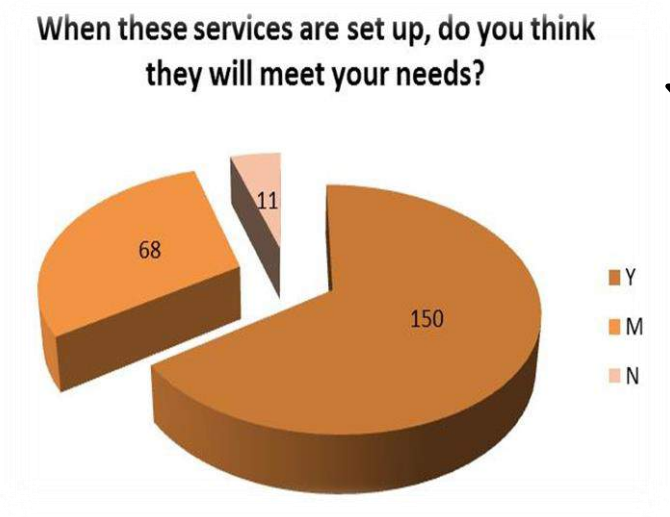
The following charts reflect the positive responses of the consultation questions asked on the values model and outcomes.



Of the 179 who said they would change the values, 101 provided further details and we will review these comments but overall these relate to how these values will work in the new service e.g. language, cultural awareness, staffing and funding.

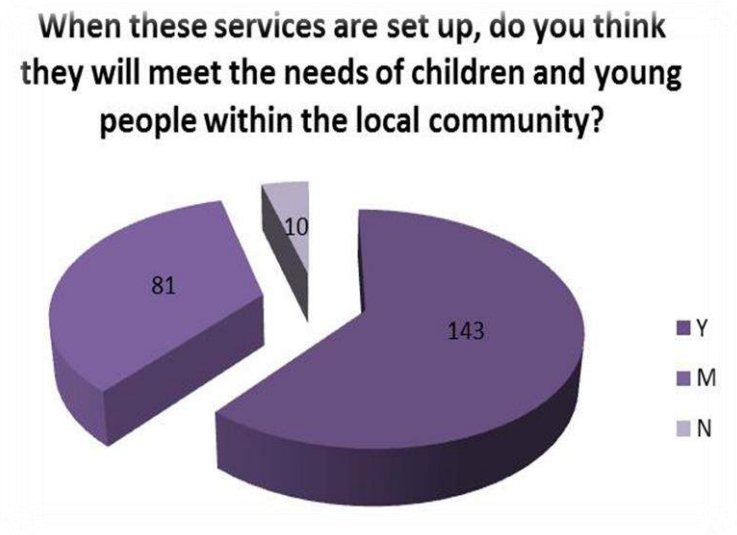


Of the 114 who said they would change the model, 108 provided further details and we will review these comments. Again overall these related to how the model would work in the new service and any are covered by the full draft specifications e.g. integrated IT systems. Again resourcing was raised and also timescales / waiting times



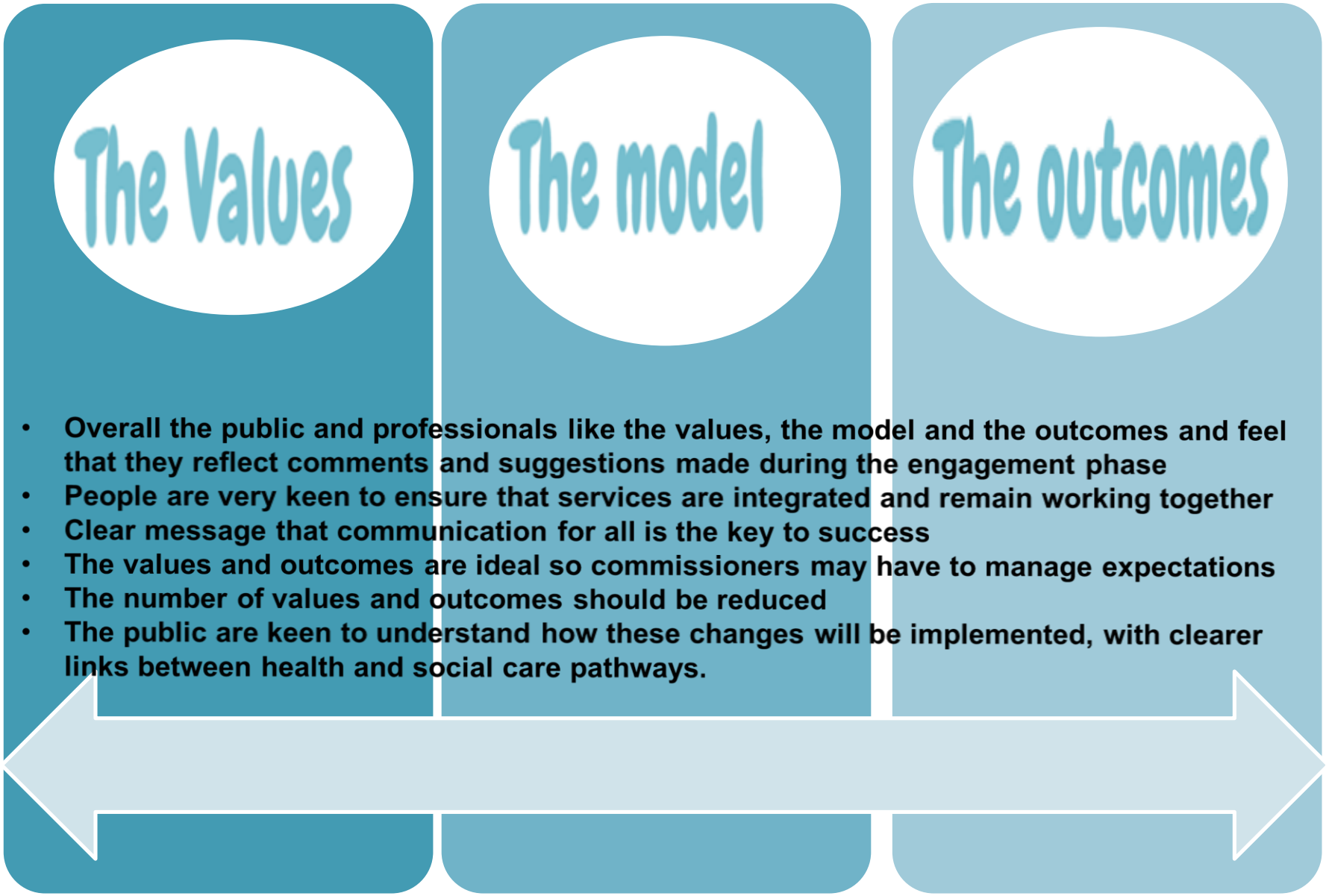
Of the 79 who responded No or Maybe 68 provided further detail and we will review these comments. The common themes were again how realistic was this, how it would be delivered and how would it be funded.

Of the 91 who responded No or Maybe 72 provided further detail and we will review these comments. Staffing, resourcing and delivery they were common themes.



These charts reflect the public's majority responses of being in favour of the proposed values, model and outcomes. The more detailed feedback received has now been collated, and the key themes drawn out. The detailed feedback responses can be found below.

Overarching Key Messages



- Overall the public and professionals like the values, the model and the outcomes and feel that they reflect comments and suggestions made during the engagement phase
- People are very keen to ensure that services are integrated and remain working together
- Clear message that communication for all is the key to success
- The values and outcomes are ideal so commissioners may have to manage expectations
- The number of values and outcomes should be reduced
- The public are keen to understand how these changes will be implemented, with clearer links between health and social care pathways.

The Values

Key Messages

- **Positive message - all the values are important; agreed across BNSSG**
- **We need to reduce and streamline the number of values by merging some**
- **Values should link directly to outcomes and indicators**
- **Ensure values are achievable and manage peoples' expectations**
- **Ensure the values are applicable to meet the needs of all young people and children**

What changes should we make to the values?

- Reduce duplications- some say similar things
- Change language to manage expectations.
- Should mention communication with those with learning difficulties & other specific communication needs e.g. BSL
- Important to include the sentence "or a guardian of choice" in case the parent/carer is the problem.
- Add a value about care at home/end of life.
- Staff to be diverse themselves not just culturally sensitive.

What young people said?

- Professionals to be more understanding and educated about all issues, e.g. gender identity.
- Professionals need to be open and honest.
- Information given is relevant and up to date.
- Need to be clear on what patient information should and shouldn't' be shared.
- Ensure that CYP, especially those with physical disabilities, can get to services
- Ensure communication with YP is in an understandable language

What did parents say?

- Most important is that people want to feel listened to
- Add a value around 'respect'.
- Add a more focused value on transitioning to adult services.
- A value around cultural sensitivity would be useful.
- Ensure they are not unrealistic and unachievable
- Include cultural competency and awareness training, so professionals can engage with families from varying cultures.

What did Professional's say?

- Reduce and streamline the number of values by merging some
- Ensure that stronger links with are made across all services including those with children's centres.
- Great values, but staff capacity impacts massively on these.
- There should be a mention of staff morale.

The Model

Key Messages

- **Overall there was significant support for the model**
- **Very positive feedback on complex needs model**
- **A line to be added for extra support if needed, e.g. an interpreter**
- **People ask for the model to give indicative time frames for care**
- **The model needs to include outreach services**

What could be changed?

- Care pathways should be created to address differing care needs whether simple or long term conditions.
- 'My care plan'- the model needs to be clearer as to when the care plan is developed.
- Ensure the model shows inter agency working with those who have multiple needs, not just clinical e.g. youth homelessness

What young people said?

- The model needs to reflect YP who require outreach, or who are in crisis
- Can there be an additional 'sub-step' before access.
- Add a link with hospital services.
- Doesn't support the needs for deaf YP. The service needs to be in a language they understand
- Some YP just want low key help - early intervention

What did parents say?

- Positive feedback! However reassurance needed on implementation.
- Lots of clarification wanted on the role of the key worker; could it be earlier in the pathway?
- Parents want services delivered locally to where they live
- Doesn't feel like the single needs model has been tested for children.
- Demonstrate clearer support for parents.

What did professionals say?

- Support for YP needs to be available throughout their care pathway.
- Reflects a health not an integrated social pathway for example with children centres or Gypsy Roma Traveller Drop ins & voluntary sector.
- Pathway needs a two-way direction of travel; Specialist children can work backwards.

The Outcomes

Key Messages

- **Overall the public liked and agreed with the outcomes but we need to reduce the number by merging some**
- **Ensure they are realistic and measurable.**
- **BME groups favoured the outcome about not being treated equally but thought it could say "treated differently".**

What could be changed or added?

- Include reference to links with education
- The definition of family for those where it is not straightforward.
- Being treated equally outcome to include health condition and mental health.
- Add an outcome about making sure YP understand what's been said – reaffirming.

What young people said?

- Include an outcome about prevention.
- Change to "well informed" not "well educated"
- Support me and my family in transition from CYP to adult services
- An outcome around services co-operating/joined up working.
- Want the option to request another worker or specialist if they feel that they don't meet their needs

What did parents say?

- Prefer us to 'encourage and empower' rather than 'support'.
- Parents want to feel like there is hope/ for staff to be positive where necessary.
- Want to have more knowledge around diagnosis and knowing what to expect.
- Need to be able to decommission parts/services that aren't working.

Professional's thoughts?

- Simplify to 10 outcomes.
- There are duplications or some that say similar things.
- The feel more like aspirations.
- The values should link to outcomes and indicators.
- Currently these are framed in a service-centred rather than person-centred way.

Lots and Specifications

Key Messages

- **Concerns raised that proposed changes will lead to a more fragmented way of working.**
- **Concerns about Speech and Language Therapy being commissioned separately.**
- **More clarification wanted on PMHS's providing tier 2 services.**
- **Concerns that the partnership and engagement is by itself**
- **Confusion over system leader function**

Commissioners need to understand

- Participation - we need to ensure we capture information for all service users
- We need to make sure we use existing engagement groups & not start something new.
- South Gloucestershire and North Somerset to consider commissioning Be safe
- Specialist services for therapeutic work for victims of sexual abuse should be included on the specification of the CCHS plan.

Parents concerns…

- Needs to include a disability section.
- Definition of family to be included; current services excluded those who have parental split.
- Partnership and Engagement needs to work across all services
- Work in partnership with 0-25 year services
- Contract someone to engage with disabled children specifically & hear what their parents say.

CAMHS Spec

- Move away from a Tiered model as it does not reflect reality.
- Therapeutic programmes should be available for victims of sexual abuse
- Have a more adolescent and outreach focus
- Work with voluntary sector and the most vulnerable
- Focus as a consultant service with clearer thresholds.
- Should be able to refer to other professionals.
- Needs to be reserved for those most in need.
- Include a fast track.
- Lower the threshold for access

Universal services

- Comprehensive local directory needed.
- 0-19 service needs to refer children on for assessments before any thresholds are reached.
- Target to reduce excess weight in 4-5 &10-11yr olds.
- Specification needs to reflect a maximum number of School Nurse visits for each referral.
- Flexibility from 08:00 to 20:00 could be difficult to deliver.
- Concerns that HV provision remains equal across the wider area

The key themes in the feedback are consistent across geographical areas and community members, with little or no differences to note. However one interesting difference in feedback is between what young people want and what professionals or parent/ carers believe to be possible. For example from the focus groups held, 19 young people felt the most important value to them was 24 hour access to services. Yet the feeling from multiple professional and parents/ carers are that under current pressures and cuts that this is unrealistic. One professional wrote “I think there needs to be a sense of realism in terms of how this would be operationalised…..”

A parent wrote “the values and outcomes are great; however they are of course an ideal world, a utopia. Sadly we don’t live in an ideal world and we need to manage the expectations of the children or young people who use these services or we will continue to disappoint. They don’t understand the money or politics side of things; they only understand what they are promised. We want care standards to be high of course, but change the language of values and outcomes to include things like “where possible” to keep things achievable and realistic”.

This leaves room for thought for an interesting discussion between commissioners around managing the gaps between what young people want and what professionals believe to be achievable in terms of values and outcomes that should be taken forward into the procurement phase and into the competitive dialogue sessions with potential providers.

We have also received 106 general comments, from our “contact us” page, mainly from healthcare professionals on the lots and specifications. These comments will be considered as we prepare the final draft specifications.

7. Conclusion

Overall the consultation has reached a diverse range of respondents. The feedback is consistent across geographical areas and community groups. The suggestions received will be used to produce what we believe will be a good model for the future of children community health services. Our analysis of the equality monitoring data and any gaps in reaching some communities must be considered in the context that equality monitoring data is not available for everyone who responded. In addition, we have varied the methods we used in the consultation process to reach as many communities as possible.

It is clear from the responses received to this public consultation that there is widespread support for our proposals. The comments on the values, model and outcomes will be considered and will be reflected in any changes, Therefore, we are confident that we can proceed to the next stage of the re-commissioning process knowing that our plans have been developed with, and supported by, the people that matter – the children, young people and their parents and carers who use these services.

This report has set out what we have heard throughout the consultation process. It has identified key messages and reflected upon the way in which different sections

of the community, whether for example by age, ethnic group or geographical location, have given their views.

8. Next steps: The changes we propose to make

This report will now be shared with the six commissioning organisations involved in this re-commissioning , and will also be made public via our respective websites, and shared directly with those who have asked us to do so.

The views we have heard have been shared with all commissioners who will take them into account when they are finalising the draft service specifications, along with other sources of evidence such as clinical best practice. Commissioners will finalise the specifications in discussion with colleagues and final versions will be presented to the Children's Community Health Services Recommissioning Programme Board on 3rd January 2016. Specifications will remain drat until the end of the procurement process as it will be a competitive dialogue process which offers an opportunity for the preferred bidder to contribute to the final version of the specifications.

The procurement process will start in January 2016 and will run through to September 2016. This report will play a key role in our discussions with potential providers during the procurement process and we will ensure that the views we have heard during consultation are kept to the forefront throughout that process. We will keep a record of what changes we make as a result of consultation feedback and where we are not able to make changes we will record why.

Once the procurement process is complete we will publish a "You Said, We Did" report which will set out how the consultation has influenced decisions and what changes have been made as a result.

Nicole Zographou
Patient and Public Involvement CCHS Recommissioning

Margaret Kemp
Senior Project Manager – CCHS Recommissioning
8th December 2015

Appendices

Appendix 1

Public and patient vision for children community health services: Engagement Overarching Themes

- Be able to access a service when you need it, not when things get worst
- Consistent practice
- Good internal communication
- Proactively communicate with young people and involve families in a way they understand
- Professionals who are a passionate, especially working with YP
- Where possible children and young people should be seen consistently by the same clinician.
- Easy access to information and clarity over what services provide
- Integrated services with a possible new keyworker role
- Smooth transition between services
- Young people friendly ways of feeding back on services
- Be Flexible- choice of appointments/ outreach to young people
- Treat us as individuals not as a problem or diagnosis
- Services are responsible for being able to communicate directly with all their patients
- Services need to have more of an online presence
- Staff need to reflect the community and be culturally aware
- Shorter waiting times- a personalised road map in the meantime!
- Be clear on confidentiality

To read full reports of feedback from the engagement phase please look at

https://www.bristolccg.nhs.uk/media/medialibrary/2014/09/PPI_report_Final.pdf and

https://www.bristolccg.nhs.uk/media/medialibrary/2015/10/cchs_involvement_phase_report.pdf

Appendix 2

A Full List of consultation events

Children's Community Health Services Patient and Public Consultation Events		
Date	**Event**	**Numbers**
September		
03/09/15	S.G Priority Neighbourhoods Steering Group	N/A
10/09/15	Participation Event – Bristol Zoo	10
10/09/15	Transformation Planning, Mentality THT	29
15/09/15	Participation and Involvement Professional Workers, Brunel House	7
15/09/15	Redland Green School enrichment event	13
17/09/15	Mentality	11
18/09/15	Youth Film showing at Mud Dock	2
21/09/15	Early Years Health and Family Support Meeting, Horfield	39
22/09/15	Children's Hospital	15
22/09/15	S.G Children's Mental Health Strategy group	N/A
23/09/15	S.G YOS Management Board	N/A
23/09/15	Bristol Youth Council	14
23/09/15	N.S CCG EVENT 1 - For all Healthy Living Centre	15
24/09/15	Colston's Girls school	22
24/09/15	Specialist Children Services, Knowle	5
25/09/15	N.S Parent & Healthwatch meeting	2
30/09/15	Bristol Parent Carers	10
30/09/15	Chipping Sodbury sixth form	7
		201

October		
01/10/15	Professional Engagement Event	46
07/10/15	National Autistic Society Parents Group	4
08/10/15	S.G Lead GP meeting	N/A
08/10/15	S.G Safeguarding Children Board	N/A
12/10/15	Boys Club, Southmead Adventure Playground	12
12/10/15	Women's Health Evening Portishead Medical Group	60
13/10/15	Voluntary Action North Somerset AGM	50
13/10/15	Healthwatch North Somerset AGM	54
13/10/15	Healthy City Week	2
13/10/15	Healthwatch radio show	N/A
14/10/15	S.G Clinical Operational Exec	N/A
14/10/15	S.G Improving the Patient Experience Forum	N/A
14/10/15	Young carers group	4
14/10/15	N.S Parent meeting	1
15/10/15	St Pauls BME group	5
16/10/15	Chair NS LGBT Forum	1
16/10/15	Greenfield Gypsy, Roma Traveller (GRT) site	3
20/10/15	Worle School	7
20/10/15	Learning Partnership West	20
20/10/15	Worle School Council	7
21/10/15	N.S Parent meeting	1
21/10/15	Claremont School - National Children's Bureau	11
21/10/15	CCHS interactive session organised by the care forum	16
28/10/15	N.S CCG Board	N/A
28/10/15	S.G Young Carers' Voice	N/A
30/10/15	Family Fun Day @Bristol	4
		308

November		
02/11/15	Two sessions with South Gloucestershire Councillors	N/A
03/11/15	Weston Super Mare Library – Storytime	17
04/11/15	Mobile library – Rurals and Wrington	44
04/11/15	S.G Troubled Families Project Board	N/A
04/11/15	Bristol Education Centre, Sheridan Road, Horfield	13
05/11/15	Priory women's unit	13
05/11/15	Winscombe library - Storytime	12
05/11/15	Winscombe Indoor Market	8
05/11/15	For All Healthy Living Centre library	1
06/11/15	Pill library- Rhymetime	14
10/11/15	Engagement event, S.G. Parents and Carers (open to all parents and carers in the area)	N/A
11/11/15	Castlewood meeting with parents	2
12/11/15	N.S Parents meeting	2
12/11/15	Bradley Stoke School Council	39
12/11/15	1625 Forum	8
13/11/15	Campus Library Weston	20
16/11/15	Worle library - Rhymetime	16
16/11/15	Congresbury Library – Lego Club	8
17/11/15	N.S Our Voice Counts	40
17/11/15	N.S Gypsy, Roma Traveller Stay and Play	1
17/11/15	Hospital Education Service	6
18/11/15	N.S. Black and Minority Ethnic Network AGM/Weston College attendees	48
18/11/15	S.G Children's Centre Steering Group	N/A
19/11/15	N.S CCG EVENT 2 – Clevedon Community Centre	16
19/11/15	Hospital Education Service	10
19/11/15	N.S. Meeting with Primary School Head Teachers	N/A
19/11/15	N.S. Meeting with Secondary School Head Teachers	N/A
20/11/15	Nailsea library - Rhymetime	14
20/11/15	LGBT – Youth Drop In For all Healthy Living Centre	8
23/11/15	Clevedon Library - Rhymetime	9
23/11/15	Kings Weston Special School	14
23/11/15	Polish women's group	7
23/11/15	Bristol Metropolitan School	18
24/11/15	Elmfield School for the Deaf	3

24/11/15	St Andrews Primary School – GRT session	3
25/11/15	North Somerset Councillors - session	12
		426
Total from the whole consultation period		**935**
Total number of events from Consultation period		**81**

Appendix 3

What different methods did we use when consulting the public?

There were different opportunities for the public to feedback into the consultation. In addition to the online consultation they could consult by email, write, attend a focus group or telephone and there was printout option for those who preferred it.

There was also extensive face to face consultation with groups and a number of professional events. The face to face consultation activities spoke to many people including the following:

- A number of schools including special schools
- Youth groups around the city including young carer groups and mental health support groups
- Organisations working with the Black and Minority Ethnic (BME) communities
- Voluntary sector agencies
- Parent organisations such as Bristol parent Carers and the National Autistic society
- Members of the Lesbian, Gay, Bisexual and Transgender communities (LGBTQ)
- Homelessness services
- Learning disability services

In professional or parental face to face events a brief introduction to the consultation was given providing a context to the proposed changes, showing the website and animation. Then in groups copies of the proposed values, model and outcomes were give out and there were discussing addressing the following questions:

The Values

Q1 Do you think these are the most important values for the service?

Yes/ No

Q2 Are there any values you would change or add?

Yes/ No

Q3 If you answered 'Yes' to question 2, tell us which values you would add or change

The Model

Q1 Do you think that this is a good model for future children and young people's community health services?

Yes/ No

Q2 Is there anything about the model you would change or add?

Yes/ No

Q3 If you answered 'Yes' to question 2, please tell us what you would change or add.

The Outcomes

Q1 When these services are set up, do you think they will meet your needs?

Yes/ No/ Sometimes

Q2 If you answered 'No' or 'Sometimes' to question 1, please tell us why

Yes/ No/Sometimes

Q3 When these services are set up, do you think they will meet the needs of children and young people within the local community

Yes/ No/ Sometimes

Q4 If you answered 'No' or 'Sometimes' to question 3, please tell us why

Q5 Please tell us anything else that you think will help us shape the future of children and young people's community health services

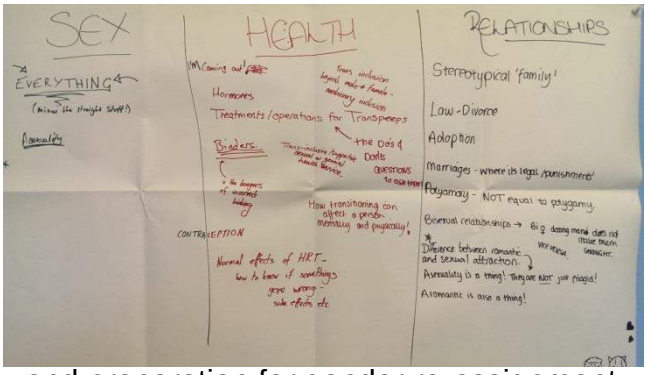
In face to face events, each group had time to look at the values, model and outcomes individually and discuss in their groups. Groups then feedback back as a whole around the questions. There was also an opportunity to comment on the lots and specifications, mainly for parents and professionals, with the understanding that these were not being consulted on. Notes were taken at each table at every event, on a pro forma template or flip chart paper and these were then collected and typed up.

In Bristol face to face activities involving young people worked slightly differently. A short recap on the recommissioning was presented, followed by a viewing of the animation; groups were then split into three, receiving laminated, individually cut, set of values and outcomes. They had 20 minutes to choose the most important ones to them, discuss the language and its appropriateness, and decide if there were any missing or any they would change recorded on post it notes. Comments were then discussed and debated as a whole group, whilst the facilitator took notes and pictures. Afterwards the model was shown on a projector and groups had the opportunity to ask any questions. If the availability of laptops were possible then individually the group would go online and complete the consultation questions. If not, answers to the consultation were recorded on a pro-forma template, collated and returned to a central point.

It was important for us to allow people to consult in a method that was suitable for them. Prior to face to face meetings, facilitators would ask if the group had any additional needs or a preferable way to communicate. This then allowed facilitators to plan discussions accordingly. For example in Bristol a face to face consultation was organised with a group of young people, some who were profoundly deaf and some with a cochlear implant. It was agreed that an interpreter would need to be organised and the facilitator was made aware that the reading level of some of the students was low. It was suitable for the group to have this session interactively in school time. After the signed introduction was shown and the animation with subtitles, the group were asked in what way they would like to feedback, it was decided a open discussion would be most suitable. The model was explained, the values and outcomes were read out, and interpreted, followed by a discussion evaluating these and sharing stories of their own health experiences.

South Gloucestershire wanted to engage with parents and carers. We met with representatives from the South Gloucestershire Parents and Carers group to talk about how we could work with them to provide an activity which would meet their needs. They asked us for a session during school hours, and which would particularly focus on demonstrating how what they had told us during the pre-procurement phase had been reflected in the work we had done so far, including draft service specifications. We therefore designed a session which could deliver this, looking at two specific specifications in more detail to show how we had provided assurance that feedback given in the pre-procurement phase had made a practical difference to specifications. They also asked us to invite healthcare professionals to join in the event, and we did this, having a Health Visitor, a School Nurse and a Continence Nurse in attendances that were able to talk with parents and carers and undertake shared activities on the morning. The group were also happy to open the session up to all South Gloucestershire parents and carers and worked with us to promote the session.

North Somerset wished to engage with young people from the Lesbian, Gay, Bisexual and Trans (LGBT) community. We met with a group of four students who were attending a drop in at the For All Healthy Living Centre in Weston super Mare. Two were Lesbian and two were male to female transgender/gender fluid. An explanation of the consultation was provided to the students and their feedback was requested for the online survey. In the drop in session they then worked on a poster that explored their particular needs for sex education, health and relationships. This is the photo of that work:



The female to male trans people expressed a wish that health professionals be sensitive to their particular needs and be knowledgeable about interventions such as breast binding, and preparation for gender re-assignment surgery. The young people talked about serious issues resulting from ‘make shift’ binding such as causing broken and/or deformed ribs and bruising. This could be helped by having more understanding from health professionals that they came into contact with. They also wanted health professionals to know what things to ask and which things not to say. They wanted to know what undesired symptoms things to look out for when on hormone treatment. They would also like more information about the services that are available to them on the NHS.

Appendix 4

Who did we hear from in the consultation?

The approach to inclusive engagement has been a theme which we have built on from the earlier involvement process. We engaged with our diverse communities through focus groups, events and via the online survey.

Equality group representation at Bristol focus group discussions:

A total of 440 participants took part in the focus group discussions. An analysis of the equality data available from these focus group discussions is as follows:

Age:
Of these 62% (274 participants) were young people, 9% (39 participants) were parents and 28% (127) were professionals.

BME:
Of the 274 young people that took part in the focus group discussions, only 4% (10 participants) identified as BME. In addition, 18% (7 participants) of the parents that took part in the focus group discussions identified as BME.
None of the professionals involved in the focus group discussions identified as BME. This was also highlighted during the earlier involvement stages.

Gender:
Of the young people that took parts in 30% (81) were male and 70% (124) were female. This was significantly higher than 8% (3 participants) male representation and 92% (36 participants) female representation. For professionals, males made up 16% (21 participants) of participants, with the remainder of participants.

Transgender:
Of all 440 participants, 0.5% (3 participants) identified as transgender. All of these were young people.

Disability:
Of the young people that participated in focus group discussions, 3% (10 participants) identified as disabled, 1% (3 participants) identified as Deaf and 5% (14 participants) identified as Autistic. In addition, 2% (1 participant) was a parent to a disabled child, and 10% (4 participants) were parents to Autistic children.

Sexual Orientation:
Of all the 440 participants, 1% (5 participants) identified as Gay. All of these were young people.

Equality group representation at South Gloucestershire focus group discussions:

A total of 10 participants took part in the focus group discussions. All of these were parents. An analysis of the equality data available from these focus group discussions is as follows:

Age:
40% (4 participants) were aged 25-49, 30% (3 participants) were aged 50-65.

Ethnicity:
70% (7 participants) identified as white.

Gender:
All of the focus group participants were women.

Sexual orientation:
70% (7 participants) identified as heterosexual.

Religion and belief:
50% (5 participants) identified as Christian, and 20% (2 participants) identified as not having a religion or belief.

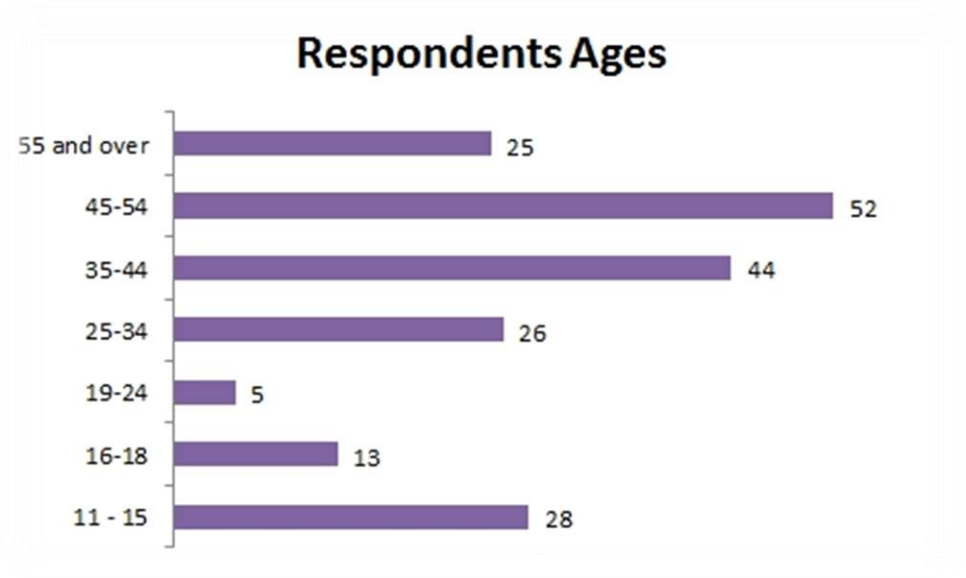
Disability:
20% (2 participants) identified as disabled, and 50% (5 participants) identified as not having a disability.

Equality analysis of the online survey:

It is important to point out that 36% (109) of respondents did not complete the equality monitoring questions, and therefore these figures might not be entirely reflective of the totality of equality groups that responded. The equality analysis has therefore been undertaken on the 64% (194 responses) equality monitoring responses.

Response rate to the survey:
There have been 303 survey responses received. Of these 64% completed their equality monitoring questions. The following analysis has been undertaken per protected group:

Age:
The age profile of the respondents suggests that the majority of the survey responses have been completed by parents, carers and professionals.



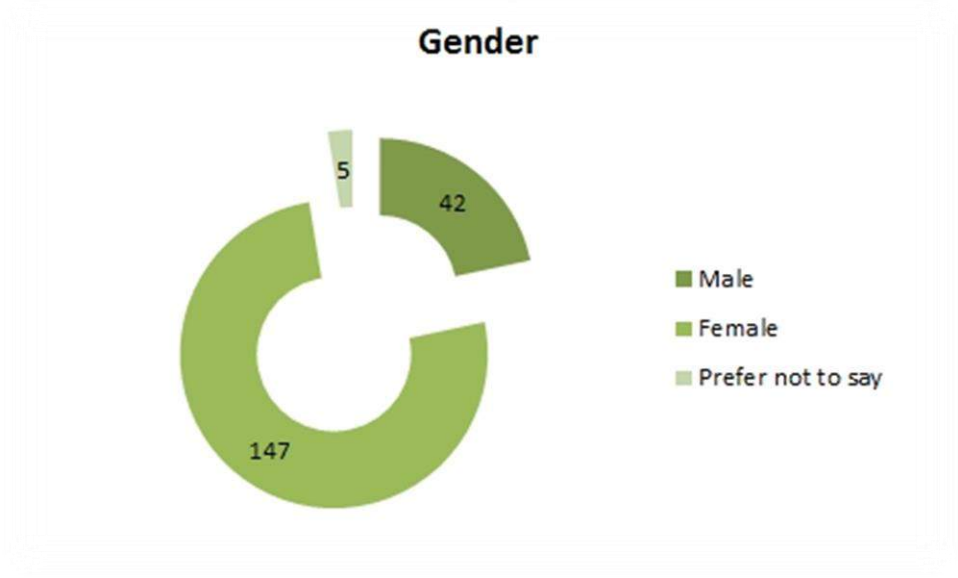
Disability:

Only 8% of the respondents identified as disabled, however given that the majority of respondents are either parents, carers or professionals, it is highly likely some of these respondents would have completed the survey on behalf of a disabled child. In addition, a proportion of the respondents did not complete the equality monitoring questions which could account for the small numbers.

Other issues to consider are the preference some groups have for focus group discussions despite efforts such as the sign language video which was deployed to make the online consultation as inclusive as possible.

Gender:

The majority of the respondents are female (75%), with 21% of respondents being male, and 2.5% “preferred not to say”.



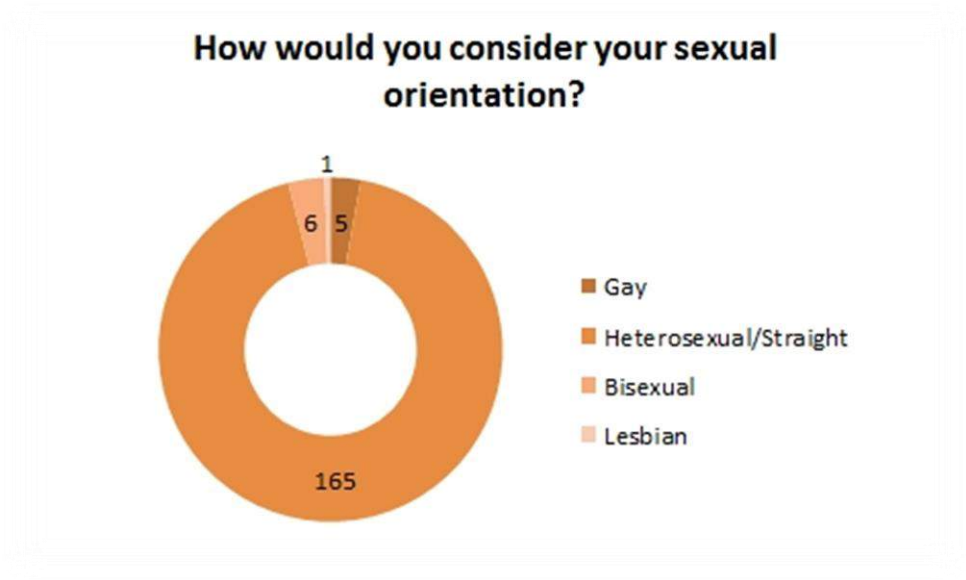
Transgender:

None of the survey respondents identified as Transgender. It is important to note however that we did engage some people that identified as Transgender (0.5%) through focus group discussions.

This compares to the Gender Identity Research and Education Society and the Bristol LGBT Forum estimates which indicate that 1% of the population being on a “gender variant spectrum”. This demographic is applicable across BNSSG.

Sexual Orientation:

93% (165 of respondents) identified as heterosexual, 3% (5 respondents) as Gay, 3% (6 respondents) as Bisexual and 0.5% (1 respondent) identified as Lesbian. All of the LGB respondents were Bristol based.



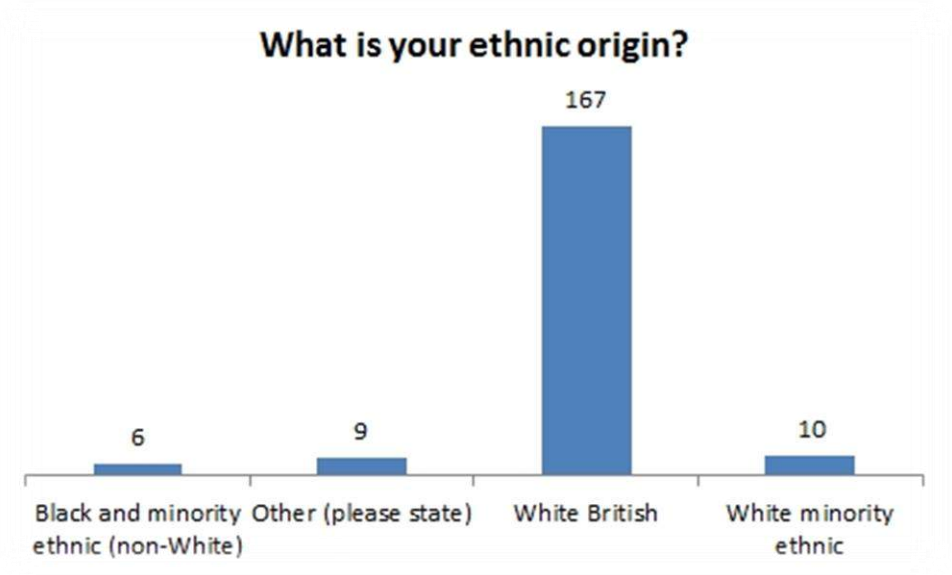
This compares to local demographic data of:
Bristol:
Stonewall estimate 6% of the local population being LGB, (The Bristol LGBT Forum estimate that this figure is closer to 10-15%)

South Gloucestershire:
There is no definitive figure for these groups in South Gloucestershire but 1.5% of the population was estimated to be Lesbian, Gay or Bisexual according to the Office of National Statistic's "Integrated Household Survey" (2012).

North Somerset:
Government estimates that 5%-7% of the population are LGB.

BME:

Only 3% (6 respondents) identified as BME. This is exceptionally low given that 16.5% of Bristol's population is BME, along with 5% in South Gloucestershire and 2.7% in North Somerset.



A further analysis of the data supplied highlighted that 3 of these respondents Bristol based, 1 is South Gloucestershire based, and 1 is North Somerset based.
Whilst respondents identified as "other" make up 5% (9 respondents) of responses, and these could be from a BME background, it is possible therefore that the number of BME respondents could be higher. Further interrogation of the data supplied could not provide any further detail as to the ethnicity of these respondents. It must also be noted that 37% of all respondents did not provide the details of their ethnicity. In addition, we have undertaken to engage BME people through focus groups. The outcome of this was that an additional 4% (17 participants) across focus groups for parents, young people and professionals took part in the engagement process.

Religion and Belief:

The respondents reflected diverse religious and none religious backgrounds with 50% of all respondents declaring their religious identity (Table). Noticeably however were no responses from people that identified as Jewish (Census figures for Bristol: 0.2%, North Somerset 0.09% and South Gloucestershire 0.1%) , Hindu (Census figures for Bristol 0.6%, North Somerset 0.1% and South Gloucestershire 0.6%) or Buddhist (Census figures Bristol 0.6%, North Somerset 0.17 and South Gloucestershire 0.3%) compared to demographic data.

The largest single group of responses 38% were from people that identified as not having a religion, followed closely by respondents that identified as Christian 35%. This compares with census data across BNSSG indicating that the largest religion represented is Christianity, followed by those that identify as not having a religion or belief.

Table

Religion	Percentage response rate from the online survey. %
Agnostic	4.5
Atheist	6
Christian	35
Muslim	3
No Religion	38
Roman Catholic	3
Sikh	0.5
Church of Jesus Christ Latter Day Saints.	0.5
Other	9

Conclusion:

Overall the consultation has reached a diverse range of respondents. Our analysis of the equality monitoring data and any gaps in reaching some groups/ communities must be considered in the context that equality monitoring data is not available for every participant. In addition, we have varied the methods we used in the consultation process to reach as many groups/ communities as possible

Appendix 5

The data below is the final information of hits and user movement pulled from the online consultation. From this data we can see that 2,716 people viewed the online consultation. 939 of these went on to view the draft plan for CCHS. Yet we know only 303 completed the survey questions. 391 of these viewers came from social media and 239 through Facebook alone. This CCGs Facebook presence is not particularly strong, so these figures could suggest the strength of the YPRG social media push to share the online consultation amongst their peers.

All Sessions
100.00%

How many visitors so far

Year	Users
2015	2,716

How many visitors each month

Month of Year	Users
201509	1,660
201510	881
201511	437

New v Returning Visitors

How people found the site

Default Channel Grouping	Users
Direct	1,889
Social	391
Referral	356
Organic Search	208

How many came from social media

Social Network	Users
Facebook	293
Twitter	97
Blogger	1
HootSuite	1
LinkedIn	1

What were the top pages?

Page Title	Users
Your healthy future	1,965
The draft plan for NHS Children's Community Health Services NHS	939
The model for NHS Children's Community Health Services	816
Your Healthy Future	730
Values for the NHS Children's Community Health Services	715
Services	674
Pathway model for single needs	654
The outcomes for our NHS Community Health Services	489
Pathway model for multiple needs	419
From draft to reality: Children's Community Health Services	417

Where visitors came from

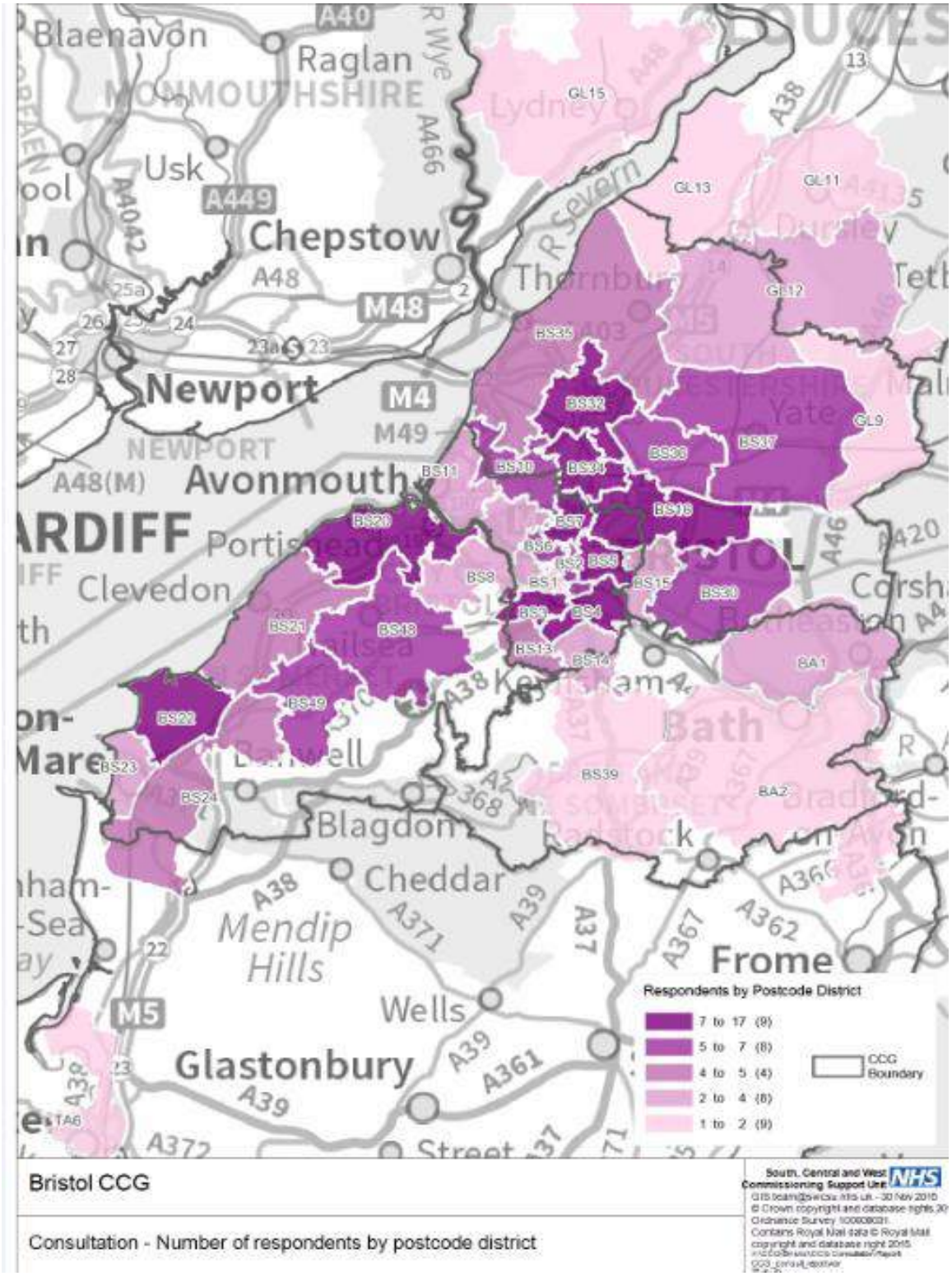
Source	Users
(direct)	1,889
m.facebook.com	200
google	171
t.co	90
facebook.com	85
southglos.gov.uk	40
bristolccg.nhs.uk	37
bing	36
bristol.gov.uk	36

What was downloaded the most

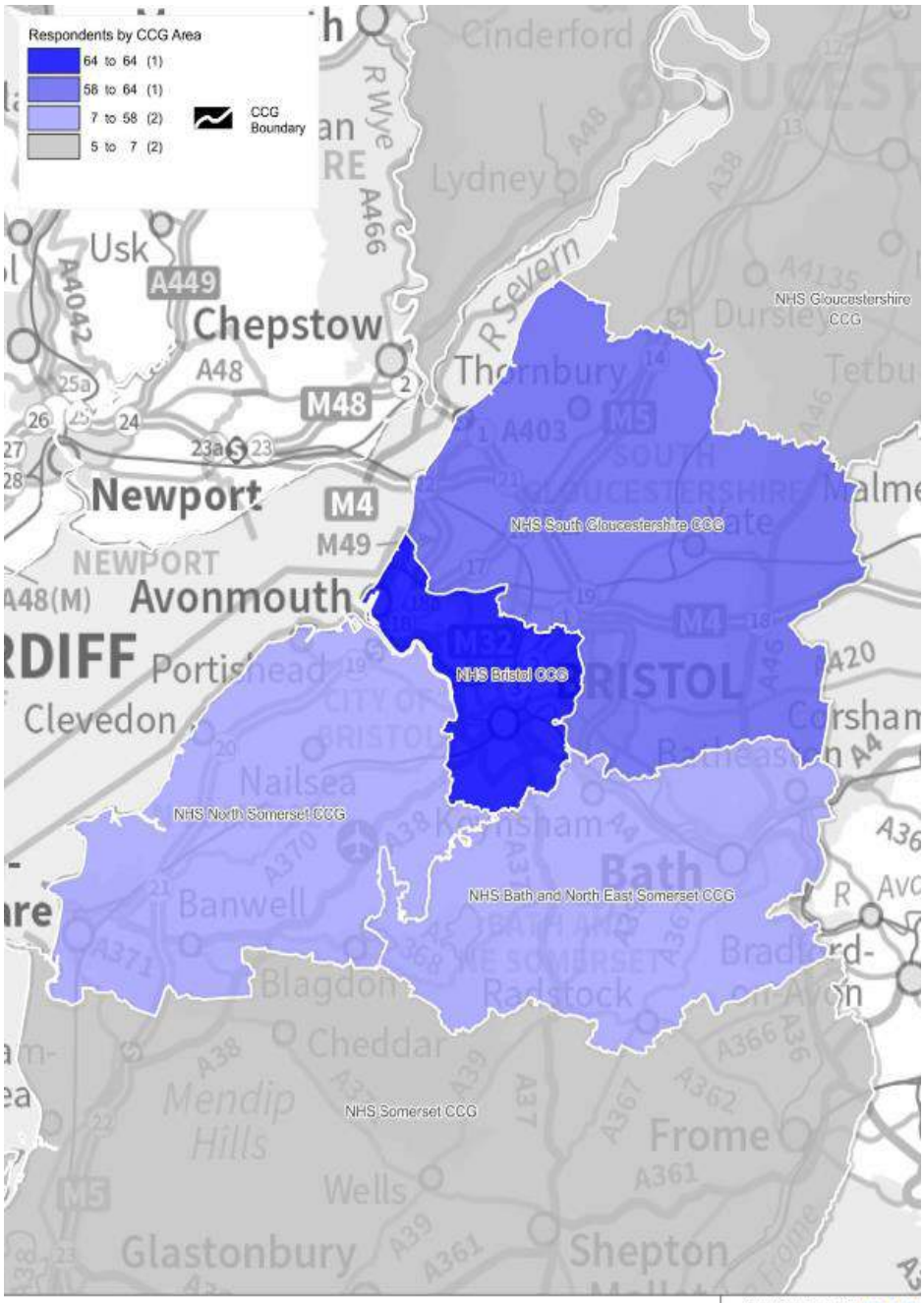
Event Label	Total Events	Unique Events
the-model	187	172
the-values	164	134
child-adolescent-mental-health-service-camhs	139	121
019-years-public-health-nursing	102	91
overarching-cchs-specification	83	74
tell-us-what-you-think-of-the-plan	81	77
childrens-community-therapies	70	61
the-outcomes	57	49
thank-you	56	45
speech-and-language-therapies	53	50

Appendix 6

A map of responses to the online consultation by postcode.



A map of responses to the online consultation by a geographical area.



Appendix 2 Procurement Route

Title: Outline Procurement Design

1 Purpose & Background

This paper recommends the high-level design and approach to the procurement process for Children's Community Health Services.

With a planned formal commencement to the procurement of 1st February 2016, it is necessary to progress pre-procurement design and readiness.

This includes the approach to the different procurement lots, the allocation of tasks (evaluation question and process design etc.) and the high level timetable for the overall process.

2 Procurement Lots – recommended procurement process

2.1 The Lots

One of the key re-commissioning variables is how the discrete services are 'bundled' to ensure the most efficient outcome.

The following Lots have been agreed and are under discussion in this paper:

Lot 1

Community Paediatrics including;

- Looked after children designated doctor
- SARC
- CONI

Community Therapies

Community Nursing including;

- Homecare
- Lifetime
- Continence
- Nurse at Claremont

Speech and Language Therapy & Communication aids

Public Health Nursing including;

- Youth Offending Team – Nursing

Family Nurse Partnership

School immunisations

Partnership and Engagement

Lot 2

CAMHS including;

- Looked after Children (mental health nurses)
- Youth Offending Team (mental health nurse)
- Substance Misuse
- Troubled Families Family Intervention Team

- Be Safe

Learning disabilities including;

- Art Therapy
- Positive Behaviour
- Nursing / support workers for residential short breaks
- Young Peoples Substance Misuse

Lot 3
Counselling

Lot 4
Tier 4 CAMHS

Lot 5
GP with Special Interest

2.2 The available processes

The optimal procurement route depends on the following:

- Complexity of the service requirements
- Whether a clear specification can be established
- The value and size of the service
- The time available for commissioners and evaluators.

There are two relevant procurement procedures. These routes mirror the procurement routes available under the 2006 Regulations but can be applied with some flexibility whilst still providing for a fair, open and transparent process.

When discussing procurement routes, it should be noted that each care pathway could potentially be procured using a different (or variant) route. However this would add a layer of complexity to the procurement process that would require significantly enhanced overall management.

2.2.1 The standard (single-stage) procedure

This procedure is analogous to the OJEU Restricted procedure. Under this procedure a selection via a Pre-Qualification Questionnaire (PQQ) is made of those who respond to the advertisement, and only successful PQQ applicants are invited to submit a tender for the contract. This allows Commissioners to avoid dealing with an overwhelmingly large number of tenders.

After PQQ, the standard procedure will have a single tendering stage.

Benefits of the standard procedure:

- Simple – single stage
- Less risk of legal challenge due to simpler evaluation model
- Quicker than a multi-stage procedure
- Less burdensome for bidders

Risks of standard procedure:

- More than 1 stage of tendering could be required to properly assess complex bids

- Any required change to the evaluation model would not be allowed, and could result in a legal challenge
- No shortlisting after PQQ, potentially creating a burden on the evaluation panel

2.2.2 The Complex (multi-stage) procedure

This procedure is analogous to the OJEU Negotiated procedure. Following an advertisement and selection process via a Pre-Qualification Questionnaire, the commissioner then enters into negotiation with bidders to develop one or more suitable solutions for its requirements on which chosen bidders will be invited to submit best and final tenders.

The multi-stage process may include multiple tendering rounds (at the discretion of the commissioner), and bidders can be excluded from the process in an iterative manner.

Benefits of the multi-stage procedure:

- More flexible than restricted, allowing multiple tendering stages
- Changes can be made to the evaluation model during the tender
- More suited to high value and highly complex procurements

Risks of multi-stage procedure:

- Resource intensive to conduct properly – The programme would need to ensure that sufficient resources are available
- Due to complexity – liable to legal challenge if not managed properly
- More burdensome for bidders – could potentially disadvantage small bidders

2.3 Issues affecting choice of procurement procedure

2.3.1 Complexity of the service specifications

The complexities of the service and the completeness of the specification will have an effect on the choice of tendering process.

One of the key reasons for using a multi-stage procedure is where the commissioner is either not clear on what it requires, or where the services are of such a complex nature that there is the possibility of the specification changing through the process. If the commissioner is entirely clear on its model(s) and there is no possibility for any change to the model(s) then a multi-stage procedure is less likely to be required.

2.3.2 The bidder market

The commissioner would always wish to receive bids from every level and type of provider that is capable of providing the service, and the procurement route should not advantage or disadvantage any bidder. The multi-stage procedure, as a more complex and resource intensive procedure, has the potential to advantage larger bidders that have more resources available to bid. To ensure this does not happen, the procurement process will need to be tested at each stage to ensure equality of opportunity amongst bidders.

The commissioners value the contribution that Voluntary and Community Sector organisations and other small to medium sized enterprises could bring to the new re-commissioned pathways. There should also be an opportunity for these organisations to meet with other larger providers to explore the possibility of partnership working or of becoming sub-contractors particularly with the delivery of specialist services to specific groups within the populations. The commissioner must also allow sufficient opportunity and time in the procurement timetable for these innovative partnerships to be formed.

2.3.3 Relative risk of legal challenge

The restricted procedure is simpler than a multi-stage procedure, so may be seen as resulting in a lower risk of associated legal challenge. However this might not actually be the case, as the restrictions placed on the commissioner when using the restricted procedure mean that the commissioner is more likely to take an action that is outside of the rules, therefore inviting a legal challenge. Examples of such actions would be altering the evaluation process or conducting any substantial shortlisting during the process.

2.4 Recommended procurement procedures

Based on the issues discussed above, the following procedures are recommended for use against each Lot:

Lot 1 (Community Paeds, SaLT, Public Health Nursing)

Process: Multi-stage procedure

Lot 2 (CAMHS & LD)

Process: Multi-stage procedure

Lot 3 (Counselling)

Process: Single stage procedure

Lot 4 (Tier 4 CAMHS)

Process: Single stage procedure

Lot 5 (GPwSI)

Process: Single stage procedure**

** Regarding the GPwSI service, commissioners are still in discussion as to the most appropriate procurement route for this service, and specifically whether there is a strong market in existence. Given this, it may be the case that this service is commissioned through a ‘closed’ procurement, where specific organisations are invited to bid, rather than through an open advert. Commissioners will make this decision based on an objective gathering of soft market intelligence and through an understanding of whether similar services have been competitively commissioned elsewhere.

3 Creation and approval of procurement tasks and products

The Procurement Lead has established a Procurement Group as an advisory group to the Programme. The Terms of Reference to the Procurement Group are provided as **Appendix 2**.

The Procurement Group takes membership from each of the commissioning partners, as well as work stream leads such as IM&T, finance, workforce and equality & diversity.

The Procurement Group will support the Procurement Lead in the creation and initial drafting of procurement products such as tender documentation and evaluation questions and criteria, before these products are then taken to Programme Board for formal approval.

4 Procurement timetable

Two procurement timetables are supplied as **Appendix 1**, they are:

- Single stage process (Lots 3, 4 and 5)
- Multiple stage process (Lots 1 & 2)

Both processes begin with a formal OJEU advert in the first week of February, and conclude with an award in September 2016.

4.1 Scheduling of multiple procurements

Given the strategy of procuring 5 lots within the overall re-procurement exercise, there will be a considerable burden for both commissioners and bidders. The idea of 'phasing' or scheduling the procurement of the different pathways at different times has been considered. However the approach does itself create some significant difficulties for both the commissioner and bidders.

To be useful to bidders whose resources are stretched, the gap between procurements would need to be at least 3 months – and more probably 6 months. Any time period less than this would mean that a stretched bidder might, for example, be trying to complete a PQQ submission for one part of the project whilst completing a tender submission for another part of the project. A useful gap, therefore, would mean that the overall tendering period for all services could stretch over several years.

Another problem with phasing is that it would reduce the potential for receiving integrated bids for multiple pathways. In the same manner, bidders would not be able to take advantage of any economies of scale or offer the commissioner any additional efficiencies generated by bidding simultaneously for multiple pathways.

In terms of the incumbent provider, phasing the procurement could further complicate an already highly complex TUPE environment in the circumstance where new pathways are not analogous to existing services. TUPE is a stressful and confusing experience for staff.

It is not clear that the burden on bidders would actually be reduced by phasing the procurement. If the procurement of the pathways was separated in time, bidders would have to resubmit their entire bid each time, as well as potentially

having to resubmit financial, regulatory and other operational information for the PQQ stage.

It is therefore proposed that the procurements are all conducted simultaneously, but within the context of the procedures and processes discussed above to minimise the burden on bidders. The only phasing of the procurement will be with respect to the delivery of final tenders, with final tenders for Lots 1, 4 and 5 delivered two weeks in advance of the final tenders for Lots 2 and 3. This gap will allow commissioners to concentrate their evaluation on the 'simple' Lots before then moving on to the two more complex Lots.

5 Existing contract & data requests

5.1 The incumbent

The existing contract with Sirona Care & Health (and Bristol Community Health and Avon & Wiltshire Partnership Trust as associates) is a traditional 'block' contract, commissioned by Bristol Clinical Commissioning Group with other local commissioners as associates. The contract is a NHS Standard Contract. The current contract expires on 31st March 2017.

Sirona has been awarded the contract to deliver the service for an interim period of 1 year (1st April 2016 – 31st March 2017) and so there will be particular difficulties regarding requesting data from them at a point in time when they are still trying to establish the service.

Significant data and other information will be required from the incumbent to enable an efficient procurement process, and allow bidders to properly assess the risks and benefits of taking over any of the services. The main areas in which data will be requested are workforce (TUPE), estates, activity and IM&T. It has to be recognised that the volume of data that will be requested of Sirona is very significant. With up to 1,000 staff affected, it will be necessary to start this process early, well before the advert. Headline information on TUPE, IM&T and estates will be provided to bidders within a Memorandum of Information alongside the advert.

It is suggested that a separate strategy is created in conjunction with Sirona and North Bristol Trust in order to sensibly manage data requests and requirements from bidders.

6 Bidder Engagement

It is clear that a high level of engagement with interested organisations will be required to obtain the best outcome from the procurement and to ensure the commissioners meet all of their statutory duties. The commissioners will engage with organisations through the facilitation of events and 1:1 meetings during the advertisement, pre-qualification and tender stages, and, in addition, will consider the following issues.

6.1 A general willingness to support providers

A fear of ‘breaking the rules’ or being perceived as not acting with total impartiality causes public authorities to become insular during procurement exercises, refusing to engage with providers except for responding to formal clarification questions.

The commissioners will, wherever reasonable, take an open stance and provide bidders with as much guidance as reasonably practical. This will include market events and meetings (both group and 1:1). The commissioners will also welcome feedback from the market on what support would be most beneficial to them during the process.

6.2 Encouraging partnership working

There are a number of ways that the process will encourage partnership working between bidders:

6.2.1 Lists of possible partners

A recurring theme of bidder feedback following previous procurements is that they could not form proper partnerships as they were not aware of all the relevant local organisations, or were not aware of them sufficiently early in the process.

The Programme will compile a list of local organisations already involved in the provision of services within the area (along with their specialities). With the permission of those organisations, bidders will be provided the list in the Memorandum of Information so that they can begin to form partnerships. Bidders will be notified that any list of local organisations provided by the commissioner is non-exhaustive and does not indicate preference.

6.2.2 Attendance at events

An enduring problem for the formation of partnerships is that it is difficult to get small/third sector organisations to attend the same events as larger organisations (and vice versa). It tends to be larger organisations who attend commissioner-led events, whereas smaller local organisations will attend events managed by their peers such as the Care Forum.

The commissioners will design events in such a way that we have as many different types of organisations ‘in the room’ at the same time as possible, giving them strong opportunities to network. To this end, the commissioners will work with facilitation organisations such as Voscur and the Care Forum to advertise events to small, local organisations, as well as the usual channels such as Contracts Finder for large organisations.

6.2.3 Partnership facilitation

The commissioner will facilitate events during the tender process to draw together potential prime-contractors and their potential sub-contractors or partners.

For example, at the tender stage, after the tender documents have been sent out to bidders, we will arrange an event where the remaining bidders all attend an event, and local organisations interested in providing parts of the service in conjunction with those bidders can meet them and discuss specifically how they could work together.

6.2.4 Acting on feedback

A number of specific events have already been held as part of the consultation period, at which a significant amount of useful feedback was received. Provider events during each stage of the procurement (pre-advert, advert, PQQ, ITT) will be used to help shape the next stages of the procurement where reasonable.

The Programme will be open to suggestions from providers and will encourage bidder feedback.

7 Minimising the burden on commissioners and bidders

The procurement process will be extremely resource intensive on bidders. In order to ensure the best possible outcome, the commissioner will be proactive in its approach to minimising the administrative and logistical burden on bidders throughout the process. The commissioner will do the following:

7.1 Find the balance between receiving adequate assurance whilst not seeking excess information for no additional benefit

Recent Government guidance has indicated that the pre-qualification stage of procurements should be much more streamlined, and that the questions should relate only to issues directly relevant to the service. We will adopt this approach, and only request documentation/information which is strictly necessary.

7.2 Use a 'hub and spoke' set of evaluation questions

Bidders who are interested in bidding for multiple Lots will only need to complete some of the evaluation questions once (particularly at PQQ stage), as they will be generic across all Lots. Each individual Lot will then have its own subset of questions that are unique.

7.3 Limit the length and breadth of the evaluation

Apply rigid word-limits to each answer, and limit the number of questions asked overall, taking consideration of the overall length of responses we are expecting to receive.

7.4 Work with providers to prepare them for the bidding process

Providers are always very clear about their desire for support throughout the procurement process. We will hold group events and workshops before and throughout the process on points such as how to complete documentation (PQQ/ITT).

1:1 meetings will be held with bidders during the tender stage, and communication channels throughout the re-commissioning process will be very clear.

7.5 Provide bidders with additional information

Non-local bidders can spend a considerable amount of time during the tender stage simply trying to find which local organisations they need to speak to in order to put together a locally integrated bid. Whilst remaining impartial, the commissioners will signpost bidders to local organisations that have specialities in certain elements of a pathway.

7.6 Give information to bidders when we have it

On some occasions, the service specifications or other pertinent information is ready several months before the tender document is sent out, but it is not given to bidders. This is inefficient. If information is ready and available, and its release would not be prejudicial to any party, then it will be released.

8 Contracting

8.1 Contract periods

A number of discrete services are being procured. Given this, every service will not automatically have to be commissioned for the same period.

There is however a strong case for all services to have the same contract period, as any misalignment of future commissioning timetables (for example if some of the services are commissioned for 3 years and others for 5 years), will make it difficult to realign or re-model them as a cohesive whole at some future date.

In terms of what that period should be, the preferred option is for services to have an initial term of 5 years, with an extension period of 2 years available dependent on successful outcomes and other factors determined by the commissioner.

8.2 Contract drafting

The NHS Standard Contract is mandated for use for all commissioned healthcare services.

The contract is re-drafted annually, so the contract that will be used for drafting purposes is not the version of the contract that will actually be used in 2016/17 when awards are made. For this reason, it will be made clear to bidders that the relevant national contract will be used at the time of contracting (i.e. April 2017), and that any non-standard clauses and specifications will be ported in to that contract.

The contracts will be drafted so that they are made available to bidders with the advert (or shortly thereafter). This is important so that the contract negotiation

phase after award is kept as simple as possible. It is also important that bidders understand their future contractual obligations when they are bidding.

9 Next Steps

The Procurement lead, in association with the Programme Director and others, will continue work to finalise the procurement process as approved.

10 Recommendation

That the approaches outlined in this paper regarding procurement route, outline timetables, and approach to the market be approved.

Mike Pingstone – Lead Senior Clinical Procurement Manager

24th November 2015

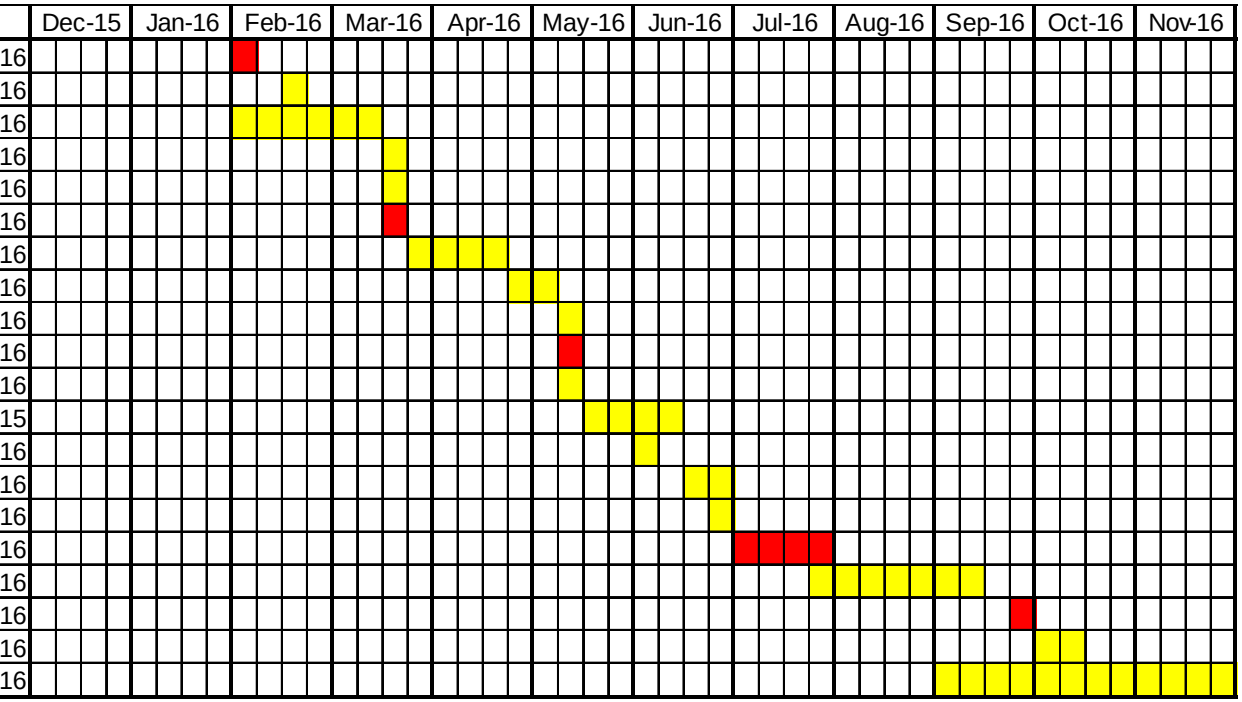
Appendix 1 – Procurement timetables

Single stage process

Task	Date	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16
Advert and Memorandum of Information	01/02/16												
Mid-advert briefing	w/c 14/02/16												
PQQ	01/02/16 - 17/03/16												
PQQ Evaluation	18/02/16 - 24/03/16												
PQQ Consensus meeting	24/03/16												
PQQ Shortlisting	25/03/16												
ITT	28/03/16 - 01/06/16												
ITT Bidder meeting	21/04/16												
ITT Evaluation	02/06/16 - 14/06/16												
ITT Consensus meeting	14/06/16												
Preferred Bidder decision made	05/07/16 - 26/07/16												
Preferred Bidder period	27/07/16 -16/09/16												
Award	30/09/16												
Standstill period	01/10/16 - 12/10/16												
Contract drafting	01/09/16 - 30/11/16												

Multiple stage process

Task	Date
Advert and Memorandum of Information	01/02/16
Mid-advert briefing	w/c 14/02/16
PQQ	01/02/16 - 17/03/16
PQQ Evaluation	18/02/16 - 24/03/16
PQQ Consensus meeting	24/03/16
PQQ Shortlisting	25/03/16
ISOP	28/03/16 - 28/04/16
ISOP Evaluation	29/04/16 - 09/05/16
ISOP Consensus meeting	09/05/16
ISOP Shortlisting	12/05/16
ISOP Dialogue	16/05/16 - 17/05/16
ISDP	20/05/16 - 16/06/15
ISDP Bidder meetings	02/06/16
ISDP Evaluation	17/06/16 - 28/06/16
ISDP Consensus meeting	28/06/16
Preferred Bidder decision made	05/07/16 - 26/07/16
Preferred Bidder period	27/07/16 -16/09/16
Award	30/09/16
Standstill period	01/10/16 - 12/10/16
Contract drafting	01/09/16 - 30/11/16



Terms of Reference

Bristol, North Somerset, South Gloucestershire Children's Community Health Services Procurement Group

11 Purpose

The group will allow the procurement lead to receive advice from specific members of the programme, and other stakeholders as necessary, on the procurement process and deliverables for the commissioning of the services.

12 Members

Name	Role on Group	Organisation
Mike Pingstone (Chair)	Procurement Lead	South, Central West CSU
John Gibbs	Procurement Support	South, Central West CSU
Margaret Kemp	Project manager	Bristol CCG
Anne Colquhoun	Commissioner	Bristol LA – PH
Rebecca Cross	Commissioner	Bristol CCG & LA – People
Lesley Causon or Lindsey Thomas	Commissioner	South Glos LA - PH
Nikki Churchley	Commissioner	NHSE
Mark Hemmings	Commissioner	North Somerset CCG
Rebecca Harold	Commissioner	South Glos LA
Melanie Iddon or Lindsey Gee	Commissioner	South Glos CCG
Inge Shepherd	Commissioner	Bristol CCG
Lisa Harvey	Safeguarding lead	South Glos CCG
Catherine Thomas	Workforce lead	South, Central West CSU
Nicole Zographou	PPI lead	Bristol CCG
Niema Burns	E&D lead	Bristol CCG
Jane Schofield	IM&T lead	South, Central West CSU
Padma Ramanan	Finance lead	Bristol CCG

The Group will be supplemented on an ad-hoc basis by members of the Programme Board and Project Group.

The PPI lead on the group will be supported as appropriate by service user reference groups. This will be particularly relevant for tasks such as evaluation question design.

13 Responsibilities

- Support the Procurement Lead in the design key deliverables namely;
    - Advert
    - Bidder Events
    - Pre-Qualification Questionnaire
    - Pre-Qualification Questionnaire evaluation process
    - Tender documentation
    - Tender evaluation process
    - Bidder Presentations Sessions (as appropriate)
    - Contract
    - Award Letters
    - Preferred Bidder phase

14 Structure of meetings and frequency

The frequency will be determined by project schedule. Further dates may need to be added as the procurement schedule is further developed and the following list is subject to change as the project demands. The group will largely function as a 'virtual' group', with the Chair requesting comment and agreement on products by e-mail circulation.

Meeting ref	Tasks	Date	Attendees (or distribution list)
1	Agree TOR. Confirm outcome and route follow decision by Bristol CCG. Discuss the practicalities of implementing commissioning strategy.		All
2	- Procurement Strategy - Bidder event - Evaluation question process		All
3	- Agree Bidder event details - Agree advert wording - Review ISOP evaluation questions		All
4	- Review ISOP evaluation questions - Agree PQQ evaluation questions		All

5	- Agree ISOP evaluation criteria, methodology and financials		All
6	- Notification of PQQ outcome		All
7	- Mid ISOP progress meeting		All
8	- Notification of ISOPs submitted		All
9	- Progress meeting (Notification of results of dialogue phase) and agree ISDP changes		All
10	- Progress meeting		All
11	- Agree shortlisted bidder presentation session content		All
12	- Agree planned award and declines		All
13	- Discuss ongoing contract negotiations		All
14	- Discuss ongoing contract negotiations		All

15 Reporting arrangements

The group will report to the Programme Board.

16 Administration details

- Send out agenda and papers at least five working days before the meeting.
- Minutes of the meeting to be sent out no later than ten working days after the meeting.
- All correspondence will be via e-mail where possible.
- Where agreement to a product is requested via e-mail circulation, a minimum of five working days will be provided for members to comment and provide their agreement.

17 Review

It is not anticipated that these Terms of Reference will require review.