Oxfordshire County Council

Review of Children and Adult’s Advocacy Services: Key Findings

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Oxfordshire’s Advocates
1. Introduction

This review of children and adults’ advocacy services was conducted to look at demand, existing resources and make recommendations, based upon the qualitative and quantitative data collected, to inform future commissioning intentions. It was also intended to increase our understanding of using co-production within the commissioning cycle to support with developing this approach further across council teams and services. This review was undertaken with the involvement of advocacy service providers, advocates, people who have used/ may use advocacy services, people who refer to services and other interested parties.

2. National to Local Context

Advocacy has existed in the UK for more than 30 years\(^1\) and throughout this time a range of models and schemes have emerged, each with distinctive characteristics relating to the type of work undertaken, length of involvement and appropriate person who should undertake the role. The models widely used include self-advocacy\(^2\), peer-advocacy\(^3\), volunteer citizen advocacy\(^4\), independent/ professional advocacy\(^5\) and non-instructed advocacy\(^6\).

Advocacy plays an important role in enabling people, of all ages, to represent themselves and have a voice in resolving their own problems, accessing services, participating in decisions about their own lives as well as speaking up and participating in service design, delivery and feedback. In addition, people using advocacy services gain personal skills which can also be used elsewhere, thus promoting their independence across their life.

Similarly, to other Local Authorities, Oxfordshire County Council has a duty (see appendix 1) to deliver a range of advocacy services for vulnerable children and adults (see appendix 2) to

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2 Individuals represent and speak up for themselves, with support, either individually or collectively. This support can be in a paid or unpaid capacity.
3 The advocate and the person have a common background, for example, they may have shared experience of service provision
4 Involves volunteers (unpaid) who are recruited, trained and matched with an individual – generally only one at a time. It involves a one to-one relationship over an extended period of time.
5 A partnership between a paid advocate and a person who accesses support. The advocate provides support, information and representation, with the aim of empowering their partner and enabling them to express their needs and choices.
6 Advocacy can be provided to those who are, for reasons of capacity, unable to personally instruct their advocate.
support them to get their voice heard and ensure that they are being listened to or taken seriously.

2.1 Oxfordshire’s Advocacy Services

The advocacy services currently funded by OCC are:

<table>
<thead>
<tr>
<th>Advocacy service area</th>
<th>Service recipients</th>
<th>Overarching service responsible</th>
<th>Service Provider</th>
<th>Approximate Annual cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>VIVA (Volunteer Independent Visiting and Advocacy)</td>
<td>Children and young people</td>
<td>Joint Commissioning - Complaints</td>
<td>Provided in-house</td>
<td>£103,445 per annum</td>
</tr>
<tr>
<td>Adults Advocacy Services</td>
<td>Adults</td>
<td>Joint Commissioning - Adults</td>
<td>Provided by Getting Heard</td>
<td>£368,110(^9) contract per annum</td>
</tr>
<tr>
<td>Appropriate Adult Service</td>
<td>Young people and adults</td>
<td>Youth Justice Service</td>
<td>Provided in-house</td>
<td>£10,000(^10) per annum</td>
</tr>
<tr>
<td>Self-Advocacy</td>
<td>Young people and adults</td>
<td>Joint Commissioning-Adults</td>
<td>My Life My Choice (MLMC)</td>
<td>£60,000(^11) per annum</td>
</tr>
</tbody>
</table>

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7 Includes Independent Mental Health Advocates (IMHA), Independent Mental Capacity Advocates (IMCA), Independent Care Act Advocacy (ICAA) and NHS Independent Complaints Advocacy Service.
8 Getting Heard is a partnership between Oxfordshire Advocacy (the previous provider) and seAp a regional advocacy charity (which delivered the NHS complaints service).
9 There was a previous issue around capacity for IMCA. Additional funding of £50k per year was sourced to allow for additional staff to support the demand. This has allowed us to have the capacity to respond to referrals, which can fluctuate considerably between the number of ICAA and IMCA. Our advocates are trained to deliver both types of advocacy, so the flexibility we have suits the changing referral trends. Numbers for ICAA were previously low but are now increasing.
10 The 10k mentioned is funded through OCC adults social care budget and there is another £10,000 funded through a variety of sources such as police, probation etc.
11 Funding agreement in place for a year for the delivery of this service in conjunction with the delivery of some other services.
3. Case for Change

The costs of delivering these advocacy services are relatively low and rely in large on the successful recruitment and retention of volunteers which enables delivery at low cost. However, this is not without its risks as volunteers need appropriate support, management and recruitment is not always easy.

Advocacy commissioned by and provided within the same corporate body risks a conflict of interest in terms of the organisational commitment to support complaints and critical comments about it. Whilst the commitment of face-to-face advocates and staff committed to managing the service is not in doubt, there comes a point where the connection to the advocacy service meets the core of the organisation. This point provides an unnecessary risk for tension and possible conflict. A properly externalised service has the added advantage that people are more likely to trust and use it based on its independence.

Whilst these services are valued and considered to be highly effective, there are fragmented advocacy services, across children and adults, some internally delivered and some commissioned. OCC provide some advocacy and independent visiting services beyond the statutory duties. The council needs to consider how these services should be provided in the future at a time when the VIVA service requires review and to ensure that ongoing arrangements are in place for advocacy services when the Oxfordshire Advocacy contract with 'Getting Heard' ends in March 2019.

The current arrangements for the VIVA service are not sustainable, both in terms of independence from the council and in managing the growing demand for the service. In 2015/16, VIVA experienced a 55% increase in the number of young people they supported. This is not surprising in the context of growing demand in children’s social care and the

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13 Donnachie, L. (2015) conducted a review of Oxfordshire’s adult advocacy services and there was 100% overwhelming praise for the advocacy services from both service users and referrers. The service users cited the respect they were given throughout their involvement with a service and identified final outcomes due to the support and advice given from an advocate.
14 Although there is the option to extend for 2 years in the existing contract if the review and subsequent business case demonstrates that this is the preferred option
15 Similarly, Getting Heard are experiencing an increase of people who need support from the service. People are living longer and have more complex needs. The contract at present does not allow for further capacity to support this increase in demand.
increasing number of children in local authority care\textsuperscript{17} (often referred to as Looked After Children (LAC)). A review of advocacy services conducted in 2013\textsuperscript{18}, recommended that the VIVA service should have greater independence from the council. A new model for the service began in April 2014 but a second phase to make it independent of the council was never implemented.

Advocacy is a demand-driven service and the service reviews conducted to date reinforce increasing demand and heavier caseloads. Whilst previous monitoring can be used to gauge future service provision, it will only ever be a reasonable estimate. However, we are aware that advocacy is most needed by vulnerable people or those living in vulnerable situations (see appendix 3) and that the population numbers\textsuperscript{19} that fall within this group are increasing, so it can be fairly assumed that the demand for advocacy, to enable voices to be heard, will grow.

4. Growing a Co-production Approach Across our Commissioning Cycle

This review of Advocacy services was one of several projects targeted to build upon our learning about the challenges and opportunities of incorporating a co-production approach\textsuperscript{20}.

Co-production\textsuperscript{21} is about developing more equal partnerships between people who use services, carers and professionals. There is a commitment\textsuperscript{22} from the Directorate Leadership Team (DLT) to use co-production across our commissioning cycle, to shift the balance of power from the local authority to the community and to begin to utilise this approach across the organisation. Oxfordshire has a good history of engagement with users of adult and children's social care including supporting user led groups, service user input in commissioning and procurement, developing quality standards and contract monitoring, alongside high quality consultation activity around service change. We have used elements of co-production for many years\textsuperscript{23} and the

\begin{flushleft}
\textsuperscript{17} We have opened four new children’s residential homes in Oxfordshire in response to this but still are struggling to meet placement demand.
\textsuperscript{18} McDowall, E. (2013)
\textsuperscript{19} OCC’s Joint Strategic Needs Assessment 2017 predicts an increase in the number of Oxfordshire residents of +183,900 people (+27\%) between 2015 and 2030, taking the total population of the county from 677,900 to 864,200. Between 2015 and 2030, the number of people aged 85 and over is expected to increase by 92\% in Oxfordshire overall.
\textsuperscript{20} Leigh, B., Breton, S. & Gregory, L. (2016), Co-production- moving forward in 2017
\textsuperscript{21} The Care Act 2014 statutory guidance offers the following definition: "Co-production" is when an individual influences the support and services received, or when groups of people get together to influence the way that services are designed, commissioned and delivered.
\textsuperscript{22} Leigh, B., Breton, S. & Gregory, L. (2016), Co-production- moving forward in 2017
\textsuperscript{23} We have a long history of co-producing services, policies, and service change alongside the Children in Care Council (CICC) and have recently piloted using a co-production approach to select new provision for supported living for people with learning disabilities and develop models for daytime support.
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Social Care Institute of Excellence (SCIE)\textsuperscript{24}, identified that Advocacy under the Care Act should be commissioned in meaningful partnership with people who use services and carers.

5. Review Findings

5.1 Key Messages about Advocates

5.1.1 Desktop Review and Best Practice
The Institute of Research and Innovation in Social Services (IRISS) conducted a review\textsuperscript{25} of advocacy models and good practice and identified the following features to be central to any type of model of advocacy:

- A calm thoughtful and sensitive disposition
- The ability to raise relevant issues on behalf of the person in an appropriate and fair manner
- Good at building relationships with people
- Provision of support to individual when upset
- Ensure the person’s views are discussed and incorporated
- The ability to be succinct, articulate, thorough and offer alternative ways of thinking
- Facilitate understanding among other professionals of the person’s situation.

5.1.2 Oxfordshire’s Advocates
This was echoed in the feedback received from stakeholders who identified that a good advocate is:

- Helpful
- Supportive
- A good listener
- Kind
- Able to help you to speak out
- Able to guide you through the confusing system
- Warm
- Able to get to the point

\textsuperscript{24} SCIE (2016) Commissioning advocacy under the Care Act: Emerging good practice
\textsuperscript{25} Institute of Research and Innovation in Social Services (2013) Insights- Advocacy: Models and Effectiveness
• Respectful
• Able to support with decision-making
• Able to help to reduce anxieties and worries
• Able to offer gentle support
• Trustworthy

The advocates in Oxfordshire were described as passionate about the work they are doing, as being supportive and doing a good job. However, it was recognised that some advocacy services are delivered by volunteers which can cause challenges around availability, as well as ensuring a consistent approach.

5.2 Key messages about Advocacy Services

5.2.1 Desktop research and best practice

When completing a desk top review of how other local authorities choose to deliver their advocacy services, the approach taken is widely varied and the majority do not have one sole provider delivering their advocacy services for both children and adults. Of the twelve local authorities researched, Cambridgeshire is the only one which offers an integrated service across all children and adult’s advocacy services.

POhWER is a charity and membership organisation that provides information, advice, support and advocacy to people who experience disability, vulnerability, distress and social exclusion. POhWER works in over fifty local authority areas across the country, delivering the full range of statutory and non-statutory services. They operate in five of our statistical neighbours; Hertfordshire, Buckinghamshire, West Berkshire, West Sussex and Gloucestershire but the breadth of services they offer in each area differs.

Some local authorities have introduced a single point of access for all their advocacy services to ensure that people can access advocacy appropriate to their needs. SCIE’s service review

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26 Cambridgeshire, Hertfordshire, Buckinghamshire, West Berkshire, West Sussex, Gloucestershire, Bracknell forest, Hampshire, Bath and North East Somerset, Wiltshire, Kent and Swindon
27 Cambridgeshire County Council and Peterborough City Council joined to offer an integrated service called ‘Total Voice’
28 It was set up in 1996 and was developed by service users
29 SCIE (2016) Commissioning advocacy under the Care Act: Emerging good practice
identified that several areas favour the hub model\textsuperscript{30,31}, as it can be easier to respond to people’s individual needs by providing access to different types of advocacy through a range of specialist providers. It can also facilitate long-term relationships whereby a single advocate may adopt several advocacy roles (e.g. Independent Mental Health Advocate (IMHA), Independent Mental Capacity Advocate (IMCA), generic advocate) with an individual service user as their needs and eligibility for advocacy changes.

5.2.2 Oxfordshire’s Advocacy Services

The feedback on the delivery of advocacy services in Oxfordshire is very positive and it was identified that if you already know something about advocacy services, then further information and support is available to you. However, if was recognised that if you had never come across advocacy services before, then it was difficult to know what it was all about. It was reported that if people don’t know about their ‘right to advocacy’ that they often don’t understand what it is and how it works.

There were concerns raised around the increasing demand for advocacy services, with waiting times for advocacy support being too long\textsuperscript{32}. It was also mentioned that on occasion, professionals cancelled or rearranged meetings at short notice and advocates were unable to attend the new dates and times.

5.3 Areas for improvement in Oxfordshire

When stakeholders were asked, what was needed for future advocacy services in Oxfordshire, there were three emerging themes which were echoed by the SCIE when reviewing emerging good practice in the commissioning of advocacy services under the Care Act:

- Increased awareness
- Better management of increasing demand
- Provision of more diverse advocacy support

\textsuperscript{30} An example of this is the Manchester Advocacy Hub which was established in April 2015 and brings together all statutory advocacy provision regarding Care Act in Manchester. The Hub is delivered by the Gaddum Centre; however, it does not provide advocacy to children and young people.

\textsuperscript{31} SCIE review states that the Hub model may not be the most appropriate practice in rural areas or areas that have a limited number of providers. The local context (population, geography, local views and provider capacity) play a role in determining the appropriate model.

\textsuperscript{32} Much work has been undertaken by both VIVA and Getting Heard to reduce waiting times and this is ensuring that people can access advocacy services quickly once a referral has been made.
5.3.1 Increased awareness

5.3.1.1 Desktop Research and Best Practice
The SCIE identified that where frontline staff did not understand advocacy, this was a major barrier to access and uptake of advocacy under the Care Act and that this may skew the assessment of need and demand. Advocacy was shown to be a complex field and that it can sometimes be confusing for both people who use services and professionals. Their report showed that finding the right type of advocate and working out eligibility for statutory advocacy often can be bewildering. They encouraged local authorities to consider introducing a single point of access for all but recognised that people’s advocacy needs are diverse and require support from the right type of advocate. They highlighted the overlaps between different forms of statutory advocacy and informal advocacy (e.g. peer advocacy, generic advocacy, citizen advocacy and self-advocacy) with each having a critical role to play in enabling people who use social care to have a greater voice and more control over their lives.

The SCIE went on to recommend that everyone involved in social care locally needs to develop a clear understanding of advocacy, why it needs to be independent, its various forms, the legal context, its role in implementing the Care Act wellbeing principle and duties in relation to prevention as well as supporting peoples’ involvement in their care.

5.3.1.2 Oxfordshire’s Advocacy Services
Stakeholders in Oxfordshire identified that there needed to be:

- More awareness raising needed of the existence of advocacy services and signposting to services, with examples such as an information helpline, or one stop shop type approach given.
- More training offered to social workers and health professionals around the basic criteria for eligibility so there are less inappropriate referrals.
- More targeting of Black, Asian and Minority Ethnic (BAME) communities so they know how to access services.

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33 Social Care Institute of Excellence (2016) Commissioning advocacy under the Care Act: Emerging good practice, pg. 10
34 This includes capacity building and support for commissioners and frontline staff, including co-produced training, to develop an understanding of advocacy and their roles in promoting and supporting access and uptake.
5.3.2 Managing Increasing Demand

5.3.2.1 Desktop Research and Best Practice

In the SCIE review of advocacy provision across the country they discovered that there was a wide variation in the total spend on advocacy, ranging from contracts of under £25k to others over £200k. When they compared the size of contracts for 2015/16 and 2016/17, it suggested a trend towards a reduction in contracts of under £25k, which may reflect the changing nature of advocacy commissioning as experience unfolds. While some local authorities are allocating relatively little resource to develop advocacy services, there was an indication that some are subsequently investing £150–£200k in advocacy. Nonetheless, concerns were expressed from providers about potential reductions in resources for advocacy alongside increasing demand.

The SCIE also found no evidence to suggest that rates of referral\(^{35}\) were linked to the model of provision.

5.3.2.2 Oxfordshire’s Advocacy Services

Stakeholders in Oxfordshire identified that there needed to be:

- Advocacy support which is consistent across the county and which is available in the local community.
- Services that are easier to access, with much shorter waiting times for referral.

5.3.3 Providing more diverse advocacy support

5.3.3.1 Desktop Research and Best Practice

The SCIE identified that Commissioners need to provide advocacy services that reflect and meet the diversity of the needs of local people which are evidenced through needs assessments that use a range of methods, which embed quality\(^{36}\) and diversity in the scoping design, provision and monitoring of advocacy services. Evidence demonstrated that where a limited needs assessment was conducted, there was a lack of consideration of diversity, which risks a single

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\(^{35}\) Many providers highlighted a lack of effective training for frontline staff in local authorities as causing the low number of referrals which contradicted the feedback from local authority respondents who reported that 90% of frontline staff had been trained. However, providers were observing variation in the number of referrals between teams working with similar vulnerable groups in the same authority.

\(^{36}\) In response to the introduction of the Care Act, there has been further development of the national Advocacy Quality Performance Mark (QPM), which is a robust, quality assessment and assurance system. Advocacy providers are encouraged to work towards this QPM to enable independent advocacy providers to demonstrate and promote their commitment and ability to provide high quality advocacy.
provider being commissioned that can meet the needs of the majority. This provider is then not able to provide equal access to advocacy for all local people and further disadvantages minority groups.

The SCIE collated evidence that co-production with users, carers and the wider community, a population needs assessment and an equality impact assessment for advocacy, will all support commissioning that responds appropriately to local need. They further identified that this should include an analysis of demographic data, referral for assessment and support to the local authority, as well as events (open space events, focus groups, surveys) to identify the range of views and preferences for providing advocacy.

The SCIE highlighted that attention should be paid to:

- older people
- people from BAME communities
- people with learning difficulties, physical disabilities and/or sensory impairments
- lesbian, gay, bisexual and transgender people
- asylum seekers
- carers.

They identified that the views of people from these groups may often be overlooked and that proactive measures need to be adopted to ensure they are included because they may have specific preferences for advocacy provision or face barriers in accessing advocacy. They further identified that partnership working between different advocacy providers can increase access to advocacy for marginalised groups and promote learning across the sector.

The SCIE reinforced the importance of independence from service provision as being critical as conflicts of interest can arise if the service providing advocacy also has a role in providing care and support to individuals. This does not mean that social workers, care managers or care providers cannot promote an individual’s views but it does mean they cannot act as independent advocates. Advocacy under the Care Act services were evidenced as working well when there is an information and advice service in place to deal with a broad range of queries regarding social care, and means that the advocacy service is more likely to receive appropriate referrals.
5.3.3.2 Oxfordshire’s Advocacy Services

Stakeholders in Oxfordshire identified that there needed to be:

- Better understanding of the increasing demand of advocacy services.
- More funding for advocacy services, including community advocacy services.
- Consider the emerging needs for advocacy support for the people of Oxfordshire. Examples given, were more support for:
  - refugees and asylum seekers
  - when there are conflicts over health care
  - for people under the Mental Health Act
  - for women and children who have been through domestic violence
  - families
- Funding generic volunteer advocacy which is currently not available.
- That there is a named advocate for every child in local authority care (LAC).

6. Conclusions about Oxfordshire’s Advocacy Services

- Oxfordshire’s advocates are doing a good job but there needs to be more of them, with consideration given as to how to manage the level of complexity of cases as it continues to rise.
- We need to harness and grow the advocacy provision we have in Oxfordshire and recognise that different models of advocacy support are required and need to be delivered by a diverse group of advocacy providers.
- That the delivery of advocacy support is specialist and needs to be delivered by the right appropriately trained type of advocate.
- Both people needing services and professionals struggle to understand the criteria around the different types of advocacy support.37
- There needs to be continued investment into advocacy services to ensure that the emerging needs of Oxfordshire residents can be met.
- Providers need to work together to promote advocacy services in a more coherent way that can be understood by a diverse community of potential users of services, as well as professionals who may refer in for services.

37 Despite providers undertaking activities to promote their services and make the referral criteria clearer.
Advocacy services should be independent of the county council to avoid any conflict of interest and provide complete professional scrutiny.

The range of advocacy provision is a complex path to navigate for users of services and referrers, and consideration should be given as to how to have one entry point, so that they can then be signposted to the correct advocacy service provider.

There is increasing demand for both children and adults’ advocacy services. Further work is needed to forecast the level of demand over the coming years to provide a better understanding of the resources required so that consideration can be given about how best to safely manage this whilst ensuring the delivery of high quality services.

The benefits of advocacy support shouldn’t be underestimated.

It is very difficult to get feedback from users of advocacy services who are particularly vulnerable in general, but especially when the advocacy support has been in the past. Advocacy providers should continue to gather feedback using a variety of methods during the user’s advocacy journey with their organisation, to evidence outcomes for their users as well as the performance across their organisation.

There is generic advocacy being provided by frontline staff within OCC services and by our partners which is currently not being captured and some individuals may not necessarily hold an understanding of the advocacy role.

There aren’t as many referrals to the VIVA service from social workers and independent reviewing officers (IRO’s) as part of CIN, CP or LAC planning processes.

Getting Heard only use volunteers for some of their advocacy services, due to the complexity of some of the advocacy support provided.

7. Areas of Challenge for Consideration

- Volunteers within advocacy services are holding increasingly more higher risk cases as the complexity of cases continue to rise.
- Increasing a sessional pool of staff to manage complex high-risk cases will incur a greater cost.
- Increasing the number of volunteers and sessional staff will require additional management resources to effectively oversee cases.
- Increasing demand for advocacy services cannot be met through the current resources allocated for advocacy so further resources are required at a time when
Transformation programmes are underway within children and adult services, to reduce overspend and redistribute resources.

- There isn’t a clear enough understanding of the costs of commissioning the VIVA service and historically, when this service was commissioned in the past, the chosen provider was not able to deliver the service identified within the specification.
- The current numbers of LAC, Child protection (CP) and Child in Need (CIN) cases are rising, as are the number of other vulnerable children and young people who should be able to access an advocacy service, should they need it.

8. Incorporating a Co-production Approach

8.1 Desktop Research and Best Practice
The SCIE evidenced that Advocacy under the Care Act should be commissioned in meaningful partnership with people who use services and carers. Co-production is not easy and there are fundamental differences that must be negotiated, including roles, responsibility and accountability. For co-production to flourish, both within advocacy providers and in local authority commissioning, the SCIE identified that it is likely that organisational structures and culture, staff values and attitudes will need to change and develop. They described co-production in commissioning as a leap up from consultation, involvement and engagement and that it adheres to underpinning values and principles driven by the user movement. The SCIE believe that these values form the bedrock of advocacy provision and so can easily lend themselves to commissioning advocacy under the Care Act.

8.2 Review of Oxfordshire’s Advocacy Services
In the planning stages of this review, it was identified that there were only a few areas where co-production could be incorporated, due to various restrictions. One of the key restrictions was that whatever the findings of the review showed, it would not necessarily be possible to exceed the level of funding currently committed to advocacy services, nor have the final say about what the local authority chooses to commission going forward. Within OCC, there is a dedicated process for having commissioning intentions considered and approved, with the final decision being taken by our Directorate Leadership Team (DLT). The local authority would also still need to ensure that the advocacy services delivered met statutory duties, so there would be many areas of advocacy provision that could not necessarily be fully influenced.
Within this review, co-production was used in the development of:

- The engagement events with which feedback from service users is gathered.
- The key messages from the feedback collated through the engagement activities.

Advocacy providers were asked to support us with identifying users of services and advocates who may be interested and able to join a ‘Co-production Project team’, alongside advocacy providers themselves and local authority officers. From the outset, the advocacy providers said it would be challenging to get representation from most of the vulnerable users of services supported through advocacy. This proved to be the case and there was very limited representation from people who have used advocacy services on the co-production project team. However, those service users, advocates, advocacy providers and local authority officers could come together at meetings to plan and deliver engagement activities as well as consider the key messages from these activities to inform the recommendations from the review. The project team members fed back that it had been a positive and enjoyable experience and that they would consider being involved with something similar again.

8.3 Conclusions about using principles of co-production within this review

- Using this approach requires additional time as there is the need to discuss and plan things with a larger group, with everyone having the same level of influence.
- It is vital that there is transparency from the outset about which parts of the process would best suit good engagement with users of services and where co-production should be incorporated.
- When involving service users, there needs to be clarity about their role, the time commitment and where they will influence an area of work and to what degree.
- That each person involved is asked how they would like to be communicated with to ensure that this doesn’t act as a barrier to somebody participating in the experience.
- That time is given in early meetings with aiding the group to get to know each other and develop relationships, so that they can work effectively together\(^{38}\).
- That inconsistency with attendance at meetings negatively affects the process and can lead to some challenges around adhering to the co-production principles.
- That co-production may not be able to be effectively incorporated across the whole of the commissioning cycle within local authorities due to the democratic decision-

\(^{38}\) This also helps the people facilitating the process to observe the dynamics between individuals within the group, to ensure that everyone can participate equally and that there aren’t individuals that dominate.
making process that exists within the organisation and statutory duties around the delivery of some services.

- That co-production provides those people involved with a different experience due to the shared level of influence within the group, which you cannot get from engagement activities. It can also offer community members the opportunity to develop alternative skills which may not often be possible through engagement activities i.e. chairing meetings, facilitating group discussions, planning and facilitating workshops.

- Co-production can offer the opportunity to be part of the full process rather than just one part of it. This can create better understanding, consistency and commitment from group members.

- People are using the term ‘co-production’ and it means different things to different people and there isn’t always understanding of the difference between engagement activities and co-production.

### 8.4 Areas of Challenge for Consideration

- Co-production does not always lend itself to the totality of the areas within the commissioning cycle
- Co-production is not always the most effective approach to take to involve service users for every project/service area where activity is taking place.
- There isn’t always enough lead in time with a piece of work to be able to effectively incorporate co-production, ensuring that all the principles are adhered to.
- Some service areas/projects where we would like to adopt a co-production approach have service users who have such high levels of vulnerability or barriers with accessibility, that it prevents this approach from being possible/effective. e.g. a person who is accessing advocacy support through an independent mental capacity advocate (IMCA) as they have been assessed as not having ‘capacity’ to make decisions themselves about their care.

### 9. Recommendations

The table below outlines the key recommendations from this review, as well as proposing the actions required and timeframe for implementation:

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39 Co-production is becoming a word like ‘advocacy’, where it is used on an increasing level, within a variety of contexts and when used, may mean different things to the person using the word.
<table>
<thead>
<tr>
<th>Service Area</th>
<th>Recommendations</th>
<th>Evidence Base</th>
<th>Actions/Deliverables</th>
<th>Initiation Timeframe</th>
</tr>
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</table>
| Advocacy Services-Adults and Children | Undertake a piece of work to forecast future demand based upon current activity levels, unmet demand and population projections and invest additional resources into advocacy services where required. | • Desktop research  
• Contract monitoring/ performance reports | • Projection of future demand.  
• Resource requirements and budget implications identified.  
• Paper developed for DLT and Gateway review panel (if required) for approval. | March 18 |
| Advocacy Services-Adults and Children | Ensure that specialist advocacy provision continues to be delivered by advocacy organisations with the appropriate level of expertise and this is reflected in the service specifications when tendering for future services. | • Desktop research  
• Feedback from stakeholders  
• Contract monitoring/ performance information | • Reflective in tender and evaluation documentation when commissioning work. | March 18 |
| Advocacy Services-Adults and Children | Develop an online advocacy training tool for frontline staff to encourage them to continue providing generic advocacy support to an individual or family that they are working with, but to ensure that the advocacy support is high quality and consistent across the workforce. | • Feedback from stakeholders | • Online training tool developed and cascaded to staff for completion. | March-April 18 |
| Advocacy Services-Adults and Children | Support advocacy providers to work together to develop a coherent and consistent message to better explain what advocacy is and the support available. Providers should look at access into their services and streamline the approach between providers. | • Feedback from stakeholders  
• Desktop research | • Initiate provider network meetings which are then facilitated by providers going forward. | March 18 |
| Advocacy Services-Adults and Children | Insert a field within framework-Il/liquid logic which a professional will need to populate to demonstrate that they have considered any advocacy needs of an individual or family and made appropriate arrangements in response to any need arising. | • Feedback from stakeholders | • Ability to measure advocacy support being offered.  
• Vulnerable service users are offered and provided with advocacy support. | March 18 |
| Children's Advocacy | Complete an options appraisal of the VIVA service to consider if the service should be commissioned or remain internal to the county council and shape the service to meet increasing demand. | • Performance reporting  
• Feedback from stakeholders  
• Historical service reviews.  
• Desktop research  
• Feedback from stakeholders. | • Commissioning manager to develop VIVA options appraisal for DLT to consider and identify approach for future service delivery. | February 18 |
| Co-production | OCC should continue to increase awareness of co-production across the workforce (employees and partners) using one coherent approach and encourage staff to consider how they can incorporate it within their practice. | • Desktop research  
• Feedback from stakeholders | • Training for the workforce is rolled out.  
• Support and professional challenge is provided by people experienced with this approach. | This work is already underway. |
| Co-production | When co-production is used by individuals and teams, that learning about this approach is captured centrally to inform future work. | • Desktop research  
• Feedback from stakeholders | • Central log to be developed and held by one team who are responsible for keeping it up to date and staff made aware of this. | March 18 |

40 Including community IMHA cases as demand has been steadily increasing. These cases traditionally incur additional advocate input so the increase has an impact on the capacity of the team.

41 This training tool would also raise awareness about the advocacy organisations who can provide advocacy support where a professional is unable to provide this and meet the individual/family's advocacy support needs.

42 This may include developing a joint communication strategy and including an Advocacy Awareness Raising Campaign.
10. Methodology Adopted to Conduct this Review

This review was conducted by an OCC local authority officer within the Joint Commissioning team and supported by an officer within the Engagement team. Neither officer has past involvement with the delivery or management of the local authority’s advocacy services.

This review was undertaken with the involvement of advocacy service providers, advocates\(^43\), people who have used/ may use advocacy services, people who refer to services and other interested parties. A co-production approach was incorporated into some areas of this review.

The review methodology consisted of the following:

- Desktop review of performance monitoring data relating to advocacy services funded by OCC, provided by Quality and Contract monitoring officers and manager of the Complaints, Information and VIVA Service.
- Desktop review of good practice nationally and local authority learning about the delivery of advocacy services.
- Desktop review of good practice learning about using a co-production approach within the commissioning cycle.
- Desktop review of the learning taken from other historical internal reviews of advocacy services.
- Analysis of data from 47 survey responses completed by stakeholders\(^44\) via email and hard copy at engagement events, through social media, newsletters, post and telephone.\(^45\)
- Analysis of the key messages captured through face to face and creative techniques at meetings and engagement events across stakeholder groups\(^46\).

\(^{43}\) Both paid and volunteer advocates

\(^{44}\) Of the 47 survey responses received, 11 people had used advocacy services, 13 were volunteer advocates, 11 were advocates that were paid for their work through an advocacy provider, 8 were from people who referred people for advocacy, 4 were from other interested parties.

\(^{45}\) Stakeholders were asked about advocacy services across Oxfordshire and didn’t focus on the advocacy provision funded by OCC.

\(^{46}\) Stakeholders were asked about advocacy services across Oxfordshire and didn’t focus on the advocacy provision funded by OCC.
10.1 Communication about the review

Methods of reaching out to make the Oxfordshire community aware that this review was being undertaken included:

- Emailing information, an electronic version of the A3 Easy Read poster and an A4 flyer to over 80 organisations and people in Oxfordshire.
- OCVA cascading the information to over 800 contacts.
- Oxfordshire Unlimited circulating the information to their distribution list.
- Posting 65 hard copies of the flyers and information to organisations or people for whom we didn’t have email addresses.
- VIVA posting out 100 hard copy flyers to young people and emailing their contacts.
- Attending meetings to share information with professionals.
- Using social media with the support of the Family Information Service, Getting Heard and My Life My Choice.
- Requesting that information about the review was included on a range of websites such as Getting Heard, Carers’ Oxfordshire, Age UK Oxfordshire, and Oxfordshire County Council.
- Placing information about the review, the engagement events and the survey on the Oxfordshire County Council online consultation portal and intranet.
- The Talking Health and Patient Involvement newsletters advertised the review with links to the Oxfordshire County Council online consultation portal.
- Asking our 43 libraries to display information advertising the review.
Appendices

Appendix 1- Legislation and Statutory Duties

There are ten specific pieces of primary legislation that place a duty on the public sector generally, and local authorities to provide for advocacy services:

- Mental Health Act 1983
- Police and Criminal Evidence Act 1984
- The Children Act 1989
- Health and Social Care Act 2001
- The Adoption and Children Act 2002
- The Children Act 2004
- Mental Capacity Act 2005
- Mental Health Act 2007
- Health and Social Care Act 2012
- Care Act 2014

In addition, there is a range of other primary legislation which needs to be considered in the context of the provision of advocacy. This includes, but is not necessarily limited to:

- Human Rights Act 1998
- National Health Service Act 2006
- Local Government and Public Involvement in Health Act 2007
- Equality Act 2010
- Public Services (Social Value Act) 2011

When the Government introduced the Care Act 2014, which came into force in 2015, local authorities had a duty to promote wellbeing in everything they do and the statutory guidance highlights the importance of advocacy in achieving this.
Section 3.9 of the 2014 Care Act Guidance defines advocacy as “Supporting a person to understand information, express their needs and wishes, secure their rights, represent their interests and obtain the care and support they need’. However complex people’s needs are, local authorities must ensure people are supported to express their views and helped to consider what options they have, which increases individuals’ control and self-determination”.47

The Care Act, therefore, places a duty on local authorities to offer support from an independent advocate, if required, to enable people to be involved in decisions about them, their care and support. The duty to provide independent advocacy applies from first point of contact with the local authority and at all stages of assessment, planning, review, and in the case of safeguarding enquiry or review.

47 Department of Health (2016)
Appendix 2- Overview of Existing Services

Advocacy Service that Supports Children and Young People - VIVA

Both Independent Visitors (IVs) and Advocates are provided through the VIVA service which is an internally managed service delivered by volunteers. The service currently provides support to vulnerable young people and those on child protection plans which is above the statutory minimum. VIVA will support young people from 5 -18 years old, or up until the age of 25 if they have special educational needs and require continued support into adulthood.

Since 2014, referrals to the VIVA service have tripled and show an increase of young people with multiple needs or who are at risk of abuse or other issues that make them vulnerable. The role of VIVA volunteers is a high-risk responsibility and there is a necessity for the VIVA team to provide more intensive day-to-day advice and complex case management. There is an on-going need to ensure support and clear guidelines are in place to ease any pressure on volunteers and that the young people are not put at risk.

The VIVA service currently has the support of 63 volunteers48 which is a 28% increase on the 49 volunteers who worked for VIVA the previous year. 50 volunteers are female and 13 are male. There were 20 worked as advocates and 31 as Independent Visitors, and 12 worked across both roles. In May 18, they will be training and recruiting 10 new volunteers. They have also developed a small pool of 4 sessional paid advocates who take on complex cases or provide support to Private Residential Homes on a cost recovery basis. All their sessional paid advocates also agree to undertake one volunteer case at any given time.

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48 VIVA annual performance report 16-17
**Independent Visitors**

An Independent Visitor is a reliable, consistent and independent friend who visits a Looked After Child (LAC) or young person who is isolated and has limited or no family contact. Once trained and matched with a child or young person they will function independently of the council. Independent Visitors are not closely supervised or ‘case-managed’, but risk assessments are conducted as part of the matching process and safeguards and support measures are put in place for emergency situations. They are expected to maintain regular contact with VIVA staff and attend training.

Local authorities are required to provide Independent Visiting in prescribed circumstances to all children looked after by the Local Authority, whether by agreements or court order; and to all children in care if this is in their interests. In 2011 the government guidance on Independent Visiting (IV) was extended include the new duty to appoint an Independent Visitor for a Looked After Child whenever it is in the child's best interest as opposed to specific circumstances.

The average turnaround time for a referral to the independent visiting service is 2 months, but when case loads are high this can be up to 6 months.

VIVA prioritises referrals for IV services for children and young people in the following circumstances:

- Looked After Children
- Children subject to child protection
- Children at risk of sexual exploitation
- Children with no family support
- Children with mental health issues
- Children with special educational needs and disabilities (SEND)
- Any other young person deemed vulnerable within our definition

IVs provide long term one to one support to contribute to their welfare through fortnightly/or weekly visits.

There has been a 11% increase during 2016/17 in the number of young people receiving Independent Visiting support with 60 being supported during the year. There were 57 cases
which were Looked After Children. At the end of March 2017, there were 10 cases on the waiting list for services.

Advocates

Independent Advocates are adults who are trained to support children and young people to get their voice heard when they do not feel they are being listened to or taken seriously. VIVA provides issue-based advocacy support (e.g. preparation and representation for a ‘Looked After’ Review) and some specialist advocacy services.

VIVA aims to match advocates within four weeks upon receipt of a referral. For urgent cases VIVA aims to match advocates sooner, but this is dependent on the availability of volunteers with suitable skills to meet the young person’s needs. VIVA has found that cases are becoming more complex and is increasingly using paid sessional workers to deal with these cases rather than volunteers.

All young people who are considered vulnerable are eligible for advocacy support. VIVA may have to prioritise some cases in the following circumstances:

- Looked After Children who wish to be represented by an independent person
- Children and young people at risk of sexual exploitation
- Children and young people at risk of homelessness
- Children and young people with mental health issues and not accessing alternative one-to-one support
- Children and young people making a complaint
- Children and young people in residential or edge of care accommodation

Independent Advocates make weekly visits to residential care homes to raise their profile and pick up individual cases.

Demand has increased for out of county referrals for young people in care. These cases are being delivered through commissioning a national advocacy services provider.

A total of 100 young people received Independent Advocacy support through VIVA during 2016/17⁴⁹ which was a 29% decrease on the young people in receipt of advocacy the VIVA Annual Performance report 2016/17
previous year. The number of Looked After Children receiving advocacy was 81, with 8 young people on Child Protection plans, 4 were at risk of child sexual exploitation (CSE) and 7 were complex cases with multiple issues spanning several categories. The decision to reduce the advocacy numbers was a strategic decision as advocacy referral numbers had become unmanageable. As of March 2017, there were 3 young people on the waiting list for advocacy support.

Adult’s Advocacy Services - Getting Heard

The County Council has statutory responsibility for provision of several independent advocacy services and these services are delivered by volunteers and paid advocates who are recruited and overseen by the charity ‘Getting Heard’ on behalf of the county council with the current contract running from April 2016 to March 2019.

The statutory advocacy services delivered are:

- **Independent Mental Health Advocacy Service (IMHA)** - If a person is being detained under the Mental Health Act or in prison, they are legally entitled to help and support from an Independent Mental Health Advocate. Between April-September 2017, there had been 310 actioned cases, with 96 new referrals and 200 closed cases.

- **Independent Mental Capacity Advocacy (IMCA)** - A person must be referred for advocacy support if they have an impairment, injury or a disability which results in them being assessed as lacking the capacity to decide about their medical treatment and they have no ‘appropriate’ family or friends that can be consulted. Between April-September 2017, there had been 279 actioned cases, with 170 new referrals and 94 closed cases.

- **Independent Care Act Advocacy (ICAA)** - A person can be supported by an advocate to be involved in decision making about their care. Between April-September 2017, there had been 140 actioned cases, with 61 new referrals accepted and 47 closed cases.

50 Getting Heard is a new partnership between Oxfordshire Advocacy (the previous provider) and seAp a regional advocacy charity (which delivered the NHS complaints service).

51 The Independent Mental Capacity Advocacy element of the contract is experiencing an increase in demand primarily because of Deprivation of Liberty Safeguards (DoLS). This has been acknowledged and an addition to the contract has been made to manage this.
• NHS Independent Complaints Advocacy Service - A person can be supported by an advocate to make a complaint about a service received through the NHS. Between April-September 17, there had been 221 actioned cases, with 74 new referrals accepted and 17 closed cases.

Advocacy Services that Support Children and Adults

Appropriate Adult Service

The Appropriate Adult Service (AAS) provides a rapid response advocacy service for children, young people and vulnerable adults held in custody. Demand for the service is stable with an average of 2-3 cases per week. Cases are equally distributed between children & young people and adults and over the daytime and out of hours’ periods. The service is delivered by using an on-call rota of volunteers and is managed and located within the Youth Justice Service. There are advantages to the Appropriate Adult Service being run within the Youth Justice Service in terms of having oversight with cross-over of caseloads and management of complex cases. The volunteer delivered service is provided Monday-Friday in working hours with the out of hours’ service delivered through the social care Emergency Duty Team (EDT).

With complex cases, there is the option to use Youth Justice Service staff as the Appropriate Adult where it is judged this would be beneficial, e.g. the nature of the issue or if the person requiring advocacy is already known to the service. This service also provides advocacy to vulnerable adults which is not currently a statutory function.52

Self-Advocacy

My Life My Choice (MLMC) raises the levels of self-esteem and quality of life for people with learning disabilities by providing volunteering, training, employment and social opportunities for its members through various ways which include the Self Advocacy groups.

The charity is the only independent, user-led, self-advocacy organisation (all 15 trustees have learning disabilities) of its kind in Oxfordshire. The charity’s membership has grown from 320 in 2009 to 535 in 2017.

They are funded to deliver 9 monthly locality groups across Oxfordshire, which includes a group for young people in Oxford. Each group is supported by a volunteer facilitator and the groups are set up with a committee and include a Chair, Treasurer and Secretary. Members pay a small fee each month. Each group differs from the next and is defined by the peoples attending and the local community. The Self-Advocacy groups and their members meet up monthly in various towns and colleges in Oxfordshire. It is at these groups that people make new friends, get out of their homes, speak up for their rights, increase their confidence, get advice, talk about their interests and learn new skills. They are also funded by OCC to provide 'experts by experience' and 'family carers by experience' to carry out monitoring tasks related to services for people with learning disabilities commissioned by OCC. Currently MLMC sub-contracts to Oxfordshire Family Support Network (OxFSN) to provide the ‘family carers by experience.’
Appendix 3 - Need for Advocacy Services

There is a correlation between a need for advocacy and:

- Disability and long term health conditions
- Ethnicity
- Mental Health
- Number of carers
- Number of people using health and social care services
- Population ageing
- Population growth
- Poverty/deprivation