

Advocacy Outcomes Toolkit

An accompanying guide to the
advocacy outcomes framework



National Development Team for Inclusion

**"Not everything that can be counted counts and
not everything that counts can be counted."
(Albert Einstein)**

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Foreword

Independent advocacy is an essential component of local services and supports for people who are at risk of exclusion from our society. Having access to support will be important to many people in order to help them say what they want, secure their rights, represent their interests and obtain services they need – in relation to the health, social care and education systems and beyond. Advocacy can and should often be that support.

However, in these changing times, what used to be widely understood as being a ‘given’ i.e. that independent advocacy should be available, is increasingly open to challenge. A number of advocacy services have ceased to exist as they have lost funding whilst, for others, there has been a move towards just being contracted to delivery statutory advocacy functions rather than providing wider advocacy support. There are several reasons for this, but a central one is that advocacy services are being expected to justify in new ways the funding they receive and ways of doing that have not been readily available. Advocacy is effectively in competition with other aspects of the health and social care system for limited resources.

The advocacy sector needs to have an effective and evidence based way to argue for funding. Whilst, in part, this should be driven by the moral and values based arguments for advocacy, it also needs to be about demonstrating outcomes and value for money. This framework has been designed, in partnership with the advocacy sector, to help achieve that. Our hope and aim is that these resources will be used by the sector, not only to help it make the case for continued funding and support, but also as an internal developmental ‘toolkit’ that will ensure continual improvement and better advocacy outcomes for people.

We would particularly like to thank the Esmée Fairbairn Foundation for their foresight and generous financial support in providing the funding to enable us to produce these materials.

The continuing strength of independent advocacy is vitally important to many people in our society, and indeed to those responsible for services, as it will assist services to hear the voices of people more effectively. We hope that these resources will make a contribution towards ensuring advocacy’s continued vitality.

Rob Greig

NDTi Chief Executive

Acknowledgements

Special acknowledgement and thanks go to the following people and organisations who shaped the toolkit either through commenting on various drafts, testing the toolkit out in practice or sharing experience and views on advocacy outcomes:

OCAAY, ICANN, VoiceAbility, Ace Anglia, Dorset Advocacy, OPAAL, Karen Newbigging – University of Birmingham, Liz Whitby (and her team) –Commissioner - Head of Customer Voice Suffolk County Council, Kellie Woodley – Inclusion North, Tom Raines – NDTi Associate, Skills for People – Newcastle upon Tyne, Sunderland People First, Jane Dalrymple, Advocacy Centre North, Advocacy in Barnet

The framework and toolkit were developed for NDTi by Kate Mercer – NDTi Associate and Gail Petty – Advocacy and Rights Lead, NDTi

Chapter 1: Introduction

Advocacy exists, partly in response to people's experiences of not being listened to but also as a way to achieve social justice, equality and rights¹. While it originally emerged from the user movement and citizen advocacy, independent advocacy sector now encompasses self-advocacy groups, grant funded advocacy projects, specialist advocacy services as well as increasing numbers of statutory commissioned services. However, whatever their remit, they all share a commitment to make sure people are heard, taken seriously and have increased choice and control in their lives.

The statutory right to access advocacy was first introduced in 2002 for children and young people using complaints systems² and many groups have benefitted since then from having a right to advocacy enshrined in law.³ This movement towards statutory commissioning has altered the landscape of advocacy, and advocacy providers are increasingly required to evidence the quality and impact of their service in local areas.

Whilst many advocacy services have developed their own systems for measuring outcomes there are others that are yet to develop robust tools to effectively measure its quality and impact.⁴ As a sector we don't have unified outcomes that we all measure against.

Anecdotally there are many positive stories of advocacy achievements, but no accepted outcomes framework or methodology to enable advocacy organisations to demonstrate their impact. This lack of demonstrable impact makes it difficult to make the case for continued existence and funding. This toolkit has been developed to fill that gap.

This Toolkit is a detailed guide to support advocacy organisations with defining, measuring and analysing outcomes detailed in the framework as well as your own specific areas of impact. For instance a specific advocacy services providing specialist advocacy may want to tailor-make some specific outcomes to measure support.

e.g. An advocacy project for parents with learning disabilities, may want to measure if parents understood legal processes and were able to communicate with solicitors and professionals. A specific cancer advocacy project may want to measure how much choice and control a person had over their care and treatment.

At the end of the toolkit we have provided some template tools that organisations can use or adapt.

¹ Independent Mental Health Advocacy. The Right to Be Heard 2015 Newbigging et al

² DH 2004 Get it Sorted: Providing Effective Advocacy Services for Children and Young People Making a Complaint under the Children Act 1989

³ See Mental Capacity Act, Mental Health Act, Care Act, The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009

⁴ The Impact of Advocacy for People who Social Care Services 2015 NDTi

The aim of the toolkit

The primary aim of the toolkit is to assist advocacy services capture and measure outcomes so they can demonstrate the difference advocacy makes.

The toolkit is:

- ✓ To help measure the effectiveness of its advocacy interventions. People need to know if a service or project is effective and delivers on its promises.
- ✓ To identify best practice. Understanding what activities are yielding the best results enables you to adjust what you do.
- ✓ To identify areas of weakness or practices that need improvement.
- ✓ To prove the value of your service to existing and potential funders in order to secure its longevity. This is particularly important given the shift away from grant funding to more outcome focused commissioning.¹
- ✓ To gain clarity and consensus around the purpose of your program. The process of measuring and analysing outcomes will support the service and everyone involved in the organisation.

How the toolkit has been produced

The toolkit has been co-produced with people who use advocacy, people who commission advocacy and people who deliver advocacy support. The first task was a review of the body of available literature about advocacy and measuring advocacy outcomes. We then worked with two self-advocacy groups⁵ to find out what people wanted from advocacy and what actions made a good advocate and advocacy service. This led to the development of the outcomes in this toolkit.

Advocacy services, managers and commissioners were asked to review draft versions of the toolkit and their experiences and views shaped its content. A small number of services⁶ then tested the questionnaires with different stakeholders and their subsequent feedback led to the final revision of the toolkit that you see here.

Things to think about before you start!

- **There is no quick fix to measuring the impact and quality of advocacy.** If measuring advocacy was easy and simple, an agreed system would already exist!
- **It will take time to do this properly.** You will need to invest time and resources in developing your outcomes system. This will include training your staff, investing time to gather data and, importantly, effectively analyse your data once you have collected it.

⁵ Sincere thanks to Newcastle Skills for People and Sunderland People First

⁶ A total of 5 services tested the questionnaires out in real life settings. This included people using non instructed advocacy, IMCA, IMHA, generic and Care Act Advocacy.

- **Measuring outcomes isn't an annual activity.** To successfully implement an outcomes capturing system, it needs to be embedded within the day-to-day activity of advocates. This may require a shift in culture and priorities.

Defining advocacy outcomes – the challenges

The advocacy sector has been exploring ways of capturing outcomes for a number of years (see NDTi 2015, Gain 2010, Action for Advocacy 2009) and the absence of a nationally recognised approach is not the result of a lack of willingness. However there is a shared sense that succinctly capturing advocacy outcomes is difficult. Practical challenges include:

1: Competing priorities

Advocacy has a number of different stakeholders who each have 'their own priorities and consequently, each their own outcomes'.⁷ This means that stakeholders can have different service aims that may not always align, examples include:

- a commissioner who wants to improve safeguarding so commissions an advocacy project,
- a person who wants to get a benefit payment so asks for advocacy support
- a professional who wants to make sure decision making processes are in line with legislation so refers to advocacy.

2: Unintended objectives/benefits

Advocacy may set out to do one thing but in the process achieve something quite different. These unplanned goals can quickly become the key objective but then it is the *process* rather than the stated *outcome* that becomes the objective of the advocacy support.

3: Unrealistic expectations

People who commission advocacy, use it or work alongside advocates may have expectations of advocacy that cannot be achieved. The person who wants advocacy support may want the advocate to fix things, decision makers may want the advocate to make the decision⁸ and carers may want the advocate to argue for their cause or 'persuade' the person using advocacy down a particular route.

4: Tensions inherent within a user led service

Advocates work with people – who have an unlimited number of individual requirements, aspirations and needs. This means advocacy will inevitably span a wide range of activities. Advocates will often tailor their support and approach to the individual, the situation, the person's goal and the context they are working in. This can make it difficult to reach a universally acceptable description of what good advocacy should look like.

⁷ Lost in Translation. Action for Advocacy p6

⁸ This is a particularly common experience for IMCAs who are often requested to assess a person's capacity or make the decision

Consider the following areas:



Is advocacy primarily about the process of moving towards a goal in order to develop the potential of the person OR is it about achieving the goal so the person gets what they want?



Should advocacy start from a position of idealistic aspiration (ie what the person is entitled to?) OR from a more realistic position that takes into account what is likely?



Should advocacy remain totally independent from the service they operate within OR should it acknowledge the benefits of working in close partnership with providers



Should advocacy always be about seeking an instructed route on what the person wants OR is it okay to rely on other people's definition of people's wants or needs



Should advocacy adopt a helpful compliant approach that seeks quick resolution OR should it be an adversarial/questioning approach that challenges

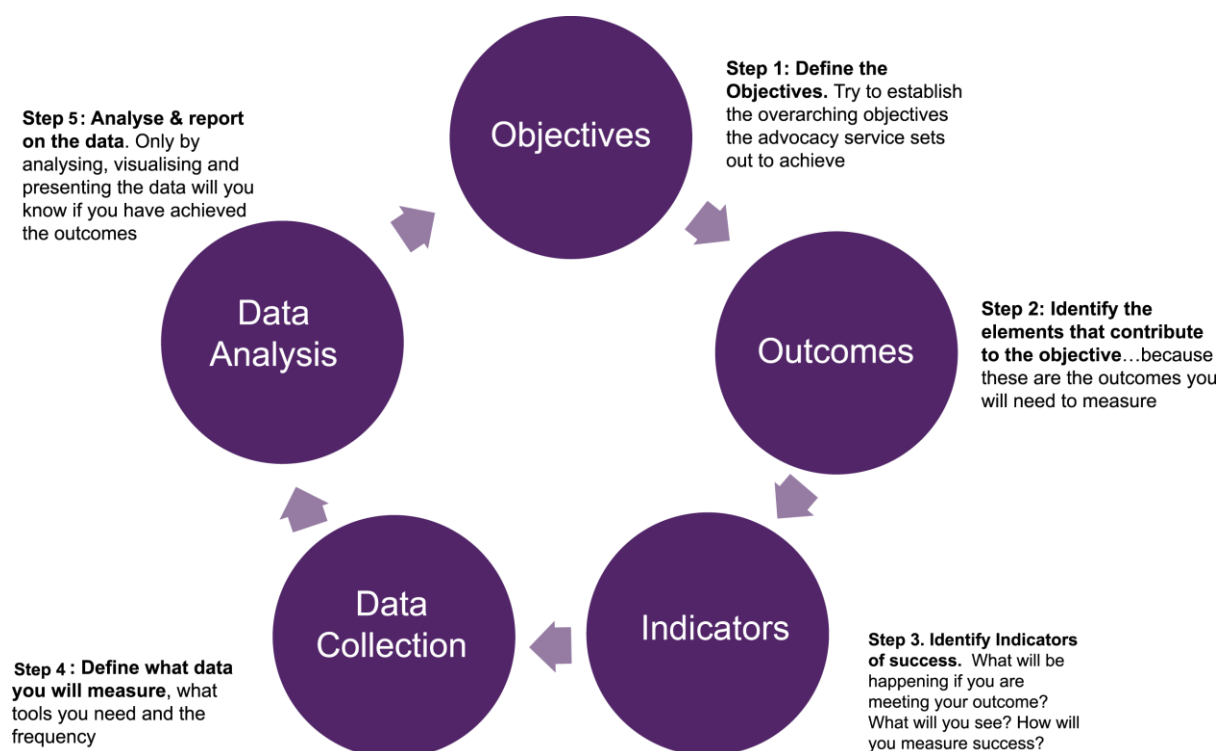


Is advocacy primarily about self advocacy and being client led OR should the advocate make decisions about when to step in and do it on a person's behalf?

The answer of course, is that advocacy is a broad activity that at some point will adopt all of the above approaches. None of the above in isolation will tell the whole advocacy story. Ultimately the person using the advocacy, their goals and aspirations and how they want to lead the process should define the approach.

Chapter 2: An Approach to measuring Independent Advocacy Outcomes

The following four chapters will take you through four steps you should complete when creating a robust approach to measuring the impact of advocacy. It is recommended you use each chapter interactively, read the information and then pause to answer key questions before moving onto the next area.



Plan first. Use a Logic Model.

Before we start, you may find it helpful to organise your thinking and we recommend you use a logic model. In this section of the toolkit you will:

Learn what a logic model is.

Learn why it is useful.

See an example.

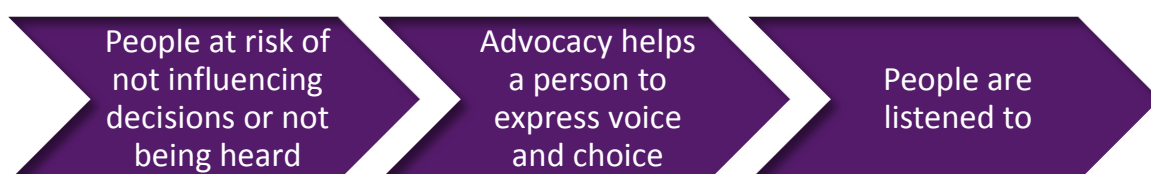
Have an opportunity to generate your own logic model.

What is a logic model?

A logic model is a useful tool that can help you to organise your thinking so that it is simpler to create your objectives and plan your outcomes thinking. It takes you through a process of reflecting on key questions and identifying resources you have available so you know exactly where you are. The model can also help you to have considered conversations with stakeholders about underlying assumptions – ‘what is the point of this service?’ or ‘why do you think this will work in this way’. These conversations are essential at the point of creating or reviewing your outcome framework as stakeholders need to be involved and influence the work.

Why is it useful?

The logic model approach can illustrate the sequence of cause and effect rather than focusing on specific targeted outcomes. It shows a causal connection between the need you have identified, what you do and how this makes a difference.⁹



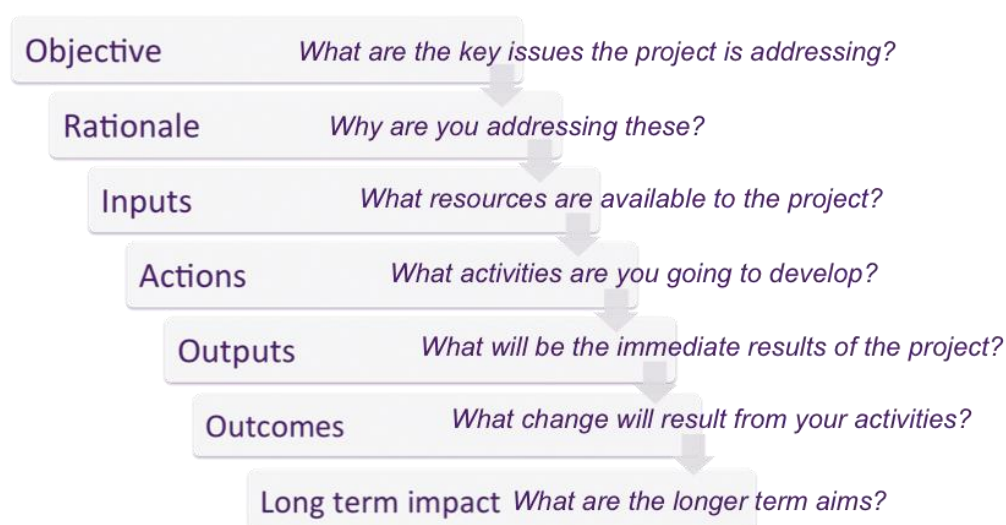
This makes it a useful approach as advocacy is often involved with outcomes that need to be seen as ‘working towards’ but not always ‘accomplished’. By focusing on *how* the intervention is meant to work, the focus becomes on the extent to which the outcomes have been achieved.¹⁰

There is a danger that any traditional process which begins with a focus on inputs and outputs may limit ideas. To avoid an over-reliance on activities that are tried and tested and to encourage thinking outside of the box, the logic model therefore flips the process: instead of the sequence being ‘*what is being done*’ the question posed becomes ‘*what needs to be done*’.

⁹ Support Guide 1.2 Developing a Logic Model Evaluation Support Scotland

¹⁰ IMHA: The Right to be Heard Newbigging et al 2015

A logic model address 7 key areas:



An example logic model

The following example uses an Independent Mental Health Advocacy service to demonstrate the logic model. :

Objective	Rationale	Inputs	Mechanisms	Outputs	Short/medium outcomes	Impact
People who are use mental health services have increased choice and control in their care and treatment	Peoples experiences of being detained under the Mental Health Act mean they:	A statutory service commissioned by the Local Authority	IMHAs knowledgeable about the MHA and skilled in providing advocacy	Regular drop in sessions in each ward	Easy access to the IMHA service	A mental health provision that reflects the needs, views and aspirations of service users
For mental health services to be person centred and responsive to people's views and preferences	- can find the experience distressing - Face difficulty in speaking up - Face barriers in accessing information and require advocacy support Legally , IMHA is a statutory service introduced by the Mental Health Act	Trained IMHAs completing C&G quals Supported and supervised advocates A service that is monitored and evaluated A service that is evidence based A service that is responsive to equality and meets a diverse range of needs	Commissioners undertake needs analysis Services that are co-produced Mental Health Teams raising awareness of IMHA Mental Health staff referring and supporting access to IMHA An opt out referral process	Advocates support people attend ward rounds Patients supported to apply to Tribunal Awareness sessions delivered to mental health teams	Increased attendance during ward rounds Increased understanding of rights Patient/staff relationships are improved Patient's more likely to raise concerns and offer feedback about their experience Increased participation within care and treatment plans	Advocacy that is used to achieve individual goals Recovery from mental health problem is improved Equality of access to IMHA



Toolkit. Over to you...

In this section you can *have a go* at using the logic model. Don't worry about answering every question perfectly... at this point it is much more important to get your thoughts on paper. You can tweak them later.

Area 1: Objective:

Setting what we want to achieve

Write down what you want to achieve through your advocacy service. You may want to consider what problem(s) or issue(s) your project/service is trying to resolve or contribute towards.¹¹

What is the objective of your service?

Area 2: Rationale:

Knowing why you want to achieve this objective

Being clear about your reason why (your rationale) will provide focus and momentum in achieving your goals. Are the reasons why shared across your stakeholders or do different groups have other reasons why they want to achieve a particular objective. Clarifying your rationale ensures it is aligned¹² and you can use this to take people with you.

Why do you want to achieve this objective?

¹¹ This could be taken from your mission statement, value statement, constitution.

¹² If your rationale – or reasons why – are not aligned, you may find they are competing with one another.

Area 3: Inputs:

Identifying what resources are available to do this. This includes people, money, knowledge, infrastructure

Write down all the resources you have at your disposal to achieve your objectives. While money will be likely to feature, the biggest resource within any project is usually its people. What are the strengths of your team? How will you use these?

What resources (inputs) do you have available?

Area 4: Actions:

What are the activities you are developing and for whom.

Consider who your target audience are and what your key actions are. Is it the delivery of a service, campaign, product, a combination of these?

What will be your key activities?

Area 5: Outputs:

What will be done to generate the change (this could include services, products, information)

Write down what you expect your service to produce through its life. This could include products (for instance self advocacy resources, literature including information and advice, social media); services (for instance 1:1 advocacy, group advocacy, peer advocacy); training (for instance awareness raising on when to refer to advocacy, personalisation, rights).

What outputs will your service generate?

Area 6: Outcomes:

What will have changed as a result of meeting the objective

Consider what outcomes you are going to set so that you can clearly see that you have achieved your objective (or not!). This could include changes to practice, changes to behaviour, changes to individuals or changes within health and social care services.

What outcomes will help me understand I have achieved the objective in step 1

Area 7: Impact:

What will be the broader impact of these outcomes

Write down the longer term goals your advocacy project will also contribute towards. This is important as it establishes how advocacy fits into the current context of health and social care services and changes in the wider community. This could include changed circumstances, sustained change or a legacy the advocacy service will leave.

What is the broader impact the advocacy project will have?

You can now use this template to transfer your thoughts onto a more formal table.
Congratulations – you now have a logic model!

Chapter 3: Define your objective (Step 1)

In this section you will:

1. *Learn about the power of co-production*
2. *Learn how to write objectives.*
3. *Be introduced to some off the shelf examples to supplement your own toolkit.*

The Power of Co- Production

Co-producing service objectives means coming together with people who ultimately use the service and others (commissioners, carers, professionals) to decide together what the objective(s) for the service should be.

The benefits of adopting a co-productive model of designing, evaluating and reviewing services is that it can:

- Improve service delivery by making services more relevant
- Improve the experience of people using the services
- Improve the experience for carers of people using the service
- Increase community capacity
- Create outcome-focused and preventative services
- Support integration¹³

Co-production in action¹⁴

In Suffolk the co-production group are looking at what should be included in the service specification for their advocacy services. The group includes organisations delivering advocacy, individuals that have used advocacy and commissioners. In the early stages, the co-production group held two meetings to discuss how they would;

1. Produce a framework for co-production in the timescale.
2. Look at the elements of training and awareness where needed
3. Look at the balance between formal and informal advocacy
4. Support group advocacy where appropriate
5. Set high level outcomes linking to National Making it Real I statements.

¹³ Co-production: What is it and how to do it. SCIE Guide 51 2015

¹⁴ Thank you to Ace Anglia Ltd who kindly provided this practice example of co-producing service

The co-production group agreed they would engage with a wide range of people and professionals who have used or been in contact with the current advocacy service, and also those who don't to find out:

- What does advocacy mean to you?
- What works well?
- What doesn't work well?
- How can we support people to become self-advocates?
- What are the target groups –i.e. prisons?

This led to the identification of areas where access had previously been difficult – for example the IMHA pilot and the parents with learning disabilities self-advocacy group – and implementing ideas to improve accessibility.

The benefits of this approach have been to ensure a wide group of people have had the opportunity to have a voice, there have been no hidden surprises as the service has developed and through developing relationships there has been a positive change in culture.



Toolkit. Over to you...

CURRENTLY: Do you co-produce your service objectives?

What are some the reasons that may prevent you from co-producing your service objectives?

KNOW YOUR REASON WHY: Why should you co-produce your service objectives?¹⁵

¹⁵ For more information on the importance and benefits of co-production see <http://www.thinklocalactpersonal.org.uk/> and <http://www.scie.org.uk/publications/guides/guide51/what-is-coproduction/>

Writing your own objectives.

Keep it easy to understand

For objectives to be owned by everyone involved in the organisation they must be easily understood by everyone.

Example of complicated objectives:

[The advocacy service] will address issues such as health care delivery systems, technological developments affecting the delivery of health care services, the economics of medical practice, organizational and management plans, health manpower needs and production, and quality assurance/utilization systems

Example of easy to understand objectives:

The service will enable people to live their lives as they want to

Be aspirational – let it be big!

Advocacy involves an element of pushing for what should be instead of settling for what is. Without aspiration advocacy risks people accepting what is offered or having such low expectations there is no effective change. This ultimately lessens the impact of advocacy.

Introducing aspirational objectives can also keep the service focused on bigger issues that affect larger numbers of people therefore increasing the impact of the service.

Here is one example taken from a random Internet search¹⁶

This service, with limited resources, aims to empower people so they are listened to

And here is a different objective, which is slightly more aspirational.

This service makes things better. We enable people to influence and control decisions about their life

¹⁶ Using the search term 'objectives of advocacy services' January 2016



Toolkit. Over to you...

Write one or two objectives for your advocacy service. Think big and broad – what is the point of your service, what are you setting out to do?

Take another look at these objectives. See if you can rewrite these making them *even easier* to understand and *even more* aspirational.

Off the shelf: Ready Made ‘Objectives’

Need some ideas? This section provides you with an ‘off the shelf’ set of objectives you can use. This toolkit suggests that for advocacy services to be successful it should achieve change (and have impact) in four areas.



Let's look at each area in detail.

Change for individuals

Why this is important

Changes for individuals

An effective advocacy service is one that delivers good outcomes for the person receiving the advocacy support¹⁷ and the most important objective of advocacy is supporting a person to achieve their goals. These goals can be related to a whole raft of outcomes including accessing services, influencing decisions, making a complaint or achieving change.

People wanting advocacy support often have specific outcomes in mind. So the first stage within the advocacy relationship (in both instructed and non instructed advocacy) is to clearly identify what the advocate is working with the person to achieve. Advocacy can also lead to secondary gains: these are outcomes (changes and benefits) the individual experiences through the advocacy support but were not identified as specific issues to achieve. Such gains include increased confidence, choice and control or empowerment

¹⁷ Making a difference: measuring the impact of IMHA, 2015 SCIE and UCLan accessed 10.11.15 <http://www.scie.org.uk/independent-mental-health-advocacy/measuring-effectiveness-and-commissioning/impact/>

It is therefore critical that the overall objective of an advocacy service, reflects the need to support people to achieve their own personal goals.

Ready made objectives you can use within your service:

The advocacy service will ensure people are listened to

The advocacy service will achieve change for the individual

The advocacy service will ensure people's rights' are upheld

Change to the health and social care sector¹⁸

Why this is important

Effective advocacy will frequently lead to changes and improvements in how health and social care services are planned, delivered and evaluated. A good advocacy service can shine a spotlight on areas that are failing people by analysing themes and trends – and acting upon them, with the result that services change how they do things.

Setting objectives and measuring outcomes in this area can demonstrate to people, including funders, that advocacy also exists to achieve systemic change. This could include:

- improving how services are delivered or experienced,
- enabling services to be more responsive to people's needs
- impacting how services are structured to increase people's independence or natural support networks.

Ready made objectives you can use within your service:

The advocacy service will improve the quality of health (or social care) services

The advocacy service will help health (or social care) services to be responsive to user's experiences

The advocacy service will improve compliance with the Mental Capacity Act

¹⁸ In this context, this includes health, social care, education, justice or any other service or setting

Change to the wider community

Why this is important

Advocacy promotes social inclusion, equality and social justice¹⁹ and has a critical role to play in changing how communities are experienced and accessed by its members. From national political campaigns to local pressure groups, advocacy can reduce social exclusion, increase participation and represent groups who are at risk of being ignored. As a result, communities and 'non-service' organisations may change how they do things so they become more inclusive.

These objectives reflect the broader impact of advocacy provision within a community.

Ready made objectives you can use within your service:

The advocacy service will reduce social exclusion

The advocacy service will improve the social networks of people using its services

The advocacy service will improve equality of access to community services

The advocacy service will reduce hate crime within the community

Changes to the advocacy service

Why this is important

Measuring what works (or otherwise) within advocacy provision is an important way of improving the impact of advocacy. By developing better ways of providing advocacy, the advocacy service can increase its reach and effectiveness.

These objectives require the service to gather evidence that can be measured and analysed to inform service improvement, performance management and business planning.

Ready made objectives you can use within your service:

The advocacy service will improve the way it delivers advocacy support

The advocacy service will offer value for money

The advocacy service will be responsive to the needs of people who use it

¹⁹ QPM Code of Practice NDTi 2014

Chapter 4: Identify outcomes to measure (Step 2)

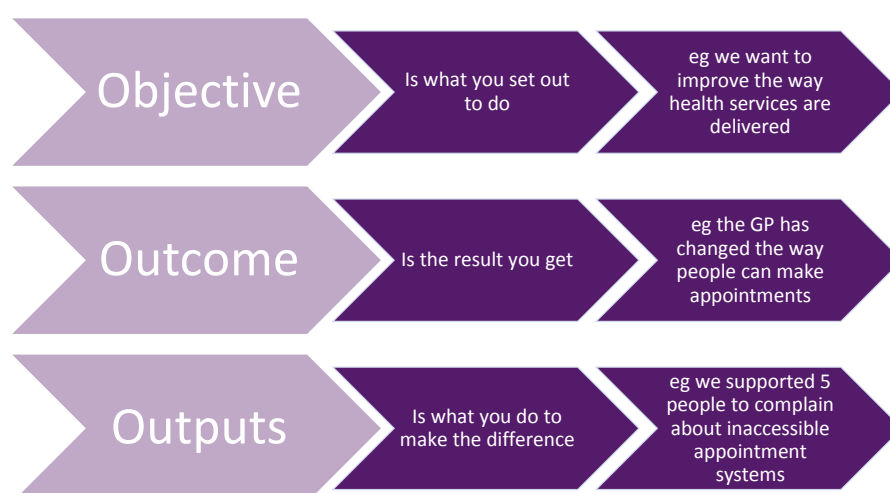
Once you have established your overarching objectives, you are now ready to move to Step 2. This includes identifying the individual outcomes that contribute to the broader objective because these are things that you need to measure.

In this section you will:

1. *Learn what an outcome is*
2. *Learn how to write outcomes.*
3. *Be introduced to some off the shelf examples to supplement your toolkit.*

What is an outcome

An outcome is, quite simply, the difference that has been made as a result of your service providing advocacy support. Outcomes are experienced when things change. They can become easily confused with objectives and outputs, however the three areas can be clearly differentiated:



Rather than looking at what you do, or who you reach (which are better described as outputs), outcomes focus on the difference you have made or the impact you have had: with impact being the overall effect of advocacy on individuals or services.

There are different *types* of outcomes that you can measure.²⁰

- 1: Outcomes relating to the *experience* people have as a result of using advocacy (eg I feel more confident, I am more likely to attend my care review). These may be described as 'process', 'soft' or 'qualitative' outcomes.

²⁰ See Chapter 8 Independent Mental Health Advocacy The Right to Be Heard 2015 Newbigging et al

2: Outcomes reflecting *changes* the person achieves that are produced as a result of the advocacy support (eg I got out of hospital, I made a complaint). These are often described as ‘change’, ‘hard’ or ‘quantitative’ outcomes.

Furthermore, outcomes can be viewed through time: *short term outcomes* are those that happen immediately (eg I understood information, I made a decision); long *term outcomes* relate to changes that happen over a period of time (eg I developed my self advocacy skills, I got a job).

While it is helpful to develop an understanding of the different types, there is no evidence to suggest that any one type is more effective than the others. In fact, most outcomes may connect across groups (developing confidence for instance could be a short, long, process or change outcome). The key factor is to choose the right outcome to monitor the objective you are working towards.

Writing outcomes

A well written outcome will clearly outline *WHAT* has changed (or not) through the delivery of advocacy. When writing your outcomes consider the following:

Align the outcome to your objective

Good outcomes will be aligned to the overarching objective and connect to how the advocacy service will achieve its desired impact. Consider the easiest way of measuring whether you have achieved your objective and you have the start of your outcome. First start with the specific objective you want to achieve, then think about what activities will tell you if you are achieving this. For example:

Objective: To ensure people are supported to make their own decisions	
outcome 1	More people feel listened to
OUTCOME 2	More people have increased choice
OUTCOME 3	Care and support plans are person centred
OUTCOME 4	Care and support plans include the views, choices and aspiration of the individual
OUTCOME 5	The person made decisions they are happy with

Focus on the end result

Remember that objectives are *intended results* (or impact); your outcomes will reflect the *actual* results you have achieved. Put simply, consider what will happen as a result of using/commissioning/working with the advocacy service.

Chunk it down

Another good way of creating your outcome is to

1. identify your target audience. Is it the person using the advocacy service, professionals, the wider community, carers, Government, the advocates?
2. identify the change you are seeking to capture. Do you want to increase, reduce, improve, involve, learn, challenge etc
3. identify the area(s) where you expect the results to show up.

For instance:

Who /what	Change/Desired affect	In what
<i>People receiving treatment for mental health problems...</i>	<i>...increase...</i>	<i>...their participation in ward rounds</i>
<i>People using advocacy...</i>	<i>...achieve...</i>	<i>...their goal</i>
<i>People with learning disabilities are...</i>	<i>...less isolated...</i>	<i>...in their communities</i>
<i>People affected by the Mental Capacity Act are...</i>	<i>...supported...</i>	<i>...to make their own decisions</i>
<i>Advocates...</i>	<i>...learn...</i>	<i>...how to deliver better advocacy</i>



Toolkit. Over to you...

Write your first objective from the previous section.

Now describe some outcomes that you expect to achieve as a result of providing advocacy)

Who /what	Change/Desired affect	In what

INDITIFYING INDICATORS OF SUCCESS (Step 3)

It can also be useful to identify **Indicators of success** – what are the changes that you will see if you have achieved your outcome? What are the signs that things are changing? How will you gauge success?

When you know what the indicators are, it easier to decide on how to collect evidence that things are changing



Toolkit. Over to you...

Write the first outcome you recorded above

Now try to define the indicators for success. What will be happening if you are meeting your outcome? What will you see? How will you measure success?

Chapter 5: Define how to measure outcomes (Step 4)

Once you have established the specific outcomes you want to measure, you are ready to move to Step 4. This includes identifying **how** you are going to measure.

In this section you will:

Learn about subjective (or attitudinal) tools you can use

Learn what quantitative (or objective) data you can capture

Learn what an outcome matrix is

The decision about which outcomes you want to measure is just as important as the decision about the *tool* you use to capture the data. This chapter will explore a number of measurement tools that are currently available to obtain different types of information.

Not all approaches will be appropriate for every service to use – nor are they always the most effective for all types of data. We therefore recommend that you consider which tool is the most appropriate for each type of data you want to measure.

The first group of tools have been designed to collate *subjective* measures - put simply this is asking someone for their opinion. The second group of tools are better suited to capturing objective or “hard” data measures.

Subjective (attitudinal) approaches

Perhaps the simplest way of finding out about someone’s experience and their attitudes towards the quality and impact of advocacy is to simply ask them.

There are three main strengths of using an attitudinal survey:

1. Attitudinal surveys are easy to access, understand and use.
2. They provide a universal method of collecting data that does not force people to express an either/or opinion as it allows people to offer a range of answers, including the option to remain neutral.
3. They provide substantial data that makes it easy to draw conclusions, results and track issues from responses.

Attitudinal surveys can have their problems: namely that obtaining enough data for it to be meaningful and reliable can be difficult. People do not always want to or have the time, desire or ability to feedback their views (particularly in instances where Non Instructed Advocacy is used).

Furthermore, attitudes, beliefs and views about the advocacy provided will be related to self image, social acceptance, expectations and group behaviour which invites the risk the person presents a view (or an attitude) that is based on what they think you want to hear, expectations they have of others or expectations they believe others have of them. This will be particularly pertinent if the advocate who delivered the

support is the advocate asking the person about their views on the quality of their work – the person may feel under pressure to provide positive or untrue feedback.

Furthermore, attitudes will be influenced by bias and pre-conceived expectations that may or may not be realistic. For instance a complainant may approach the advocacy service with the single issue of 'I want that consultant sacked'. Whatever the activities of the advocate this outcome is not likely to be realised since it is outside the scope of the advocacy service to make that decision. It is possible the person using advocacy will be left dissatisfied with the advocacy offered regardless of what action the advocate took to explain their role or support the person through the complaint service.

The risk, therefore, is that detailed feedback will more easily capture the extreme views of those who are either extremely satisfied or extremely dissatisfied and will therefore be difficult to interpret.

Let us now take a look at 4 practical tools that can capture attitudes:

1. The Likert Scale
2. The Outcome Star/Daisy/Radar Plot
3. Asking questions
4. The Net Promoter Score (NPS)

1. Likert scale²¹

A Likert scale is a psychometric scale commonly involved in research or when measuring outcomes. It is a questionnaire that involves an ordered scale from which respondents choose one option that best aligns with their view. It is often used to measure respondents' attitudes by asking the extent to which they agree or disagree with a particular question or statement.

Features of a traditional Likert scale include:

- a declarative statement
- an ordered continuum of response categories
- balanced number of positive and negative options
- descriptive and numerical value assigned to each category

For instance:

	Totally Disagree	Disagree	Neutral	Agree	Totally Agree
	1	2	3	4	5
I found the advocacy service easy to access					
My advocate explained their role clearly					
I feel less socially isolated as a result of using advocacy					

²¹ Named after its inventor the psychologist Rensis Likert (1932) A Technique for the Measurement of Attitudes

2. Outcome star/daisy/radar plot²²

The Star has been widely used as a tool for measuring advocacy outcomes²³. It is a variant of the well known Radar Plot and initially developed to monitor outcomes of work with homeless people. More recently a 'Recovery Star' and Outcomes StarTM has been developed by the Mental Health Providers Forum and Triangle consulting to measure the impact of mental health services.²⁴ Variants within advocacy have also been developed such as the Advocacy Daisy²⁵ and Wellbeing Star²⁶

The Outcomes StarTM measures and supports progress for people's progress towards self-reliance or other goals. The Stars consist of a number of scales onto which the person and advocate plot where they are, in their journey.

The star method of capturing progress relies on the advocacy partner being able to self monitor and self evaluate. This is therefore not appropriate for people who have not consented to the advocacy support (such as within IMCA or other non instructed forms of advocacy) or are unable to identify specific goals they wish to achieve. One way to address this is for the advocate, carer or other professional to make a decision on what the outcomes are and judge progress – but this introduces its own obvious problems of collecting attitudes of staff and other stakeholders but not of the advocacy partner.

A second problem is the star can be seen as a complicated way to think about what advocacy is achieving or a patronising way to 'encourage' the person to grow.

The third problem is a threat to independence. People using advocacy – especially within mental health – can see the star as very similar to the 'Recovery Star' which can suggest that advocacy is part of the 'system' rather than independent from it.

How to use

- Step 1. Create the chart. The advocate supports their partner at the beginning of the relationship to identify what goals they want to achieve.
- Step 2. Record progress. Mid way through, the advocate supports the person to review progress towards the goal(s). This process is repeated at the final meeting as the advocacy is reviewed and closed.
- Step 3. Interpret the data. Record the 'distance travelled' towards each goal.

The benefit of using a distance travelled model is that it captures movement which for some may seem insignificant, but for others the leap forward in achieving these outcomes is immense.

²² A radar plot can be generated in Microsoft Excel for free. See <https://support.office.com>

²³ Lost In Translation 2008 Action for Advocacy

²⁴ See www.outcomesstar.org . Please note the Star has been developed by Triangle. It is free to try out on paper. If you decide to implement fully, there is a licence fee for use online or within paperwork.

²⁵ See Independent Living Association www.ilaessex.com

²⁶ SEAP in Essex,

Practice example

Stuart has motor neurone disease and has asked to work with an advocate as he wants support through a care and support assessment.

At the beginning of the relationship he identifies his goals are:

- 1. to understand the process of assessment*
- 2. to lead the process of assessment and possibly complete a support self assessment*
- 3. to get an assessment that identifies all of his eligible needs*

Working with the advocate they create a personalised star/daisy with five spokes (four were based on the 1, 2, 3 above and one was left blank to allow for future new goals.

At the beginning of the process Stuart self assessed himself as being on the following scale:

- | | |
|---|--------------------|
| <i>1. Understanding the assessment process.</i> | <i>Position: 1</i> |
| <i>2. Leading process of assessment</i> | <i>Position: 0</i> |
| <i>3. Completing a self assessment</i> | <i>Position: 0</i> |
| <i>4. Make sure all needs are identified</i> | <i>Position: 0</i> |

The advocate worked with Stuart and supported him to complete his self assessment. This took 6 visits over a 3 week period. At the end of the assessment they reviewed Stuarts goals and Stuart reflected on where he felt he was at the end:

- | | |
|---|--------------------|
| <i>1. Understanding the assessment process.</i> | <i>Position: 4</i> |
| <i>2. Leading process of assessment</i> | <i>Position: 5</i> |
| <i>3. Completing a self assessment</i> | <i>Position: 5</i> |
| <i>4. Make sure all needs are identified</i> | <i>Position: 4</i> |

This data was used by the manager to report on distance travelled towards goals and Stuart and the advocate opened another star to look at his goals within the care and support planning process.

3. Asking open questions

Asking targeted questions about people's experience of using advocacy can be an effective way of gathering specific data.

Questions are a great way of:

- learning things about how your service is experienced
- identifying what the service is doing well
- identifying training needs

- learning about areas that need improving
- keeping the service in tune with current experiences of people who use advocacy
- hearing directly from people who use or work alongside advocates about what made the difference and what is important to the user

Introducing a tool of asking open ended questions, allows you to find out about the quality of your service by exploring the person's experience and their views. The problem with using questions is how to analyse large amounts of data (consider the depth of feedback from 500 open ended questions – how do you pull this together into an objective report).

Open ended questions are, however, a truly effective way of learning more about your service, the people who use your service and the people who commission or work alongside advocates. For instance: imagine an advocacy service has identified its objective and what outcomes it wants to measure:

Objective: To improve access to the advocacy service of people from BME communities

OUTCOME
1

50% more people from BME communities will have used the advocacy service

OUTCOME
2

More people from BME communities understand how advocacy is a relevant service for them

OUTCOME
3

The advocacy service increased its understanding of engaging and supporting people from BME communities

It now wants to decide what methodology or measurement tools it will use to monitor progress.

Gathering **quantitative data** on numbers of people from BME communities who have used the service will illustrate if outcome 1 has been achieved. **Attitudinal surveys** will help to identify progress towards outcomes 2 and 3. But neither of these methodologies will help to develop an understanding and appreciation of *what* activities are specifically working to achieve the overarching objective. Asking targeted questions will. Imagine the quality of information the service could receive by asking:

- What do you think the service needs to do, in order to improve access for people from BME communities?
- Did you feel the advocate provided culturally sensitive advocacy support? Tell me more about your response...
- What should the advocacy service be investing in to make sure it is accessible to people from BME communities?

4. Net promoter score (NPS)

The "Net Promoter Score" is a customer loyalty metric developed by (and a registered trademark of) Fred Reichheld, Bain & Company, and Satmetrix. It was introduced by Reichheld in his 2003 Harvard Business Review article "One Number You Need to Grow".

Net Promoter Scoring is based upon the answer to a single question asked of people who currently use your service or product. This can be followed up with an open-ended request for more information exploring the reasons for why they have offered the rating.

The Net Promoter question asks people who have used your service: "How likely would you be to recommend *<this organisation>* to a friend or colleague?" Your resulting Net Promoter Score produces a clear measure of your organization's performance as seen through your clients' eyes.

Within health and social care this approach is rapidly gaining credibility as a way to benchmark user experience. In 2015 the NHS have started to use this question calling it the 'friend and family test' and have rolled this out across hospitals and GP surgeries.

NPS can be as low as -100 (everybody is a detractor) or as high as +100 (everybody is a promoter). An NPS that is positive (i.e., higher than zero) is felt to be good, and an NPS of +50 is excellent.

The main benefit of using the NPS is that it gives a single transparent number that can be used to compare different services. It also captures very succinctly and effectively whether people value your service or not. It is also very easy to use.

A secondary benefit of the NPS, is it provides an easy way to gather views of ALL people who are affected by the advocacy services including professionals, people who use advocacy, carers and family members.

How to find out your NPS

Step 1: Ask people who use your service to answer the very simple question on a scale of 1 – 10. "How likely would you be to recommend *<this organisation>* to a friend or colleague?"

Step 2: Add together the number of people who are 'promoters' of your service, These are people who are so enthusiastic about your service that they not only increase how often they use you, but also refer other people. These are people that give a rating of 9 or 10.

Step 3: Add together the number of people who are 'neutral'. These are people who give you a rating of 7 or 8 are considered neutral and do not factor into the Net Promoter Score.

Step 4: Add together the number of people who are 'detractors'. These are people who feel so let down by your service that they stop using you, switch to other

services, and may even warn others to stay away from your company. These are people that give a rating of 6 or lower.

Step 5: Work out your Net Promoter Score by subtracting the percentage of 'detractors' from 'promoters' to get an overall NPS number as shown below:

$\% \text{ of Promoters} - \% \text{ of Detractors} = \text{Net Promoter Score (NPS)}$

Case study

An IMCA service uses the NPS with decision makers and referrers. At the end of one quarter they receive the following data:

50 responses spread over the following categories:

Would you recommend the IMCA service to your friends, colleagues and family?

	Definitely not Definitely									
Scale	1	2	3	4	5	6	7	8	9	10
People			1	6		4	9	5	13	12

Total of Promoters (score 9 + 10) = (25) 50%

Total of Detractors (score 1- 6) = (11) 22%

Total Neutral (score 7 or 8) = (14) 28%

Subtract the Detractors (22) from the Promoters (50) to arrive at the NPS.

The final NPS score for this service is 38.



Toolkit. Over to you...

Which of the following attitudinal tools can you use in your service?:

Tool	Use already	Interested in using	Not relevant	Comments
Likert scale				
Outcome Star				
Asking questions				
Net Promoter Score				

Using your outcome and identified indicators of success, decide which qualitative tools will be most helpful to you?

Quantitative Objective measures

While subjective approaches to capturing data against outcomes are a very useful way to hear about people's experiences and views, they are not by any means a totally reliable source of accurate information. As previously explored they suffer from being a reflection of a person's perception, value base or unconscious bias.

Objective measures on the other hand are measures that capture precise and factual data. These are quantitative measures that are not opinion but grounded in facts based on data. Examples could be the number of cases opened and closed, the time spent on a case, the number of complaints submitted.

They are a useful measure of data collection as they provide 'clean' data that can be audited, traced and checked. This allows the service to:

- provide robust evidence of progress towards objectives
- make direct comparisons (between quarters, areas, services, advocates)
- identify change as it happens.

However, you cannot rely on these types of measures in isolation, when exploring issues of quality, effectiveness or success. Most data collected by the advocacy service means nothing without analysis, context and meaning. The length of time cases are open for says nothing about quality, intensity of support offered or why some cases take disproportionately more time. You should therefore consider adopting both types of tools when designing your framework to capture outcomes.

Which objective measures to use?

The following are a number of objective measures an advocacy service may want to consider using:

TIME	This could include the length of time cases were open for, waiting times, how long it took to move from referral to response, the time spent waiting for ward rounds (or other meetings) etc
FREQUENCY	This could include the number of times a person attended their meeting, had their views recorded in the care plan, accessed information about their rights, the number of challenges made, safeguarding alerts raised, systemic changes, complaints upheld etc
INTENSITY	This could include the amount of work provided, visits taking place, meetings attended
VOLUME	This could include the amount of people who accessed or used the advocacy service.

Outcome Matrix

An outcome matrix is a way of tracking and monitoring the aims or objectives of individual advocacy relationships against the wider objectives of the advocacy service. It is a simple way of checking if individual pieces of work contribute to wider service objectives.

By using the outcome matrix you are able to see if your service outcomes are truly reflecting what people want from the advocacy service - if none of the service outcomes are aligned to people's individual outcomes serious questions would need to be asked about the appropriateness or relevance of the service outcomes.

You create the matrix by identifying the service objectives and outcomes across the top of the matrix. Next, transfer the individual outcomes from the person using advocacy down the side. Mark at the points where they meet:

	Service Objective	To help people achieve their goals					
	Service Outcomes	The person is more likely to achieve their outcome(s)	The person feels listened to (by health or care provider)	The person has increased choice	The person is supported to make their own decision	The person is supported to appeal, complain or raise concerns	When professionals make decisions about a person's life, these are taken in line with current legislation
Individual outcomes	I want to get discharged from hospital and go home	X			X		X
	I want to see my daughter	X			X		
	I want support to attend my ward round	X	X	X	X		X
	I want leave so I can go to the shopping centre	X	X	X			X

By completing these outcomes across the service and with large numbers of advocacy relationships/interventions, you can build up a picture of how the two are aligned... and this tick box activity does not require significant time being invested.

You can also use an outcome matrix to track how individual outcomes feed into the overall impact as set out in the *associated framework*



Toolkit. Over to you...

Have a go at writing an outcome matrix from your last experience of providing advocacy. Write your service outcome across the top, the person's outcome down the side. Mark where they meet.

	Service objective						
	Service Outcomes						
Individual Outcomes							

Chapter 6: Analyse & Present the data (Step 5)

Once you have decided the tools you will use to measure your outcomes you are ready to move to Step 5. This includes analysing and presenting your data.

In this section you will:

- 1. Learn why analysing data is important*
- 2. Be introduced to basic statistics and data visualisation*
- 3. Be introduced to ways of analysing quantitative and qualitative data*
- 4. Explore how to present your data*

The final step in the process of measuring advocacy outcomes is deciding how to analyse and present the information. The power of collecting all of the data discussed within this toolkit, is that when you analyse it, you can easily identify indicators and themes to explore. This is likely to include:

- Service themes that occur across the advocacy provision (the common advocacy issues that are being consistently raised that you want to bring to the attention of the commissioner/service manager)
- Things you are doing well (so you can celebrate and do more of this)
- Things you are not doing well (so you can take action to make things better)
- Unmet need
- Systemic change (issues relating to the health or care 'system' that need addressing at high levels).

Please do be aware, that the information presented here is an introduction into the wide and complex field of research analysis. The following sections have been written to offer you a flavour of data analysis. If you decide to use any approach you can find lots more detailed information on line.

Analysing the Data

A common problem – or missed opportunity – in the reporting of outcomes is the failure to analyse the findings from the data. Simply organising and visualising the data you have collected from measuring the advocacy outcomes in the right ways can provide useful insights into your practice and impact of the advocacy you conduct. Going a step further your analysis can extrapolate beyond the data you have collected to draw wider conclusions about the client groups you deal with and the impacts of advocacy.

Good analysis methods can be directly beneficial to organisations in numerous ways:

Continuous improvement

A continuous improvement model reflects an ongoing effort to improve your service. By seeking out small or incremental improvements over time, your service

continuously improves and increases its effectiveness, efficiency and therefore increases its impact. A continuous improvement model is based on small changes being identified from front line staff using their insights into how to improve the services. It follows a bottom up approach of seeking change rather than top down strategic changes instigated by senior management.

For example: A group of Independent Mental Health Advocates identify that having a regular physical presence on the ward seems to lead to an increase in self referrals. The service decides to begin to record data on who makes the referral (professional, nearest relative, person themselves) and observe higher referrals from wards where the IMHA has a daily, regular visit. The advocacy service change their policy so an advocate visits a ward at least 3 times a week at regular times.

Surveillance

A surveillance model relates to a system of data collection that makes it easy to see when things go wrong and prompts you to take action to deal with problems as they arise. It is particularly useful for identifying sudden unexpected changes within the operation of the service.

For example: the advocacy service collects data on the number and source of referrals they receive. They notice from this regular monitoring a sudden negative reduction in the number of referrals from social workers in a local team. This triggers action to understand the nature of the problem and the advocacy manager learns that a recent restructure has meant an influx of new social workers. The advocacy service responds by arranging a number of awareness sessions with the social work team to ensure they understand when they need to offer advocacy.

Team or individual performance management

Data collection is an important part of monitoring team or individual performance. Whilst it will not provide a full picture in isolation, data is a useful way to compare and contrast the performance of individuals and teams in order to identify best practice and best use of resources.

For example: the manager analyses individual feedback from people who have been supported by a certain advocate. The feedback identifies that the advocate is particularly effective at supporting people with learning disabilities to participate within meetings. This allows the service to draw from the advocates approach to glean best practice to disseminate amongst the rest of the team.

The Spotlight model

The spotlight model is a great way of collecting data which flags up areas of concern within a service. This could be within the advocacy service itself or within the health or social care provision the advocacy service operates within. The latter is an excellent tool to deliver systemic advocacy: this is the raising of themes and trends of problems within the health or care system.

For example: the advocacy service analyses feedback from people who use the advocacy service and compares the data from different hospitals. This identifies

significant differences in the experiences of people being listened to. This provides robust evidence for the advocacy service to approach the service that could improve.

How to analyse quantitative data.

Being able to analyse the numerical data you collect is important but it's impossible to consider how to analyse quantitative data without touching on statistics. Statistics in its simplest form is about describing the data you have, and this first step into the world of statistics is all that's needed to start to provide useful analysis.

Descriptive statistics are a recognised and well-understood set of measures used to provide simple summaries of numerical data. Together with graphical analysis, they form the basis of virtually every quantitative analysis of data.

Descriptive statistics are used to present large amounts of information in a manageable form by reducing data into a simple summary. For instance, consider how collecting large amounts of data on a single factor could be summarised to show how well an advocacy service responds to local need. One option could be to calculate the average number of days a client waits for an advocate to be allocated to them. This single number is simply the number of days all clients have waited in total divided by the total number of clients. The single number describes a large number of discrete events. The average (or mean) is a key descriptive statistic.

Descriptive statistics can provide a powerful summary that may enable many useful comparisons across people, times, services or other factors. For our example we could:

- Compare the waiting time average month by month over time to see if it improves or gets worse.
- Compare the waiting time of an individual client to the average in order to flag when people have been waiting longer than average.
- Compare the average waiting time by different case types. This could identify the ones that are waiting longest, (and perhaps from this identify a recruitment or resource need).

The key ways of summarising data rely on describing it correctly. To do this, you need to understand three key metrics:

1. Distribution

This is a summary of the frequency of which individual values appear across the data captured. For example, categorising the frequency of how long advocacy cases are active for from referral to closure in your service will provide a long list of different case durations (one for each case). However each can be categorised in a specific range of case length, e.g. 1 to 20 days, 21- 40 days, 41-60 days etc. It is then also likely that cases are much more likely to last for some durations than others. So there will be higher frequencies of cases in those categories than in others:

Case length categories (in days)	No. of Cases (Frequency)
1 – 20	19
21 – 40	7
41 – 60	17
61 – 80	28
81- 100	20
Over 100 days	9

2. Central Tendency

This is an estimate of where the central point of all the data collected is, and is most familiar to us when expressed in the measures we use to summarise the average, (or mean). Other measures used are the mode, (most frequently occurring value) and median, (the middle value in the set of all values).

3. Dispersion

This is a summary of the spread of the data, or the extent from the smallest value collected to the largest. It is important to consider dispersion as well as central tendency as outliers in data that can both skew estimates of where the centre point of data actually is and also provide clues to where problems might be.

In our example data in the table above for case length lets imagine the average case length for those 100 cases was 63 days. However the range of data is very wide and investigation finds out the 19 cases which last under 20 days in fact are opened and closed the same day and are the result of wrongly directed requests from referring services. This is a useful thing to find out and solve. But additionally the inclusion of these outliers in the data has skewed how well the service thinks they are doing at managing case length. When those 19 outliers are removed the average case length of the remaining 81 cases (which they are actually dealing with) rises to 77 days. This is a much more representative figure of most client's experiences.

Measures of dispersions such as the range (which is the highest value in the data minus the lowest) provide the additional information to understand if outliers exist in the data.

Calculating descriptive statistics manually can be time intensive but luckily there are many tools available to help. All off the shelf statistical packages will also be able to calculate descriptive statistics from your data. There are also add on tools for Microsoft excel which will add basic stats to the features. In the first instance you don't need to pay to calculate your descriptive statistics. There are also free online tools that will calculate them for you by simply cutting and pasting your data into the page. Two examples are:

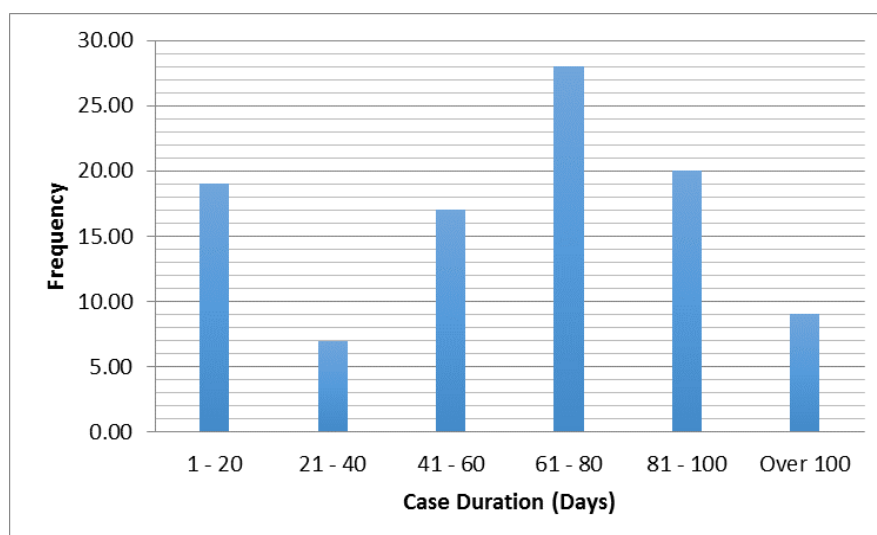
<http://www.calculatorsoup.com/calculators/statistics/descriptivestatistics.php>

http://www.ruf.rice.edu/~lane/stat_analysis/descriptive.html

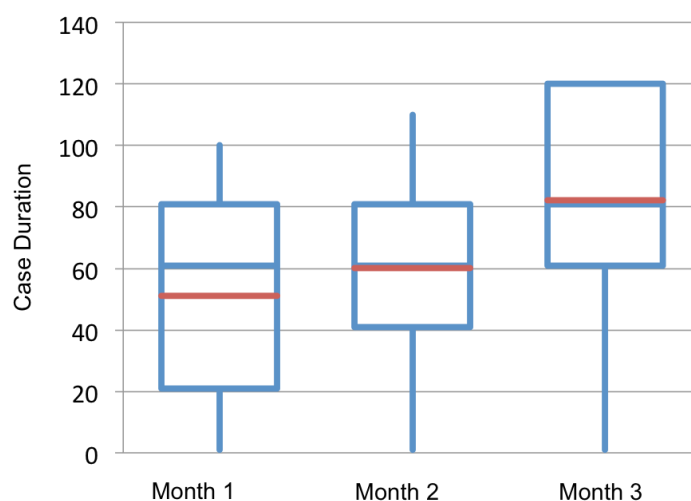
Visualising quantitative data

Visualising your data correctly greatly improves your ability to analyse the patterns it shows. You will also be able to much more easily convey your findings to others.

Charting your data is useful to explore and show comparisons between the number of responses in different categories. For example going back to our earlier example, below is a frequency distribution plotted as a **histogram** of the case duration information we looked at. This confirms both the outliers in the 1 – 20 days category and that the highest frequencies are in the 61 – 80 day category.



We could plot this same data over time. In this case we might want to compare data from one month with another. So we would want to see both the central tendency of the data and the dispersion in one contained view. We can use a **Boxplot** to do this. When creating boxplots you don't need the data in categories, you can use the raw numbers you collected. In the boxplot below, raw data from 3 consecutive months was compared side by side. The red lines on the chart are the means. Where the box is thicker this is where the highest frequencies of responses are. Half of all the data collected sits in the box. The thin blue lines are the 'tails', these show the areas with lower frequencies of responses.



From the boxplot we can clearly see what looks like a trend. Month by month the mean case duration time is increasing and by month 3 much higher frequencies of cases are taking 100 or more days.

Boxplots are a useful tool in situations like this when you want to directly compare one set of data to another.

Inferential statistics

Beyond descriptive statistics there are inferential statistics. Inferential statistics try to reach conclusions that extend beyond the immediate data alone. For instance, we use inferential statistics to try to infer from the sample data what the population might think, or we try to make judgments on the probability that an observed difference between sample groups is significant.

Inferential statistics are very powerful, but often difficult to get to grips with if you don't have a mathematical outlook. There are lots and lots of resources for inferential statistics available online and anyone interested in extending their understanding should take a look.

As a general rule we use inferential statistics when you need to make inferences from your data to more general conditions; and we use descriptive statistics simply to describe what's going on in the data we've collected.

How to analyse – surveys

The simplest way of analysing data collected from survey questions is counting up the number of responses in each category. As we described earlier getting your data into a frequency table and creating a histogram is a great way of being able to see the differences in responses by categories on the scale. Often with enough responses this is all that is needed to understand what feedback you are receiving.

Understanding differences in survey responses can get a little more complicated than understanding differences in the numerical data you might collect as surveys don't represent a continuous range of numbers. However this is not the case for scales such as Likert – where it is assumed the distance between any of the scores on the Likert is the same, and so interval data like this can be reported as averages and percentages.

Some great examples to why you might want to do this are:

- To compare your survey data overtime to know if responses are improving.
- To look at the responses from different groups and understand if they differ. For example are the responses from clients from one advocacy stream different compared to another.

Chi squared test

However not all survey data can be analysed in this way and so slightly more complicated methods are needed. Some surveys are what is known as nominal data where there is no scale between the items on the survey at all, (e.g. horse, cow, pig).

Because of this, finding the mean value of responses on a scale or comparing this to another means is not possible. Instead you want to know if differences in the two sets of data are real (they are independent) or just down to random chance.

Chi squared is a basic statistical test you can carry out to find this out. It's a test for independence and basically tells you if the differences in the frequencies of response you saw between two groups, (e.g. client groups, months, advocacy streams) is really there or just due to chance. For a statistics test Chi squared is fairly easy to do but you'll need to read up on it if you are unfamiliar with statistics. A good practical online source is:

<http://practicalsurveys.com/reporting/chisquare.php>

If you are feeling brave and like your maths you can use an online calculator to calculate chi squared for you: <http://www.quantpsy.org/chisq/chisq.htm>

How to analyse qualitative data

Qualitative data refers to data that cannot be easily reduced to numbers. It may include people's experiences, views and behaviours that you have captured directly or observed indirectly. In our toolkit, this section is useful when considering how to analyse data you collect through open questions and case study collection.

By analysing qualitative data you can garner insights into a problem that you may or may not be aware exists (such as the reasons why a person found it difficult to get an advocate), ideas for further development (such as a suggestion to put photographs of the advocates directly onto posters so people feel it's a more personal service) or understanding phenomena that impacts on the delivery of your service (such as social workers worried that waiting lists will slow up their decision making processes so they don't bother referring).

When trying to make sense of qualitative data, you may want to consider the following approaches:

Content Analysis

This allows you to analyse the written information by looking for patterns in word usage or themes to build an understanding of people's experiences. There are two approaches:

1. Hypothesis testing:

This is when you begin with an idea, or hypothesis, that certain activities yield specific results. You search through the information to look for these results. For example you believe that having a central referral line makes it easier for people to refer. You then look for evidence and experiences to support this theory. In your open questions about 'accessibility' you would expect numerous comments about how easy it was to use the central line – if they are not present you would need to rethink this approach.

2. Grounded Analysis:

Rather than beginning with some ideas about what the data may tell you, grounded analysis lets the information speak for itself with themes naturally emerging. For example through your analysis you become aware that some young people prefer to text their advocate rather than speaking on the telephone – whilst you were not anticipating this feedback, this leads you to rethink your policy on mobile phone usage.

These two techniques are often used together: grounded analysis identifies the themes in your data that are unknown to you. With this insight you then make changes which you evaluate using hypothesis testing.

Sentiment analysis

Sentiment analysis allows you to look at an open block of text and make a judgement on whether that piece of text has a negative or positive sentiment. You then count the number of positive and negative comments which gives you an overall picture of the respondent group's perceptions of your service.

For example you include an open comment box within your feedback form that asks respondents *'Is there anything else you would like to tell us?'* Using content analysis you can see groups of people are feeding back about the referral process. Sentiment analysis tells you if this is a positive experience or negative.

Presenting your data

Once you have analysed your data, you need to decide the best way to present it. Information can be used internally – to share knowledge amongst the team, plan allocation of resources, develop new activities/services, report to trustees and to deepen understanding of the impact of your service; or externally – to demonstrate accountability of money, report back to funders, influence practice, seek funding, celebrate your impact and in marketing. Whatever the purpose you should take the following into account when presenting your data.

Know your audience

An important decision is to decide on the audience you are preparing the information for. Different stakeholders will require different information presented in different ways. You must listen to your audience to select the right narrative, language, visual or graphic devices that will grab their attention.²⁷

Within advocacy outcomes there are 3 key audiences you may want to target with your data:

- Commissioners, or funders
- People who use advocacy
- Professionals (who work alongside or refer to advocates)

²⁷ Making Data Meaningful 2009 UN Economic Commission for Europe

Present your information with ‘Context’

Readers automatically interpret data in the context of its surroundings. This can introduce opportunities to enhance meaning: knowing that a service has received 30 referrals from a particular hospital takes on a different meaning when the context shows it was the same clinician who made all 30 referrals. Context can also capture local issues that impact on the data – consider how local commissioning practice can influence the ease or difficulty of accessing an advocate.

Know the impact you want to make

Another decision is to pinpoint the exact outcome you want to achieve by releasing the information. Is your goal to promote the service? secure more funding? demonstrate your success? Improve? Influence policy or practice in your area?

Once you know the primary aim of sharing your data you can frame how this is presented.


Find the story you want to tell


For data to be meaningful and have impact, it is essential to find meaning within the numbers, otherwise your reader may misinterpret, mistrust, not connect with or not understand the data.


This is not the same as creating a fictional story that you cherry pick data to support!



Toolkit. Over to you...

What have you learnt from this chapter? 

What parts can you implement quickly and easily (for quick wins)? 

What parts do you think will be useful but you need to undertake further research? 

Think about the next opportunity to report on the outcomes your service has achieved:

Who is the audience for the information?

What are the three headline messages you want to communicate as you report on advocacy outcomes?

1.

2.

L;

3.

What visual charts can assist you in communicating these messages?

Chapter 7 Example tools

This chapter of the toolkit presents you with a suite of example resources that you can use and adapt to measure advocacy outcomes to see if you have achieved your objectives.

You should see these as a standard, plain version of templates that you can then add your special flavour of advocacy too, that better reflects the setting you are operating within or the specific needs of the people accessing your service. If for instance it isn't appropriate to ask a person about their views on how advocacy has helped improve their social inclusion because the person is detained in hospital, change it to something that better reflects your outcomes.

Example star/radar plot

Recording Progress towards individual outcomes

The person using advocacy and their advocate can use this tool to monitor progress towards the goals (outcomes) the person wants to achieve. It is very effective at capturing the 'distance travelled' – which for some people is just as (if not more) important than achieving initial goals.

The advocate should use this tool at the beginning of the relationship and at the end. You can also use this partway through the relationship, which is especially relevant when advocacy takes place over a longer period of time.

Step 1 - The person receiving advocacy support is supported to record their priority goal.

This might be something like making a complaint, being heard, getting a decision changed, getting information, accessing services, understanding your rights, communicating your choice, working out what you want, writing your care plan etc.

Once you have identified the number 1 goal, record this on the star under 1).

Repeat with any other goals – or add as the relationship progresses. It's okay to have 1 goal and equally ok to have 11.

Step 2 – The person receiving advocacy support records on each line, 1 being not at all: 5 being totally, where they feel they are right now in achieving these goals?"

Once you have identified the number make a mark on the star line.

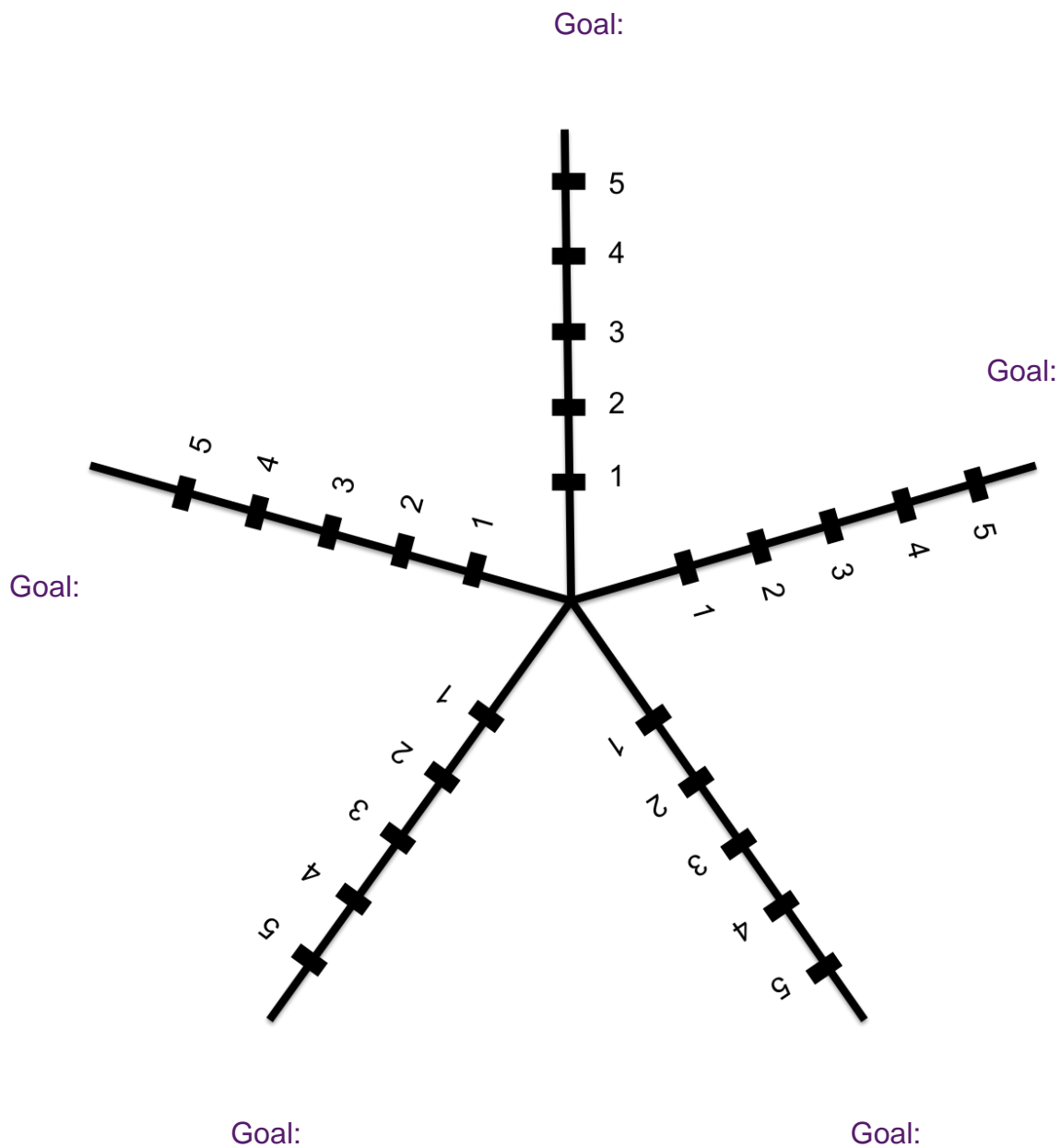
Step 3 - To be completed midway through the process and at the end.

The person using advocacy is supported to identify where they feel they are on the scale midway through the advocacy process and at the end. It is okay to move up the scale, stay the same or move down.

Step 4 - For each goal the advocate records how many steps up (or down) the scale the person felt they moved during the advocacy relationship. Work out the total (mean average²⁸) number of steps achieved and use this within reporting.

²⁸ To work out the mean average add together the total number of steps and then divide by the total number of goals.

My goals and advocacy progress



Remember this is a self assessment tool – use your personal judgement (there is no need for hard evidence)

Example attitudinal survey for a person who uses advocacy

Recording attitudinal feedback about quality and impact of advocacy

You can use this questionnaire to capture information to evidence outcomes about the quality and impact of advocacy. You should consider:

- not all questions will be relevant to every person (you may want to remove or replace some)
 - who will support the person to complete it (it is not always appropriate for the person who provided advocacy support to help with the feedback)
 - it is not appropriate to use with people who cannot instruct you
1. The first question is the Net Promoter Score – use this to work out your NPS.
 2. The second set of questions form part of a Likert scale – the first half of this can be used to gather subjective views on achieving the objectives that relate to achieving change for the individual such as:

‘The advocacy service will ensure people are listened to’

‘The advocacy service will achieve change for the individual’

The latter part of the Likert scale can be used to gather subjective views on achieving the objectives that relate to achieving change for the advocacy service such as:

‘The advocacy service will improve the way it delivers advocacy support’

‘The advocacy service will offer value for money’

‘The advocacy service will be responsive to the needs of people who use it’

3. The third set of questions also capture data to help understand how the objective of achieving change for the advocacy service is being met. The ‘open’ questions can be used to dig deeper into issues of quality, and support the advocacy service share learning about what works.

Attitudinal survey: ADVOCACY USER

How likely is it that you would recommend our service to your friends or family?

1	2	3	4	5	6	7	8	9	10

Because I had an advocate:	Totally Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Totally Agree
I felt more listened to					
I felt involved in decisions					
My experience of health (or social care) services has improved					
I feel more confident in raising concerns I might have					
My relationship(s) with my health (or care) provider has improved					
I have more people who I class as friends or supporters					
I feel more included within my community					
I feel less isolated					

About the advocacy service	Totally Disagree	Disagree	Neutral	Agree	Totally Agree
I found the advocacy service easy to use					
If I wanted to complain about my advocate, I knew how to do this					
My advocate listened to me					
My advocate clearly explained their role (I knew what they could and couldn't help with)					
My advocate understood me and my issue(s)					
My advocate helped me to get what I want					
My advocate helped me to understand my rights					

Open Questions

1. What did the advocate do that was most helpful?
2. Was there a 'tipping point' in the relationship where you felt that advocacy was making a difference? If so what was it?
3. Could the advocate have done anything differently?
4. Did the advocate do anything that was unhelpful?

Example survey for advocate

Recording attitudinal feedback about the quality and impact of advocacy from the Advocate

At the end of every case, advocates can complete this form to collect data that can be used to improve the service and demonstrate the impact of advocacy.

The form includes subjective and objective questions. Subjective questions are deliberately designed to capture personal views in each area however can build up themes and trends when taken over a large sample. Advocates are ideally placed to identify the difference they see they are making and can use this questionnaire to record these experiences.

The Likert scale can capture data to evidence objectives concerning change for the individual and change for communities.

The open questions are not only helpful when capturing data against objectives to improve the advocacy service, but can be used proactively within supervision and group meetings to learn about best practice and shared learning.

The quantitative questions focus on hard data that can be objectively measured: frequency, time, numbers etc. These are useful when showing stakeholders the frequency and occurrence of outcomes.

Attitudinal survey: ADVOCATE

	Totally Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Totally Agree
As a result of your involvement, you felt the person was more listened to throughout the decision making process?					
As a result of your involvement, you felt the person was more involved within the decision making process?					
Your involvement with this person has led to them becoming more included within their community					
Your involvement with this person has led to a reduction in their social isolation					
Your involvement with this person has meant they now have more natural allies/supporters or a greater social network?					
Your involvement with this person has led to the person being more likely to use community services that are right for them?					

1. What development or learning has taken place for you throughout this piece of advocacy support?
2. What did you do that you felt was most helpful? Was there a 'tipping point' in the relationship where you felt that you were suddenly making a difference?

Quantitative data: ADVOCATE

How many times can you evidence the person's wishes and feeling (or choices) were recorded? This could be within a meeting, a care plan or review	
How many instances were the person's views not recorded (and you felt they could have been)? <i>By collecting this data you can gather evidence for systemic concerns</i>	
Has your involvement with this person led you to identify systemic ²⁹ themes or trends that your advocacy service will act upon	
Did you support the person to take a lead role in their assessment, development of plan or review?	
Has your involvement with this person led to the raising of concerns (this could include a complaint, informal concern or formal challenge)?	
How many concerns were acted upon by the provider? ³⁰	
How long did the person wait between referral and the start of the advocacy relationship?	
How long have you spent working to support this person?	
Did you raise a safeguarding alert with or on behalf of a person?	
Did you take other specific action to keep the person safe?	
Did you signpost the person to a service that was suitable for them?	
Did you help a person to understand their human rights?	
Did you use UK or International legislation within your work?	

²⁹ 'Systemic' refers to the way the system is delivered or experienced. For instance this piece of advocacy may have involved a complaint about the quality of care provided within a care home. If this is the fourth similar complaint in a 3 month period, you may wish to highlight this as a theme or trend across the service.

³⁰ This could include (but is not limited to) the provider upholding a complaint, changing a decision or changing the way care or support is provided

Organising your quantitative data

Advocacy managers need to collect data and organise it effectively. The following questions will help you to visualise, analyse and plan how to present your data.

Outcome: Change within health and care systems:

1. How many times have you raised systemic themes or trends with a provider or commissioner? *You need to capture what these themes are (consider using a population chart to show frequency of themes)*
2. Of these, how many have led to change within the health and social care service(s)? *You could give examples of how they led to change through the use of case study story telling.*

Outcome: Change within the advocacy service:

3. How many complaints have you received about your advocacy service? *Can you group any complaints or feedback together into themes that can be analysed?*
4. What learning or changes have you implemented as a result of complaints (or other feedback) *Can you give specific examples of change or learning such as changing the way you approach an activity?*
5. How much time has been spent on raising awareness of the service? *Can you use a bar chart to capture outputs on raising awareness and referral rates?*
6. How many referrals have you received in this period? *Can you use a bar chart to show how this compares to the previous 2 quarters? Don't forget to analyse potential reasons for growth or reductions.*
7. What has been the average waiting time for people to receive advocacy support? *You could use a histogram to express mean average and range of wait times in different types of advocacy, areas or settings.*
8. What is the level of unmet need? *Can you use a bar chart to show how many people you have not been able to support and how this compares to other periods? Can a pie chart capture the spread of reasons why you cannot support?*
9. What level of training or other CPD activities have your team achieved or completed? *Can you provide quantitative data on qualifications or CPD activities?*

Outcome: Change for the individual

10. How many times did advocates help a person to understand their human rights? *Can you use data from the outcomes matrix or from attitudinal surveys to capture how many times advocates took this action?*
11. How many times did advocates use UK or International legislation within their work? *Can you use data from the outcomes matrix or from attitudinal surveys to capture how many times advocates took this action?*
12. What have been the main advocacy issues people have wanted support with? *You could use a pie chart to show the main issues – check to see how this compares against previous periods to reflect on changing issues. If they are not changing and they remain consistent you may want to flag this up as a serious concern (ie if people are consistently facing the same difficulties or problems with a service)*
13. What has been the average length of time spent on a case? *You could use a histogram to express mean average and range of time spent on cases. Does this differ across services, disabilities, settings etc?*
14. What has been the demographic make up of people using your service? Are there any gaps from people from seldom heard groups not accessing the service? *You could use a pie or population chart to capture demographic information. Compare this data to other periods – are things becoming more or less equal? What are some of your predictions as to why (and can you evidence these)?*

Example attitudinal survey for ‘Carer’

Recording attitudinal feedback about the quality and impact of advocacy from carer’s

Carer’s are ideally placed to offer important subjective feedback on how and if advocacy makes a difference. This is particularly important when the person cannot complete feedback themselves – a carer can offer another view of the quality of advocacy.

The first group of questions that form part of the Likert survey are helpful in measuring objectives that are concerned with change for the individual and also change for communities.

Data collected from the open questions will help measure outcomes concerning the quality of advocacy.

Attitudinal survey: CARER

As a result of the person using advocacy	Totally Disagree	Somewhat Disagree	Neutral	Somewhat Agree	Totally Agree
I believe the person was more listened to throughout the decision making process					
I believe the person was more involved in the decision making process					
I believe the person is more included within their community					
I believe the person is less isolated					
I believe the person is more able to contribute to their community or society					
I found the advocacy service easy to find					
The advocate clearly explained their role and I understood what they could and couldn't do					

Open questions

1. Did you feel advocacy made any difference to the person? What was the difference?
2. Could the advocate have done more to help?
3. Could the advocate have done anything differently to be more effective?

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The project was funded by a grant from the Esmée Fairbairn Trust





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