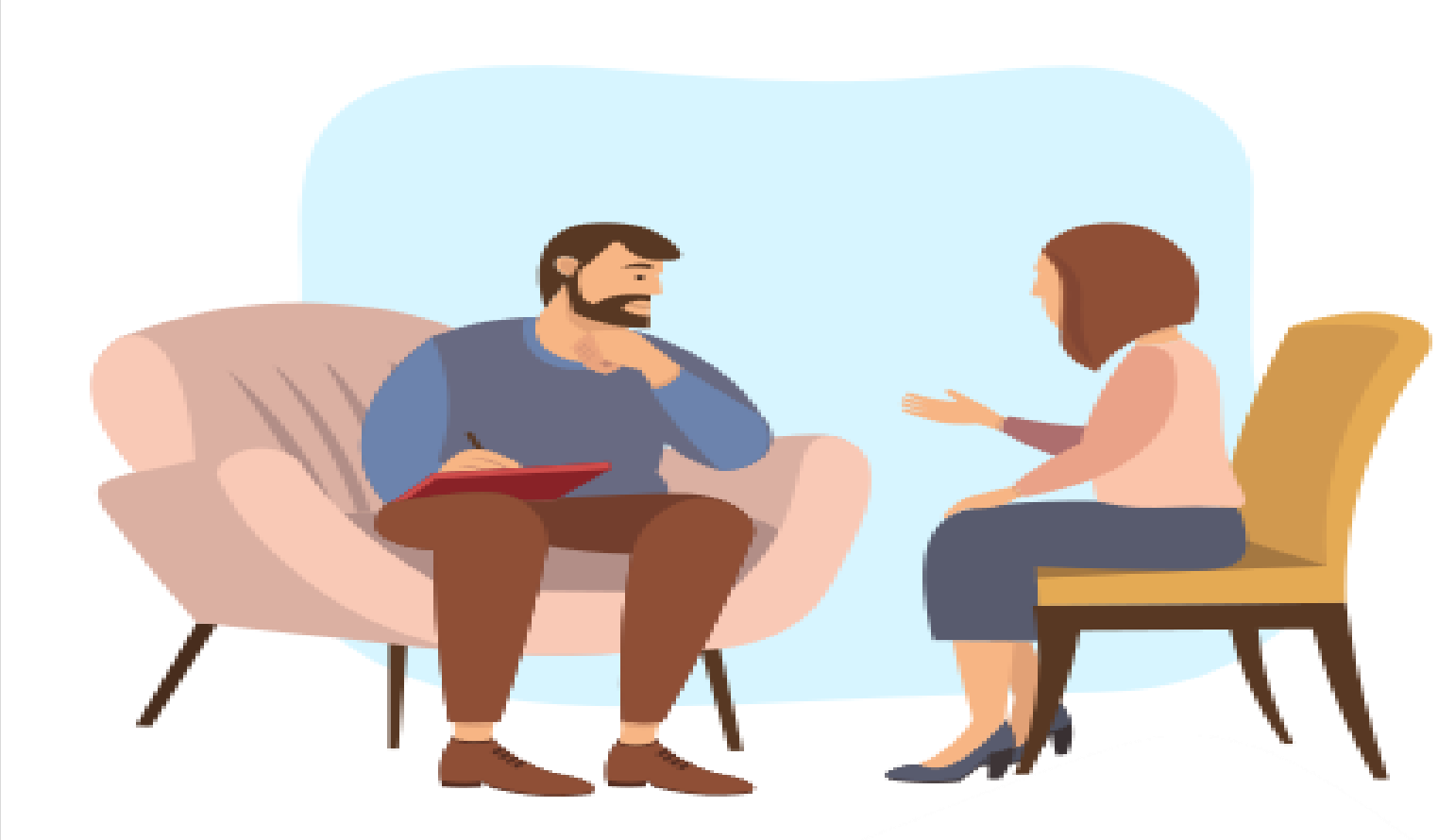
DERBYSHIRE County Council

Evidence Summary

Advice Services Delivered in Primary Care and Community Settings



Population Knowledge & Intelligence Team

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Disclaimer

The information in this evidence summary is designed to give readers an overview of the currently available research evidence on the topic in question. It is drawn from material accessible to KIT free of charge online and so only presents a sample of the available literature; this means that it may not be representative of the whole body of evidence on the topic. No critical appraisal or quality assessment of articles has been performed on the evidence included in this report

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Advice Services Delivered in Primary Care and Community Settings

This evidence summary provides a rapid review of aspects of advice services in primary care and community settings.
It has been undertaken to help inform commissioning decisions around such services.

The following abbreviations may appear in this report (typically within quotations).

IAA -Information and advice
IAG – Information, advice and guidance
CAB – Citizens Advice Bureau

Direct quotations from the literature are in the lighter coloured font throughout this report.

KEY FINDINGS:

- There is a large body of evidence that welfare rights advice in healthcare settings results in financial gain to clients.
- The literature recognizes the difficulty of attributing any health outcomes to advice.
- There are issues with the quality of the evidence – much is qualitative; not longitudinal; simple outputs are measured etc.
- The evidence is weighted towards older, sick people with regards to health outcomes.

Who is this summary for?

This evidence summary was undertaken for the Wider Determinants Team in Public Health.

Information about the evidence summary

The materials used to produce this summary have been drawn from information sources available to Public Health. No assessment of quality has been incorporated into the process of synthesis.

This summary includes:

- **Key findings** from evidence identified in a non-systematic search of journals available to Public Health via HDAS and the internet.

This summary does not include:

- Critically appraised evidence
- Recommendations

Further information about the methodology and content for this evidence summary can be obtained on request by emailing:

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1. INTRODUCTION

1.1 Background

Since 1995 Derbyshire County Council has commissioned the provision of advisory services co-located within GP Practices. The services have been deemed successful, providing practical support for problems related to debt, housing, employment etc., and playing an important role in reducing health inequalities within Derbyshire.[1] The current contract with the Citizens Advice Bureau is due to expire in September 2022 and the Public Health Department is looking to build upon existing success with an improved community offer. A summary of the evidence concerning primary care advisory services and community advisory services was requested of the Knowledge and Intelligence Team in Public Health, in order to inform commissioning of a new service which builds upon existing successes.

1.2 Purpose

The breadth of the request was understood to be wide, encompassing:

- Primary care and community venues as settings
- The range of issues which advisory services might encounter
- A broad demographic
- Various outcomes

Whilst it was understood that the summary should identify and consider as much evidence as possible, questions were determined in order to ensure a manageable and focused task, with the emphasis being on community advisory services. The following questions were decided upon for the focus of this summary:

- Do primary care advisory services save the NHS money/result in less GP visitation?
- Do advisory services in community venues save the NHS money/result in less GP visitation?
- Is there evidence that primary care advisory services result in improved health/wellbeing of recipients?
- Is there evidence that community advisory services result in improved health/wellbeing of recipients? Are any particular venues most effective?

This summary has also sought evidence for the following:

- Do community advisory services, as well as primary care advisory services improve people's finances?
- optimal channels for delivering advisory services to different demographics
- barriers (physical and societal) for people when requiring advisory services
- effective measurement of delivery and success of advisory services

2. METHODS

Databases searched included: NICE Evidence; SocIndex; HMIC; Medline; Embase; PsycInfo; Cinahl; Pubmed; PHE Discovery; Science Direct

The following core terminology was used (supplemented for different aspects e.g. cost terminology):

ADVICE (TYPE AND PROVIDER) TERMINOLOGY

(Welfare or citizen or debt or financial or housing or employment or discrimination or legal or benefit* or relationship* or consumer) adj3 (assistance or advice or advisory or advocacy or guidance or information or counsel*)
“citizen advice bureau*”
“welfare right*”
Social welfare/
Welfare rights awareness/
Welfare rights officers/
Welfare rights advice centres/
(assistance or advice or advis* or advocacy or guidance or information or counsel*) adj3 (service* or provider*)
“not for profit”
“third sector”
Public assistance/
Welfare rights/

SETTNGS TERMINOLOGY

Health centres/
Primary care/
General practice/
“health care setting*”
Family practice/
“children* center*”
“children* centre*”
“leisure cent*”
Librar*
“community cent*”
“day cent*”
“citizen* advice bureau*”
“shopping cent*”
“shopping arcade*”
“not for profit”
“third sector”
Community
Community adj3 (building* or venue*)

3. SUMMARY OF EVIDENCE

3.1 Primary Care Advice Services and clients' finances

There is a body of work concerning welfare rights advice delivered in healthcare settings and the financial benefits that are obtained for clients, dating way back to Paris' 1993 paper trialling CAB in 10 south Birmingham GP practices.[2,3,4,5,6] Adams' systematic review (2006)[7] suggests:

> There is now substantial evidence that welfare rights advice delivered in healthcare settings leads to financial benefits for clients – although typical levels cannot be precisely estimated. There is little need to conduct additional work to determine whether such advice has a financial effect, although further work is required to explore the characteristics of those most likely to benefit financially in order that such advice can be effectively targeted.

Woodhead's 2019 paper,[8] evaluating co-located welfare advice in Haringey practice settings, does give a range of financial gain per client:

> Co-located GP welfare advice services in the UK have been found to be effective in increasing income and managing debts for those seeking advice, with one-off and ongoing financial gains ranging from over £1000 to over £3000 additional income per client; exceeding the costs of funding the service.

In their literature review on the health benefits of financial inclusion (2010), Dobbie & Gillespie[9] suggest that whilst the NHS has long recognised the value of improving access to welfare benefits

> The development of the broader approach involved in financial inclusion is relatively recent and it embraces a range of services or activities including money advice and income maximisation work, awareness raising and service provision around, for example, savings or low cost credit, and financial capability or money management support and guidance. While advice is integral to financial inclusion, more holistic approaches are now recognised as essential.

Egan and Robison's 2019[10] study involved money advice services more broadly, with money advice workers integrated in nine Deep End practices across north east Glasgow over a 12-month period. This study demonstrates that financial gain and debt management was achieved for people, but clients also received advice relating to energy efficiency/fuel poverty, budgeting support, savings options.

There are of course reports from Derbyshire, and the Citizen's Advice GP Project 2019/20 report states that they helped clients secure an extra £11,548,815 of additional income, and helped to negotiate £4,343,315 of debt to be rescheduled or written off.[11]

3.2 Community Advice Services and clients' finances

There is less evidence concerning community advice services resulting in financial gain to clients because there is less history of these than advice services in healthcare environments.

Two papers by Buck et al are relevant – a 2007 paper[12] which evaluated the potential for money advice outreach in different locations (family and children centres, housing offices, credit unions, community centres and prisons), and a 2009 paper[13] evaluating outreach advice for debt problems in financially excluded people in the same locations.

The 2007 potential paper is illuminating about which locations had attendees with the most financial difficulty (the highest percentages of interviewees reporting serious financial difficulties since the beginning of 2003 were found in credit unions (41 per cent) and the lowest in community centres (28 per cent)). Of

note is that interviewees across all outreach location types reported that the impact of their financial problems on their life had been 'markedly severe', with interviewees in credit unions reporting the most severe impact, closely followed by community centres. Importantly the research questioned interviewees about the advice they would like to receive and found that most would like practical advice on money management and budgeting, how to get out of debt, as well as advice on benefits entitlement.

Buck's 2009 evaluation paper of debt outreach advice in England and Wales provided in the following locations: prisons, family centres, housing offices, community finance organisations and other community-based venues, as well as through home visits and video-link facilities, found that:

> The outreach services were very successful in reaching socially and financially excluded people who had not sought advice before, building new partnerships, and delivering advice at new locations. Overall, less than 10 per cent of clients reported having previously sought advice in relation to a debt problem. The advice led to a range of positive outcomes for clients, including payment plans, crisis avoidance, averting the loss of a home or utilities disconnection and gaining nearly £1.9 million as income for clients in a one-year period. The most common outcome for clients was to receive a payment plan.

Sinclair's paper[14] evaluated a project that ran for a year, where eight service providers worked with Parkhead job centre (Glasgow), to improve social and economic outcomes for people accessing the job centre; they delivered financial, debt and social security advice. Sinclair reports that partners achieved the following outcomes: 359 referrals; £144,777 worth of financial gain; £57,065 worth of debt managed and identified; softer outcomes such as supporting people to secure free bus passes and supporting people to use less expensive forms of credit.

Wheeler's paper[15] demonstrates that partnership between a service with clients in need and CAB can provide results. Birmingham City Council funded a collaboration between Birmingham Working Age Dementia Service and Citizens Advice Bureau for a year. The authors found the impact of this service was substantial with 178 people helped, and financial gains in excess of £196,210.00 (over 12 months) secured.

Dwyer and Hardill's research[16] which looked at the impact of village services on the lives of older people living in rural England, included examination of two services – a welfare rights service (service 3), and an information and advice service (service 5 - which also included helping people to access benefits). Dwyer reported that Services 3 and 5 claimed to have generated £690,000 and £750,000, respectively, of successful benefit claims over the two- and three-year periods since their establishment.

Frost-Gaskin's paper[17] makes use of data collected during a welfare benefit uptake project by Mind in Croydon staff whereby benefit assessments were offered to a total of 153 people attending any Croydon resource centre (run by the Health Service) other than the pilot site, or day centre (run by Social Services) for people with mental health problems. All those who were identified as under-claiming were offered help pursuing claims through to conclusion. One-third (34%) of people seen were getting their correct entitlement and two-thirds (66%) were under-claiming. All those found to be under-claiming who accepted all the help offered (87 out of 99 under claimants) did gain additional benefits as a result, of a mean annual amount of £3079 each. Under-claiming was more frequent in those under 65 years of age; having had previous advice or having a care manager did not protect against under-claiming.

3.3 Primary Care Advice Services and NHS cost savings

3.3.1 The problem

There is plenty of evidence that many people present to their GP with practical and personal issues that, in many cases, would at least partially be better dealt with by another service, thus freeing up GP time for clinical issues.[18,19,20,21]

Woodhead[8] articulates this as follows:

Individuals access GP services for direct support (e.g. appointments for help navigating an aspect of the welfare system); and, indirect support (e.g. where ill health is triggered, maintained or exacerbated by underlying social situation(s)).
Appointments for direct support were perceived to increase waiting times and reduce capacity to support patients with medical needs. Supporting patients whose mental and/or physical health was affecting or affected by their social situation was perceived as an important part of their role, however, there was often frustration at their inability to support patients with some of the 'wider determinants' of health.

Budd[18] quantifies this usage of GP time:
Consistent with previous research, GPs in England and Wales continue to estimate, on average, that patients' non-clinical issues take up almost one fifth of their consultation time (19%).

Budd also gives a figure for the cost to the health service:

In our previous research, 80% of GPs reported that dealing with non-clinical issues meant they had less time for other patients' health needs. The implied cost to the health service of this time was almost £400 million a year.[3]

Citizens Advice Reports by Caper & Plunkett (2015)[22] and Budd (2018)[18] demonstrate a high prevalence of the same non-clinical issues being taken to GPs by patients:

More than nine out of ten (92 per cent) GPs report that their patients had raised issues about personal relationship problems with them in the last month. This was followed by housing, unemployment/work related issues and welfare benefits with three-quarters (77 per cent, 77 per cent and 75 per cent respectively) of GPs indicating that their patients had raised these issues with them in the previous month. Two-thirds (67 per cent and 64 per cent respectively) of GPs report that debt and social isolation issues had been raised by patients.

The most common non-clinical issues that GPs say are raised by patients are personal relationship problems (86%), work-related issues (82%), welfare benefits (76%) and housing (72%).

3.3.2 Cost savings

Budd's research found that a large proportion of GPs thought that when patients receive help from advice agencies this is positive for their work:

72% of GPs said there was a positive effect on the overall care for patients
61% of GPs said it had a positive effect on their ability to focus on and treat patients' clinical issues
61% of GPs said there were positive effects on the number of repeat visits about the same non-clinical issue
53% of GPs said there was a positive effect on the amount of time they spend on non-clinical issues in consultations

Budd et al's research compared GP views on the effects of advice between GPs who signpost patients to advice, those who use referral pathways, and those who use co-located outreach advice services.

In every area we asked about, the group of GPs who used co-located outreach advice were more positive about the effects of advice than those who used other methods. The group of GPs using referral methods were more positive than the GPs who signpost to advice in all areas except for the effect on patients health and wellbeing, where the results were very similar.

Parkinson's review (2015)[21] has this to say about the evidence for cost efficiency or savings:

Less evidence is available which clearly demonstrates actual cost or efficiency savings delivered through advice services working in primary care. Where these are included within studies they have largely tended to infer or assume that such savings will be delivered as opposed to actually putting in place appropriate systems to measure these. Key challenges reflected in the evidence relate to the ability to establish causality between the advice services and to demonstrable efficiency improvements within primary care, including for example reducing demand for consultations or issuing fewer prescriptions.

Parkinson's review does include a study by Marshall et al (2013) as an example which has attempted to calculate cost-savings as a result of co-location of advice services in GP practices. Marshall's paper has not been viewed for this summary.

In her social value assessment of a CAB outreach service delivered in GP practices in the west end of Newcastle upon Tyne, Marshall (2013) estimates cost-savings to the NHS relating to reduced GP consultations and prescriptions amounting to £7,500 for the first year following the service and £2,700 for the following six months – nearly double the £5,500 invested in the service by commissioners. This is in addition to the £123,000 additional income secured for clients as a result of the advice they received.

Parkinson's review also includes an evaluation of the impact of a CAB health outreach service on GP surgeries in Sefton (2010).[23] This report looked at changes in health services use, comparing six months before and after referral to the service, and concluded that the service demonstrated actual and perceived benefits to the NHS in terms of staff time and prescribing costs.

The greatest change seen was in the number of GP appointments, which reduced by an average of 0.63 appointments per patient, a total of 93 fewer appointments for the 148 patients. This reduction was statistically significant (p=0.009). The number of nurse appointments also reduced, but by a smaller proportion. However, appointments which were related to mental health did not change, while referrals to mental health services showed a slight increase. There was an apparent reduction in the number of prescriptions issued for both antidepressants (22%) and hypnotics/anxiolytics (42%), the latter was statistically significant (p=0.015).

However, Woodhead's (2017)[24] London-based study did not find a positive impact to the NHS cost-wise. This paper reported on the impact and cost consequences of co-located benefits and debt advice in primary care, on mental health and service use, and involved a comparator group. One of the outcomes was consultation frequency. The welfare advice group reported more frequent consultations than controls and there was no evidence for an impact of advice on 3-month consultation frequency.

3.4 Community Advice Services and NHS cost savings

No evidence of any real significance was found concerning community advice services resulting in cost savings to the NHS; Buck's paper[13] is the most consequential paper identified about advice services in community settings, and this does not make any claims that savings to the NHS were made. Buck does note that "softer" outcomes such as reduced stress were achieved by the advice delivered in these settings (prisons, family centres, housing offices, community finance organisations) but it cannot be inferred that this would have meant less healthcare usage by advice recipients as a consequence.

Clients who accessed the project for a variety of different money problems invariably reported some level of reduced personal stress as a result of the advice received. Clients commonly described how the adviser eased the stress or pressure they were under, by taking rapid action to halt threatening letters or calls from their creditors. Where clients reported having long-term health problems, they sometimes expressed relief at the money advice outreach. In a smaller number of cases, the advice was said to have directly averted clients losing their home.

Dwyer's paper[16] explores the impact of 'village services' on the lives of people aged 70 years or more, living in former mining communities in rural England. Two of the services are welfare rights (service 3), involving a dedicated worker helping older residents access benefit entitlements; and information and advice (service 5) - a service offering information and advice on benefits and services, including a dedicated worker to visit older people in their homes to help clients access benefit entitlements. This paper suggests an incidental NHS usage preventative dimension to such services and cites examples; one from service 5:

> Similarly, the worker from Service 5 who had initially made contact with an isolated older man to explore the possibility of instigating a benefit claim on his behalf reported that she had managed to persuade him to seek medical help for a festering wound that could have led to his long-term hospitalisation.

The authors conclude:

> Village services play an important role in maintaining older rural residents in their own homes for as long as possible. Such services routinely delay or negate the need for more expensive formal health and social care packages and promote independent living among senior citizens in the countryside.

3.5 Primary Care Advice Services and Clients' Health Outcomes

Much of the evidence identified relating to health outcomes of advice in primary care is related to welfare advice. There are issues with the evidence for trying to determine health outcomes – simple output information is often what is measured (e.g. number of advice sessions delivered); where impact is measured (e.g. benefits gained for a client) this cannot be directly correlated to health outcomes. The evidence is often qualitative, not longitudinal, lacking control groups and using non-specific measures of general health.

Wiggan and Talbot's review (2006)[25] of the literature concerning the benefits of welfare rights advice has a chapter on the impact of a rise in an individual's resources on health and wellbeing, and they summarize the evidence to that date, but the later report by Parkinson (2015)[21] states that there is an absence of high-quality studies demonstrating significant impacts on health as a result of advice services:

> Where systems for capturing health outcomes are in use, evidence from the mapped services suggests that this is generally undertaken using a before and after assessment with clients, most commonly using the Warwick–Edinburgh Mental Wellbeing Scale (WEMWBS). However, there are few examples of published impact data based on this approach with the majority of services relying on anecdotal feedback from clients. Whilst qualitative feedback provides a useful source of data to support an assessment of impact this may fall short of the evidence standards that commissioners may be looking for to clearly demonstrate the impact of advice on alleviating pressure on health services and contributing to sustainable improvement in the health of the local population.

Parkinson does however draw attention to two studies which are noteworthy as evidence of the impact of advice services in improving health:

- Abbott's paper,[26] which focuses on the impact on individual health of welfare benefits advice services in GP settings, reports on a longitudinal observation of advice to participants, comparing those whose income had increased with those whose income had not. Subjects were generally in the second half of life, with one or more chronic conditions. Those who increased their income (the Income Increase group) had significantly better outcomes in mental health and emotional role functioning at 12 months than those with no income increase. There were no other significant differences between groups at 12 months, and none at 6 months.

- Moffatt's qualitative study[4] exploring the impact of welfare advice in primary care found that participants reported positive effects on their health, in particular reduced stress and anxiety, better

sleeping patterns, reversal of weight loss, changes in medication, reduced contact with the primary care team, reduction or cessation of smoking, improved diet and physical activity.

Parkinson's report[21] also considered Adams et al's systematic review[7] and it neatly summarized the shortcomings of the evidence for health impact of welfare rights advice delivered in healthcare settings:

> A systematic review of the health, social and financial impacts of welfare rights advice delivered in healthcare settings conducted by Adams et al. (2006) identified 55 studies that reported on health, social and economic impacts. However, they report that the majority of these studies were grey literature (i.e. not published in peer---reviewed journals), and were of limited scientific quality, in particular with less than 10% of studies using a control or comparison group to assess the impact of the advice. Studies that did include control or comparison groups tended to use non-specific measures of general health (e.g. SF-36, Nottingham Health Profile and Hospital Anxiety Depression Scale) and found few statistically significant differences between intervention and control or comparison groups. However, the review states that sample sizes were often small and follow-up limited to a maximum of 12 months, which they suggest is likely to be too short a period to detect changes in health following changes in financial circumstances.

There is a NIHR CLAHRC BITE[27] (a headline 'need to know' summary of evidence considered of note) of Woodhead et al's 2017 study[24] - The impact of co-located welfare advice in healthcare settings: a prospective quasi-experimental controlled study. This study aimed to address methodological weaknesses of earlier studies to examine the impact and cost consequences of co-located benefits and debt advice in primary care on mental health and service use. This was a sizeable study with a comparator group and 3 months follow-up for GP consultation and financial strain.
Key findings regarding health outcomes after 3 months were:

- Those in the advice group whose circumstances improved experienced a bigger improvement in their well-being.
- Those in the advice group experienced a bigger reduction in symptoms of common mental disorder, especially among recipients who were female, those who identified as Black and those who reported that their circumstances improved as a result of advice.

Budd's research[18], affiliated with The Royal College of General Practitioners, looked at the effects of integrating advice in primary care, and is instructive about healthcare professional's views, and those of advisors and service managers. This paper reports that 75% of GPs said there was a positive effect on patients' health and wellbeing when patients received help from advice agencies. Regarding the views of advisors and service managers:

> Interviewees reported that they see advice has tangible effects on factors that are known to determine or affect people's health and wellbeing, such as income or stress. Some highlighted that they see how resolving the practical problems people are facing can mean people are more able to focus on and engage with their health and treatment. Our case study research didn't include 'follow up' research with clients about direct effects on their health. But the experiences of these advisers and service managers support the results from the survey of GPs, as part of this research, and existing evidence about the positive effects of advice on people's wellbeing.

3.6 Community Advice Services and Clients' Health Outcomes

Much of the evidence identified for health outcomes of advice services delivered in non-healthcare locations concerns domiciliary welfare rights advice for older people and is also qualitative. Buck's 2009[13] paper about debt advice in a variety of community settings says little about health outcomes.

As Dalkin[28] articulates it is difficult to develop conclusive evidence of how reducing poverty affects health:

The relationship between poverty and health is complex, working through a combination of material, psychosocial, and behavioural mechanisms (Abbott, 2002; Benzeval et al., 2014), for example, through a reduction in stress. In addition, the spectrum of individuals' experiences of poverty means that it can be difficult to develop conclusive evidence of how reducing poverty affects health (Abbott, 2002). That advice services themselves are examples of complex interventions, highly tailored to individual needs, further adds to this challenge.

There is also the danger with qualitative studies of giving too much significance to the "phew effect" –

…this refers to the sense of relief people often feel immediately after having visited an advice service, which cannot be used in isolation as an indicator of the quality of advice received or any longer term change in behaviour or gain for the client.[29]

Moreover, clients' perceptions of quality and outcomes may not be the same as those of a professional.

Haighton et al[30] conducted a randomized controlled trial of domiciliary welfare rights advice for socioeconomically disadvantaged older people. One of the aims was to establish the effects on health-related quality of life of the intervention compared with usual practice. The authors found no evidence that the service improved health or well-being during the period of the study but there was some indication that it resulted in access to more care, and it is noteworthy that those who received new benefits were in poorer health and less active than those who did not. The qualitative findings however suggested that both participants and professionals perceived the receipt of additional financial and non-financial benefits as having a positive impact on health, and health-related quality of life.

For some participants, the increased benefits allowed them to escape a stressful financial situation; alleviated some food and fuel poverty and provided security against unplanned costs; helped them to maintain their mobility and independence and to pay for formal and informal support with activities of daily living; or allowed them to provide gifts for informal help received.

Campbell and colleagues' longitudinal observational study[31] explored the relationships between provision of welfare benefits advice and the health of elderly people. The subjects were community dwelling people aged 60 years or over referred by social services for specialist welfare benefits advice, typically delivered in the person's own home. The follow-up was at 5 months. The study population was generally very old and extremely vulnerable. Following an assessment for welfare benefits advice, physical health (SF-36 and Postal Barthel) scores remained stable, with marginal improvement in the Role Limitation (Physical) SF-36 dimension and the single Change in Health question. There was an overall reduction in GHQ-12 scores, suggesting an improvement in psychological wellbeing. Respondents who did not increase their welfare benefits were no different in respect of their physical or mental health compared with those whose benefits did change. The authors concluded that although the sample sizes for the analyses were small, these observations suggest that it is the advice itself or other external factors which may have played some part in health stability, as opposed to any increase in financial income per se.

Winder's study,[32] run in parallel and associated with Campbell's, used qualitative methods to examine the experiences of the older people, their carers and the officers from the social services-based, home-visiting advice team, regarding the provision and perceived impact of obtaining welfare benefit advice. This study echoes the qualitative findings of Haighton's study, with most interviewees who received a benefit feeling that the money gave them extra choice or control over important, practical aspects of their lives. For some it enhanced financial security and reduced anxiety, and the authors state that many stated increased options for transport.

Tangible effects were described regarding physical and mental health for some receiving additional benefits. A new 'scooter' had encouraged one couple to take turns in exercising alongside it, whilst another participant used the additional money to pay for alternative therapies. The positive impact on mental well-being was also reported by interviewees. For carers, in particular, there were clear benefits as the extra income allowed them to buy in services, which in turn gave them greater freedom and reduced the strain of caring.

A small study[33] of South Asian older people offered a full benefits assessment by Newcastle Welfare Rights Service found that additional resources awarded to participants meant that they could better afford essential items such as food, bills, and "one off" payments. Again, less stress, increased independence and better quality of life were reported, along with a positive impact on carers.

Dalkin et al's study[28] investigated if, how, and in which circumstances, an intensive advice service had an impact on stress and well-being (as precursors to health impacts), for clients attending a branch of Citizens Advice, located in the North East of England. Intensive support over a period of time (from 2 months to 2 years) was given to clients experiencing multiple and complex issues. These included (a) a project for people with severe and enduring mental health issues; (b) a project for people referred through their GP; and (c) a project for young people aged 16–25 years. All the projects, in effect, acted as the same intervention to three different client groups. As a result, the service constituted a complex intervention for those with complicated welfare issues.

The findings suggest that CA *(Citizen's Advice)* impact on well-being and stress through (a) increasing clients capabilities (b) fostering a trusting relationship and (c) by creating a facilitative Third Space to act as a buffer between the oppositional positions of the client and the state.

Moffatt et al[34] wrote a paper of their qualitative evaluation of a welfare rights advice service set up in June 2008 by Durham County Council, in collaboration with Macmillan Cancer Support, to provide a dedicated service for people with cancer and their carers in County Durham. The service was freely accessible, so people could self-refer, as well as be referred by health, social care or voluntary (charity) sector professionals. The advisors worked in a variety of locations – charity, NHS (hospital and primary care), as well as providing the service via home visits. The authors conclude that addressing the financial sequelae of a cancer diagnosis appears to have positive social and psychological consequences that could significantly enhance the clinical management of cancer and quality of life for cancer patients.

Buck's 2009 paper[13] evaluating a debt outreach service for financially excluded people delivered in community venues such as family centres, housing offices and community finance organisations, found that as well as delivering financial outcomes (payment plans, avoidance of home loss or utilities) "soft" outcomes were also achieved such as stress reduction.

3.7 Channels and Locations for Delivering Information and Advice

There is evidence concerning the preferences of different demographics for the mode of delivery of information and advice, and locations for delivery. Some of the literature is fairly old (2012/13) and so technology has advanced, and perhaps organisations now might be more successful in offering good advice services using technology; similarly, different demographics may also have moved on in their preferences, e.g. some older people may be more comfortable using the internet. Some literature considers the opinions of professionals on modes of delivery and location appropriateness.

Preferences for the mode of delivery may also be dependent upon the type of information and advice required, and possibly on the complexity and/or number of people's issues; and is obviously subjective. There is also the distinction to be made between information and advice or advocacy or guidance, whereby information need alone is possibly satisfied by a simpler mode of delivery.

A Welsh Rapid Evidence Assessment (2013)[29] makes the point that much of the evidence base stresses the importance of establishing a strong relationship between the advisor and the client if positive outcomes are to be achieved across a range of service areas.

3.7.1 Channels

3.7.1.1 Mixed

An English review[35] that focused on the provision of social welfare advice by not-for-profit advice services (2012), recognized that many not-for-profit advice providers have historically favoured face-to-face advice provision but suggests:

…initiatives involving the use of alternative channels (telephone and digital) show that a more effective exploitation of all available channels (including face to face) could improve accessibility of advice services and help the sector cope more efficiently with increasing levels of demand[11]. An effective exploitation of telephone and digital tools could present opportunities for combining economies of scale offered by national networks with the possibility of implementing outreach strategies tailored to specific local needs.

The review includes the following examples:

…Shelter is piloting video-chats, self-help interactive tools and has started providing advice via email. Gingerbread noticed that an increasing number of users of its online services were accessing it from smart phones and developed a version of the website suitable for smart phones to improve accessibility of their services. The Cambridge CAB is piloting Electronic Advice Hubs at locations across Cambridgeshire to assist in advice support and increase outreach.

A Welsh Rapid Evidence Assessment (2013)[29] looked at the effectiveness of different information, advice and guidance (IAG) delivery mechanisms for the spectrum of advice services delivered by not-for-profit, public and private sectors. The study concludes that:

The combination of different delivery methods, exploiting technology and convenience, is recognised as providing the most effective package of support to meet the IAG needs of clients. Face-to-face support is acknowledged as the predominant method of IAG delivery from which the most substantive outcomes can be achieved and especially when dealing with clients with clusters of problems. However, research has shown that there are occasions when clients either do not want a face-to-face discussion or have no preference in delivery method and simply search for help from the first available organisation (particularly for clients at crisis point).

Frost's research[36] about housing advice for older people suggests some enthusiasm from providers for mixed channels of delivery:

It was discussed with participants that a variety of channels for delivery of an I & A service would be best, as that could allow for different age groups and needs, as well as for individual preferences for accessing information in different ways. The national organisations identified that multiple channels of I & A could be offered, with clients guided towards the lower cost, self-help versions initially, such as a national phone line.

3.7.1.2 Face-to-Face

Face-to-Face contact for advice is acknowledged by several documents as the preferred method of some demographics, and in some circumstances.

The Welsh Rapid Evidence Assessment[29] looked at the following demographics: general public (mixed profile of service users); older people; young people; people with health and social care needs.

This assessment noted the importance of face-to-face contact for older people, with them valuing a personalised approach from a trusted source. Also, vulnerable groups were deemed to need more than just access to information but also help in interpreting it, with value from adopting an holistic view in providing ongoing casework to resolve complex and inter-linked issues; this presumably best achieved by face-to-face contact.

A preference for face-to-face advice was expressed by older people with housing advice needs in Frost's research:[36]

A face-to-face service, at a physical location, was the most popular channel cited, across tenures. A physical location could also offer self-service information, such as leaflets, posters, and online methods – for when it was unstaffed. Several advantages were highlighted with this method: -

- It was likely to be particularly suitable for the older old
- It was essential to support those with literacy, cognitive or communication needs, including dementia and English as another language
- It could kick-start the client journey by clarifying the presenting issues and providing a 'big picture' overview, followed by navigation, signposting or referrals
- It could provide sufficient time to allow trust to develop so that a more personalised exploration of issues can take place
- It could provide a sounding board for clients to appraise different options and clarify their thoughts thoroughly

The Welsh Rapid Evidence Assessment also noted that remote mediums, such as email and telephone are not as conducive to trust building which enables young people to "open up" about their social welfare problems. This assessment also noted the importance of some qualities in advisors for this demographic – skill to engage with troubled young people and tenacity to pursue their issue/s.

Buck's 2007[12] paper evaluating the potential for financial advice and guidance in outreach locations (prisons; Sure Start Centres; credit unions; housing offices and schools) to financially deprived and excluded people, also found a clear preference for face-to-face advice (80% of interviewees). Whilst face-to-face contact was still the favoured option amongst the following groups, Buck highlights the following differences between groups:

Interviewees in family and children centres reported more frequently than others that they would like to receive advice over the telephone (13 per cent). Credit union interviewees had the highest percentage of interviewees who would like to receive advice in writing (11 per cent). Financially excluded interviewees were less likely to prefer face-to-face advice, and significantly more likely to prefer advice in writing (10 per cent compared to 4 per cent among financially included interviewees). Arguably, financially excluded groups may prefer a more anonymous way of receiving advice on sensitive matters, such as serious money problems.

3.7.1.3 Telephone and Digital

The Welsh Rapid Evidence Assessment[29] found that providers frequently cited telephone channels as a cost-effective approach to delivering or allocating increasingly scarce resources according to complexity and need (e.g. a triage system). Online support was cited as enabling quick and up to date access to information on a range of issues although there remained concerns over barriers to access.

Regarding older people the Welsh study found that telephone support channels were a cause of frustration for service users and advisors. Frost found the same for the older people interviewed regarding housing issues:

> Once an organisation was identified to approach for I & A, the next hurdle could be reaching a relevant person or department to help with the query. Both online and telephone systems were criticised as hindering this process. It was reported to be difficult to navigate online systems to find the right pages on websites. Automated telephone services sometimes resulted in participants failing to reach the correct department, being placed on hold for a long time or being cut off before an issue was resolved.

Frost[36] did identify some positives for the telephone as a channel:

> Tenants (both social and private) would particularly welcome the continuity that could be provided by seeing a named worker and being provided with a dedicated phone number to reach that person. It was noted that it could be important to provide 0800 numbers and to ensure no complicated menu systems which tended to make it difficult to access the person or department you want.

In reference to digital channels, Frost adds:

> There were very few advocates among older people of digital only channels. Comments from all participants, but particularly from social tenants, suggested that the council required residents to communicate digitally, but that this was unwelcome as it was not always a suitable channel for older people or those with additional needs.

The Welsh Rapid Evidence Assessment suggests there is evidence to suggest that the outcomes associated with telephone support are less effective when compared to face-to-face contact

> and could also be more expensive in the longer term as problems are not tackled in the most appropriate way and/or clients are not empowered to try to address future problems earlier and on a self-help basis.

The Assessment suggests that telephone advice appears most suited to initial advice and guided self-help as opposed to supporting people to address complex problems.

3.7.2 Locations

There is evidence that co-locating advice services (CAB, welfare rights, employment, financial) in a GP setting is effective, and considered to be a good setting by providers and clients. There is also evidence concerning other locations: financial advice in outreach locations (prisons; SureStart Centres; credit unions; housing offices and schools); job centres; domiciliary.

3.7.2.1 Primary Care

3.7.2.1.1 CAB in Primary Care

Parkinson's review[21] describes PhD research (not viewed for this evidence summary) on citizens advice in GP surgeries which included ten bureaux from three regions in England and Wales, with findings based on

responses from 412 clients. In this research 57% of the clients had a long-term health problem or disability, 37% were unable to work for the same reasons, and 66% felt cut-off or alone. It is of note that this research found that 49% of GP-based advice clients said they would be unlikely to visit a high street-based advice service for a variety of reasons including concern that they would be seen visiting their local CAB.

Clients reported a range of positive outcomes from the advice including:
• feeling in control of the problem (80%);
• knowing about the law and their rights (75%);
• feeling able to enforce their rights (66%);
• feeling able to have a say in the decisions that affect them (65%);
• feeling able to deal with similar problems in the future (64%);
• feeling they have control over their life to live the way they want to (59%);
• feeling able to influence officials/people in authority (38%).

Budd's study[18] which included comparison between GPs who used an outreach advice service co-located with the surgery, those who used referral pathways and those who only signposted patients, found that the co-located outreach advice GPs were more positive about the effects of advice than those who used other methods. The referral methods GPs were more positive than the signposting GPs in all areas except for the effect on patient's health and wellbeing, where the results were very similar. Budd concluded that the use of more integrated services is a factor in whether GPs see positive effects on the areas to do with efficiency of consultation and demands on their time.

3.7.2.1.2 Welfare Rights and Financial Advice in Primary Care

Parkinson's review[21] highlights the number of studies which demonstrate that co-located services in general practice facilitate access to welfare benefits and are particularly effective in identifying health-related welfare benefits which might go unclaimed due to a lack of awareness or eligibility, with patients accessing welfare advice services that have not previously benefited from welfare advice. [26,37,38,39] Woodhead's later study[27] echoed this finding that co-located welfare advice services in a GP setting can reach people who may not otherwise have sought support or asked their GP for advice. Woodhead's study[24] also revealed people's satisfaction with the GP as a location for advice:

Nearly all reported a preference to see a GP located adviser. Open-ended responses indicated that this was because the service was easier to access (for example because of mobility problems or travel anxiety), nearer home or more convenient (129, 64.8%); or because it was a more familiar or less anxiety-provoking environment (42, 21.1%). If the service had not been available almost halt of recipients would either not have sought advice at all,or would have spoken to their GP/other practice staff.

Egan's study[10] looked at the integration of money advice services in primary care in deprived areas of Glasgow. This locality model allowed healthcare professionals to refer people to advice services based in seven health centres across north east Glasgow. GPs led the way in referring people and 68.9% of those engaged with advice services, many of whom reported no past contact with advice services. Over half of the financial gains achieved were for disability-related benefits, but support to manage household debts was also significant. Homelessness and housing issues, followed by mental health issues, were the most frequent reasons for people being referred on to other support services.

3.7.2.1.3 Employment Advice in Primary Care

A DWP paper (2008)[40] evaluating a pilot project which located employment advisors (known as Pathways Support Advisers – PSAs) from Jobcentre Plus in GPs' surgeries, found that for GPs it was important that the PSAs were based on the surgery premises as this enabled easier referral procedures, which could sometimes be immediate and could avoid the need for formal, written referrals. PSAs' presence in the surgery also aided the fostering of good relationships with practice staff. However, for some patients there were sometimes negative aspects:

There was evidence that some people spoke to the PSA because they felt under pressure to do so and some others felt they had not fully understood the purpose of the meeting beforehand. In the majority of cases, GPs took responsibility for making the patient's appointment with the PSA. On the whole, seeing the PSA the same day as the GP consultation was perceived as convenient, but this practice was criticised by people who felt they did not have sufficient time to consider their participation. On the other hand, appointments at a later date and time allowed for thought and preparation in advance.

A second study by Pittam[41] about employment advisors in GP practices in the East of England whose remit was to help people with mental health issues retain their employment or regain employment, found that confidence in their GP's advice was a contributing factor to using the employment advice service, but concluded that it might be better for the advisors to concentrate on helping those who needed to retain their employment.

3.7.2.2 Other Locations

3.7.2.2.1 Financial Advice in a Variety of Outreach Locations

Buck's study[12] evaluating the potential for financial advice in outreach locations (prisons; Sure Start Centres; credit unions; housing offices and schools) found that interviewees generally expressed a preference for money advice services in the locations where they were interviewed. There was considerable evidence that job centres would be a popular location for delivering money advice outreach. This research also noted considerable variations between the numbers of people passing through the different locations, housing offices being the busiest.

The interviewers found people refused to be interviewed for several reasons and evidently these reasons would need to be taken account of when considering setting up financial advice services in those locations. Reasons included:

- They had young children with them.
- They were with someone else.
- People were at outreach locations for classes.
- People were visiting the location for social purposes (particularly community centres) and did not want this disrupted by an interview.
- Out of the way/difficult to access interview rooms (making service unavailable to all).
- On a few occasions people were illiterate, had language problems or spoke English as their second language and, therefore, felt unable to take part in an interview.

In Buck's later paper[13] evaluating outreach advice for financially excluded people (in prisons, family centres, housing offices, community finance organisations and other community-based venues, as well as through home visits and video-link facilities), familiarity with the venue for advice was generally considered less important than the timeliness and relevance of the advice itself.

This was particularly so where the referral was made at a 'crisis point', such as bailiffs calling or a court summons, at which point clients were often anxious to receive advice as soon as possible.
Confirming findings from the target group survey, clients often identified barriers to travelling far to receive advice. These included caring responsibilities and low levels of personal confidence. The ability to 'drop in' to see the adviser during the case sometimes helped to reassure clients. For a minority of clients with chronic health problems or disabilities, a nearby location was said to be essential.

3.7.2.2.2 Advice in Job Centres

Sinclair's paper[14] on 3 collaborative and co-located projects in the Glasgow area (2 in job centres, 1 in GP practices) found that advice provision in different settings will be accessed by different members of the community.

> In the job centre, men (60%) were more likely to access the service than women. The opposite is true for advice in general practices, in which 65% of people accessing the service were female. In the job centre, 40% of people engaging with GEMAP were between the ages of 16 and 25. In general practices, the majority of people were over the age of 26. Across the two settings, people accessing advice generally had household incomes below £15,000. More generally, there was a high proportion of people with long-term health illnesses accessing advice in general practices (58%) and there was a low proportion of people that classed themselves as 'unfit for work' in the job centre (10%).

Sinclair makes the point that advice sessions should not be restricted to locations where attendance is a necessity but, exploring the use of locations which people use in their day-to-day lives would be valuable. He suggests:

> Local communities must be involved in this process. Acting upon their input; adopting a balanced approach which considers delivering services from 'locations of necessity' and those used every day; and developing accessible and discreet referral processes, may go some way to removing the concept of 'hard to reach communities' from the public policy vocabulary.

3.7.2.2.3 Advice at Home

In a qualitative 2008 study[32] of older people and their carers receiving specialist welfare benefit advice within Social Services, the authors found that older people, carers, and officers alike, emphasized the value of a specialist home visiting service, feeling that older clients "prefer someone to come round and visit". Dwyer and Hardill's 2011 qualitative study[16] concerning the impact of village services on the lives of older people also suggests that domiciliary advice or guidance is effective for older people, and also spreads the message about the service to others.

> Highly-individualised practical support is required if older people's reticence to making claims is to be overcome. Face-to-face home visits offer practical benefits beyond general telephone or internet advice lines. The positive knock-on effects of services where workers actively reach into rural communities also should not be overlooked. Home visits spread the message about entitlements to wider audiences. On several occasions, an initial visit to one person alerted others to their benefit rights and instigated further successful claims…

3.8 Barriers to Advice Services

Barriers to advisory services for prospective recipients might be physical, technological, societal, organisational, geographical or psychological, and may vary amongst demographics and individuals. The section of this report about delivery channels and locations for various demographics also touches upon barriers to using/accessing advice services.

Buck's 2007 paper[12] which evaluated the potential for money advice services in outreach locations is revealing about the reasons of interviewees who said they would not consider seeking professional advice. The numbers were small, but the authors noticed that interviewees in all non-prison outreach location types (Sure Start centres, credit unions, housing offices and schools) frequently cited their family as a reason for

not seeking external professional advice – for some, because family members were viewed as a source of advice and support, for others it was also about "keeping it in the family".

Differences were also noticed between financially included and financially excluded groups. Financially included interviewees who would not consider seeking professional advice were more confident in relying on family for support and advice concerning financial problems, whereas financially excluded interviewees were more likely to not consider seeking advice due to being embarrassed or ashamed. The authors point out that outreach advice sensitive to these feelings of shame has the potential to reach out to these individuals.

Buck et al also refer to literature which covers the different types of problem that cause barriers to accessing and using mainstream financial services for many people with limited incomes – geographical access; price exclusion; marketing exclusion and self-exclusion. They make the following point:

Breaking down barriers to seeking advice – by providing outreach money advice – may also result in breaking down the widespread mistrust of mainstream financial services companies among people who are on the margins of these financial services.[161] Trusted money advice in an outreach location can highlight the benefits of access to a basic or current account to those who are 'unbanked'.

Buck's research[13] is also revealing concerning people's views of the location of advice services and identified what people would find to be barriers:

Clients identified barriers to travelling far to receive advice – these included caring responsibilities, low personal confidence, health problems/disabilities, travel cost.

The research[12] highlighted how outreach needs to be moulded for specific circumstances/locations – different locations serve different users and a range of different barriers need to be overcome. Whereas it was found that interviewees generally expressed a preference for money advice in the locations where they were interviewed, the reasons some people refused to be interviewed are illuminating about barriers in different locations:

• They had young children with them.
• They were with someone else.
• People were at outreach locations for classes.
• People were visiting the location for social purposes (particularly community centres) and did not want this disrupted by an interview.
• Out of the way/difficult to access interview rooms (making service unavailable to all).
• On a few occasions people were illiterate, had language problems or spoke English as their second language and, therefore, felt unable to take part in an interview.

Survey respondents were informative about the positives of the locations, which is also revealing of potential barriers if locations and services didn't "live up" to their experience and expectations:

- Local, accessible locations
- Locations visited frequently so suitable for service delivery
- Familiarity and friendliness
- Benefit of multiple advice services in one place

Buck[13] makes the following points around trust in location and staff:

Prior positive experiences meant survey respondents trusted the outreach location and its staff. There is considerable potential for trust transfer from the host venue to the outreach service. Advice in trusted locations is likely to result in people feeling more at ease, confident and better equipped to articulate their money problems and advice needs in a 'safe' environment.
However, trust transfer alone is not enough. Survey results highlighted that a private space is important to target groups. Privacy and confidentiality is particularly vital for outreach venues, in which people from the

same local community are likely to meet. Whilst initial trust in an outreach venue is important, this trust needs to be further augmented through providing good, timely and relevant advice and continuity of process.

In an evaluation of a Haringey pilot of co-located welfare advice services in healthcare settings[8] semi-structured interviews with general practice staff, advice staff and service funders were held. The authors concluded that key barriers to success of this pilot included pre-existing sociocultural and organisational rules and norms largely felt to be outside of the control of service implementers, which maintained perceptions of the GP as the "go-to-location". Factors promoting the view of the GP as 'go-to-location' included local area characteristics such as housing deprivation, language barriers and social isolation. Wider structural factors included the role of GP as coordinator and gateway to a range of social support services; and, cuts to other community services available as an alternative to patients. They conclude that co-location of welfare advice services alone is unlikely to enable positive outcomes for practices.

In the area of housing the report by Frost et al[36] about housing options information and guidance for people in later life (Leeds), identified many barriers for this demographic:

- Their own psychological state and attitudes eg. facing up to being old, emotional attachment to their current home, feeling overwhelmed by the idea/logistics of moving, loss of partner etc. leading them to accessing information and guidance only at crisis point
- Late referral by housing associations
- Communication or cultural or language needs
- Clients felt that their housing options were limited anyway (both social tenants and homeowners, but for different reasons). Some social tenants felt they had no possible housing options available to them, other than their current house. Conversely, some owner occupiers also had the perception that their options were limited, as they wouldn't be able to access social housing
- Uncertainty around eligibility deterring people from seeking information and guidance
- People unclear or overwhelmed by sources of information and guidance - there was a sense that these services were not joined up – which added to the confusion and required older people to provide the same information more than once. There was a perception that finding the right person, agency or department was difficult
- 1-to-1 support needed for some people
- Digital only channels were a deterrent

This report concluded that the barriers to planning for later life are often complex and that there is a need to tailor advice and support, and that some people will need more support than others at certain points in older age.

The Welsh Government Rapid Evidence Assessment[29] of the effective delivery of information and guidance (broad scope) has much to say about different demographics preferences for delivery, and highlights how some delivery methods are barriers to some demographics – e.g. online and telephone delivery may be ineffective/undesired by: older people; those with dementia, disability or sensory impairment; those in remote areas without access to quality broadband services; people with literacy issues, language barriers or their perceived inability to act on advice given. This report also makes the point that telephone interaction reduces the ability of the advisor to pick up on non-verbal cues and may mean that they are interacting with people for whom they have limited knowledge of local support services available.

3.9 Measurement of Advice Services

The literature expounds the problems and issues around measuring the effectiveness of advice services and some suggestions are provided.

3.9.1 Frameworks

The Welsh Rapid Evidence Assessment[29] points out that there are no consistent standards or frameworks for evaluating the quality of the advice given, or the attribution of the outcomes to the advice. Sinclair[14] makes the point that consideration should be given to how rigid performance measurement frameworks can influence the behaviours and activities of staff delivering services, not allowing for flexibility in dealing with the complex issues people may present with – i.e. a reliance on predefined quantitative measurements may mean that these are achieved as opposed to delivering outcomes of meaning to the client. Sainsbury et al[40] reinforces Sinclair's point in their paper about employment advisors (PSA's) in GP surgeries:

> Any management targets would seem unsuitable because of the unpredictable flow of referrals from GPs, and because PSAs found it constructive to be able to work flexibly with individual clients.

The heterogeneity of the client base, requiring a "fluid" response is also mentioned as a barrier to outcomes measurement by Windle[42]:

> The final barrier to outcomes measurement was that of the client base. Across IAA (information and advice) services there are few if no homogenous user groups. Individuals may present with single or multiple problems. They may have a 3-5 minute 'one-off' telephone call followed by being sent a hard copy of an information sheet or leaflet. On the other hand, their problem may be so complex that they have a series of one-hour weekly meetings resulting in a legal case challenging government policy.

3.9.2 Outputs and Outcomes

Parkinson's review[21] found that it was common for advice services to collect simple output information, e.g. the number of advice sessions delivered, and where evidence of health outcomes is gathered, it is largely anecdotal and qualitative. The Welsh Rapid Evidence Assessment reiterates this:

> However, the focus within the evidence base is largely on outputs (e.g. numbers of people accessing IAG) or relatively short-term outcomes (e.g. welfare benefits accessed) rather than impacts that tend to fall outside of often short-term research timescales.

Windle et al's paper,[42] specifically focused on measuring the outcomes of information and advice services, highlights one of the difficulties as being that output rather than outcome data is demanded by funders "as this is perceived to provide tangible "evidence" and enabling far simpler comparisons across organisations."

The difficulty of attributing impact and outcomes to advice is also noted in the evidence[29]:

> The research also recognizes the difficulties in attributing impact and outcomes to one specific element of IAG given that in many cases the process of support will take the form of a multi-stage journey comprised of a range of different interventions which will be difficult to attribute to an eventual outcome.

3.9.3 Tools

Parkinson[21] reports that where systems for capturing health outcomes (the focus of the review) are in use, evidence from the services included suggests that it is generally a before and after assessment, most often using the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS); however they report that the majority of services rely on anecdotal feedback. They list the following tools as having been used successfully:

- General Health questionnaire (GHQ-12)
- Hospital Anxiety and Depression Scale
- Health Assessment questionnaire
- Nottingham Health Profile
- Patient Health questionnaire 9 (PHQ-9)

• SF-36 health questionnaire
• Warwick–Edinburgh Mental Wellbeing Scale (WEMWEBS)

The Welsh Rapid Evidence Assessment[29] which was focused on the different delivery methods of advice found:

There is a lack of consistency in the research reports regarding the measurement tools used to assess the impact of different delivery methods of IAG on clients. Indeed, a number of the studies highlight the need for follow-up research (in particular longitudinal assessments) in order to validate any findings arising from pilot or small-scale studies. This highlights the current dearth of evidence attributing IAG provision, and specifically comparing the method of delivery of the IAG, to clearly defined outcomes for clients.

Windle's paper[42] describes a project to design an outcomes measurement tool with valid outcomes within and across advice services.

The outcome tool included questions that could assess three areas: user profile, the IAA 'encounter', and outcomes (short and intermediate). The majority of questions were four-level, tick-box, Likert-type scales, ensuring easy completion. Four themes emerged from the analysis of the interviews: the level of vulnerability of users; the point at which users attend IAA interventions; outcomes of IAA services; and facilitators and barriers to outcome measurement.

Ultimately, they did not claim that their tool is a "ready-to-go" tool that could immediately be used by practitioners.

3.9.4 Outcome-based Delivery

A dissonance between staff delivering advice services and users regarding outcomes has been noted in the literature.[21,29,42] Parkinson[21] articulates this as follows:

…the research also suggests that there is a difference between user satisfaction with advice and outcomes and a professional assessment, with users often much less critical than a professional assessment of the service. The value of the service to users is such that people trust the project to take care of their interests and assume that any unmet needs are due to other people (i.e. inaction by other agencies) or to the rules. Consequently, as the report concludes there is clearly a difference between satisfaction and effectiveness and a difference between assessments made by different stakeholders.

The Welsh Rapid Evidence Assessment[29] refers to the 'phew effect'. This refers to the sense of relief people often feel immediately after having visited an advice service, which cannot be used in isolation as an indicator of the quality of advice received, or any longer term change in behaviour or gain for the client.

Outcome-based delivery would mean that advice provision is designed around client-focused outcomes, focusing on impact, and then reviewing service delivery to ensure that activities are delivering for the client.

Windle's study[42] suggests that a main outcome of the project's attempt to design an outcomes measurement tool was that initial outcomes identified through interviews with advice managers, operational staff, national informants and users, revealed the dissonance between staff and users perceived outcomes.

Operationalising such concepts produced a small core of valid and reliable questions, while the development of proxy indicators showed that greater detail may be constructed from simple, easy to complete questions… From the analysis, there are indications (given such a small sample) that a number of questions should be included within any outcomes tool. In measuring the short-term outcomes, those questions exploring the changes in knowledge and empowerment were effective. Low-burden and easy to complete for the majority of users, an assessment could begin to be made of how far their knowledge and confidence changed following their contact with the IAA service.

The Cabinet Office's Not-for-Profit Advice Services[35] promotes outcome-based delivery and has a case study from Portsmouth City Council.

Portsmouth City Council has moved to commissioning an advice service which is designed to deliver what matters to customers and to understand the levels and causes of failure in the wider system of services with which advice engages, such as benefits administration. The new service is not target-driven and has no externally imposed service standards,,but works to a clear purpose and set of principles derived from what matters to customers. Measures such as successful access, end to end problem resolution times, the number of and reasons for repeat visits, the levels of failure dealt with and customer satisfaction are used dynamically by service managers and commissioners to learn what is happening, to understand the causes and to continually improve. Contract management has become a partnership approach to solving problems, with a view to tackling the causes of demand of advice – with cost benefits across a range of public services.

3.9.5 Capacity of Providers, Expectations of Commissioners

Parkinson[21] suggests that a stronger focus on outcomes-based commissioning needs to recognize that providers need to have sufficient capacity, skills and expertise to measure their success in meeting their commissioned targets. Windle[42] makes the point that organisations offering advice are often small voluntary sector services reliant on numerous small short-term grants and may be staffed by volunteers.

Parkinson's research found that consultations with a sample of advice services found that the provision of stronger guidance and support from commissioners would assist with establishing appropriate measurement systems. This research also posed the question as to what evidence standards commissioners should realistically expect "given the context of clients accessing support through advice services, and the methodological and ethical issues presented by longitudinal tracking." Collaboration from health partners might be necessary to determine health outcomes, e.g. access to personal health records and data which could be used alongside self-reported information gathered from clients responding to questionnaire-based measurement systems.

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