PSSRU

Measuring the outcomes of information and advice services: Final report

Karen Windle, Ann Netten, James Caiels, Reena Masrani, Elizabeth Welch and Julien Forder

PSSRU Discussion Paper 2713
March 2010
www.PSSRU.ac.uk

PERSONAL SOCIAL SERVICES RESEARCH UNIT

University of Kent
University of Kent
Cornwallis Building
Canterbury
Kent
CT2 7NF
Tel: 01227 823963/823862
PSSRU@kent.ac.uk

London School of Economics
London School of Economics
LSE Health & Social Care
Houghton Street
London
WC2A 2AE
Tel: 020 7955 6238
PSSRU@lse.ac.uk

University of Manchester
University of Manchester
Dover Street Building
Oxford Road
Manchester
M13 9PL
Tel: 0161 275 5250
PSSRU@manchester.ac.uk

www.PSSRU.ac.uk

The research reported here was part of the 'Measuring Outcomes for Public Service Users' (MOPSU) project, which was funded over three years (2007-2009) by the Treasury under the Invest to Save budget and led by the Office for National Statistics (ONS). The views expressed within this report are not necessarily those of the project funders or the ONS.

Or contact the librarian at the PSSRU, University of Kent, Canterbury, Kent, CT2 7NF
email pssru_library@kent.ac.uk

Suggested reference: Windle, K., Netten, A., Caiels, J., Masrani, R., Welch, E. and Forder, J. (2010) Measuring the outcomes of information and advice services: Final report, Discussion Paper 2713, PSSRU, University of Kent, Canterbury.

Contents

1 Introduction

> *'There's no clear guidance about care and support.*
> *I feel like Alice in Wonderland – why can't I be signposted to*
> *what I need to know or be able to access what I need to help me?'*
> Person who uses services (CQC 2009:25)

1.1 Background

Information, advice and advocacy[1] (IAA) is seen as a fundamental area of activity for individuals, their families and carers who need, or in the future may need, 'services and support in order to lead their lives' (Williams et al 2009). IAA has been prioritised through numerous Governmental policy documents (e.g., see, DH 2006, DWP 2005). In particular, such services are perceived as central building blocks to achieve the envisaged transformation in social care – personalisation, early intervention and prevention (HMG 2007, Baxter et al 2006). Those organisations that have played or will play a crucial role in supporting such policy change are, in the main, based within the third sector (voluntary/community and private organisations). It is estimated that among social care third sector organisations, 42% provide IAA, while in healthcare, such services are provided by 47% of the organisations (DH 2007). Nevertheless, despite the value of the IAA services acknowledged in general and recent recommendations that 'face-to-face advice, outreach and personal information and advice about local services should be done locally' (Williams et al 2009: 8), IAA services find it difficult to obtain secure funding. In part, this is associated with the difficulty of demonstrating the value of such interventions when competing for scarce resources. Few interventions are able to capture and disseminate the necessary information that can demonstrate individual or community change and impact. Similarly, there is a lack outcome tools that commissioners can use to inform decision-making around funding.

1.2 The project

This research forms part of the Measuring Outcomes for Public Service Users (MOPSU) Project,[2] funded by the Treasury under 'Invest to Save' and led by the Office of National Statistics (ONS). The MOPSU Project consists of three main strands all working towards the overall aim of:

- More efficient and effective commissioning and procurement of services, placing the issues of quality and value for money at the heart of the decision-making process
- Encouraging the use of 'outcomes' measures to assess the impact of services on their users, across the spectrum of providers
- Examining the extent to which the third sector is involved in public service delivery and helping to alleviate barriers to entry to third sector organisations

---

[1] As we discuss below, services included in the study did undertake an advocacy role in providing advice and support, so we use the term IAA throughout. However this excludes long-term advocacy.

[2] Formerly the Quality Measurement Framework (QMF) project.

The aim of this project, ‘Measuring the Outputs of Information and Advice Services’ (IAA project), was to identify a method and design questions that could begin to enable a measurement of robust and valid outcomes within and across IAA services. Such measurement had to be low-burden, exploring the use of a single standardised tool that could cover the different processes, types of services and client groups – their activity and reach. The emphasis was very much on the ‘begin to’; the IAA work was at a much earlier stage of development than the other PSSRU research on adult social care homes and low-level services (see Caiels et al 2009, Netten et al 2009) and it was not intended that a fully tested IAA tool would be developed. The embryonic nature of work in this field (see Netten and Forder 2008) meant that the focus of any research questions by necessity had to be exploratory. Five research questions were identified (see Figure 1).

Figure 1: Research questions

- What were the existing definitions, concepts and scope of ‘outcomes’ relevant to IAA services within the wider academic and practice literature?
- How were outcomes conceptualised by IAA strategic, operational staff and users?
- Were some outcomes considered by IAA staff and users of higher importance than others and, if so, how were these weighted?
- Were outcomes being measured across the different IAA services and, if so, in what form?
- Could the development of a low burden, standardised outcome tool encompassing the range and activity of IAA services successfully measure short and intermediate outcomes, while inferring any long- term benefits?

To take these questions forward, a two-phase project was designed incorporating exploratory investigations and ‘testing’ of an initial outcome tool. The exploratory phase investigated the acceptability, plausibility and feasibility of outcome measures and developed a first draft outcomes tool to be cognitively tested (see section 2 below). The second phase involved piloting the tool across eight IAA organisations, exploring different types of administration (e.g., face-to-face, telephone, self-completion).

To ensure that we were clear about the types of outcome, service and activity that we were covering in both phases of the work, a model (Saxton et al 2007) was identified and adapted (see Netten and Forder 2008) to provide the necessary theoretical parameters (see Figure 2).

This model identified three levels across which benefit could be measured: societal, organisational and individual. At each level, outcomes could be measured to reflect the short, intermediate and long-term effects of the service. The embryonic nature of the field and the limited concentration on outcomes necessarily dictated that the IAA project focused on *individual benefit* and included *short-term and intermediate* outcomes. The timeframe of the project did not allow for wider exploration. Nevertheless, the process of developing the outcome tool enabled appropriate recommendations for further work.

Figure 2: Model of Information & Advice service inputs, outputs and outcomes (adapted from Saxton et al. 2007)

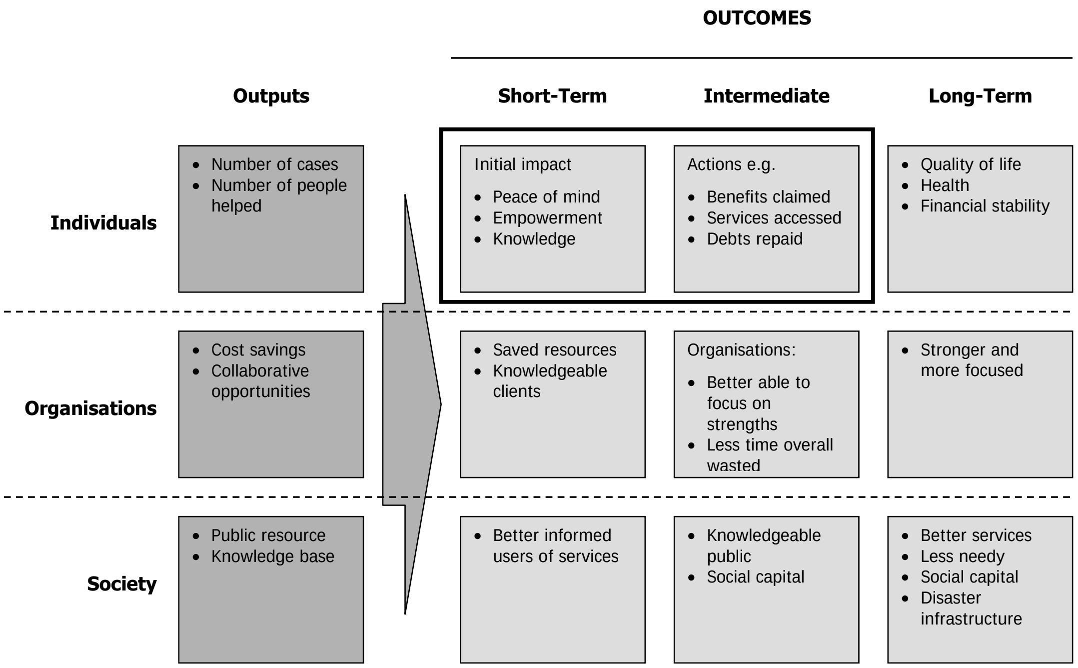
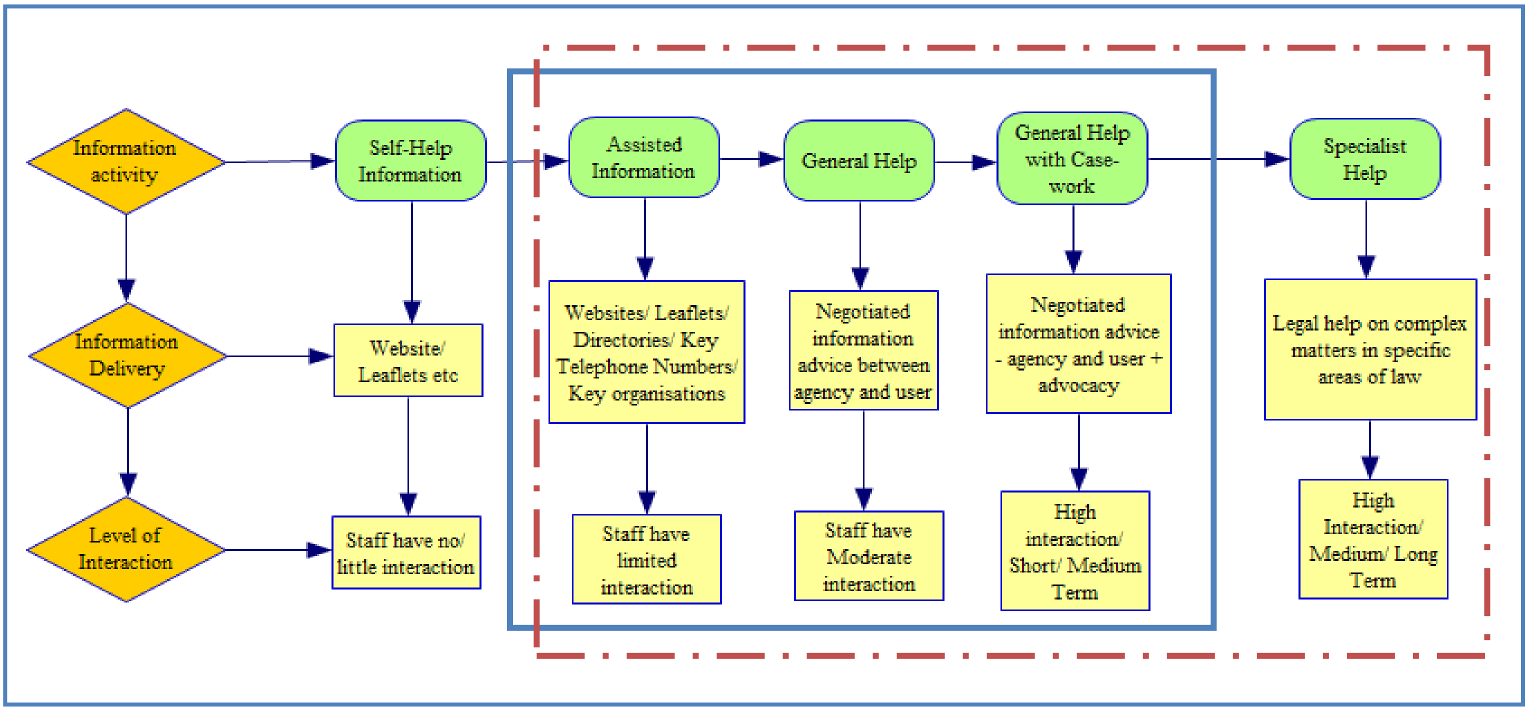


Figure 3: Continuum of Information & Advice 'activity'



Third sector IAA services incorporate a number of activities, ranging from assisted information to specialist help (see Figure 3 above). Following discussions among the research team and the external steering group, it was decided that the development of any tool would focus on activity that included face-to-face and/or telephone interaction: ‘assisted information’, ‘general help’ and ‘general help with case work’.

The services at each end of the continuum of IAA activity – one-off self help and specialist help through legal representation - were excluded. It was agreed to exclude one-off access through web-sites (self-help information) as it was unlikely that this could be measured in a robust way. There was much more discussion about what was termed ‘specialist help’ – usually the provision of legal representation and/or advocacy for complex issues. It can be problematic to separate out information, advice and advocacy services as *‘these three types of service provision overlap and are inter-related’* (Dunning 2005 cited in Williams 2009). However, it was recognised that advocacy was a very different type of support and would probably require a set of different questions. It was argued that any single standardised outcome tool could not measure such a wide range of activity. Nevertheless, in field-testing the initial outcomes tool (see 2.2 below), two of the IAA organisations included reported an advocacy role: ‘the provision of support and encouragement, or representation of individuals’ views, needs or rights’ (Margiotta et al 2003 cited in Williams et al 2009). Both organisations reported using staff or volunteers to speak on behalf of the user within a legal context (such as education committee or judicial review). The sample from which data was collected was small and ‘qualitative’. However, there was limited inclusion of services that included advocacy within their overall provision.

In the initial planning of the IAA project, it had been suggested that any field work and thus development of the tool would be restricted to those IAA organisations providing social and health care advice. Nevertheless, following an initial steering group meeting, it was suggested that effort should be made to incorporate as wide a reach as possible. It was argued that agencies provide information and advice encompassing numerous areas: education, financial information, housing, employment, immigration, nationality and asylum, with heath and social care only part of their remit. Within the consultation phase and fieldwork, care was taken to ensure inclusion of such range of service (see Table 1 below).

1.3 Conclusion

This report brings together the empirical research across the two stages. Section 2 outlines the methods employed and explores the challenges to such an evaluation. Section 3 describes the themes and outcomes from the three development phases: consultation stage, documentary analysis and cognitive interviewing. The final structure of the outcomes tool is described in the second half of this section, and the rationale behind each question is discussed. The analysis of the tool is reported in Section 4. The demographics of the responses are explored, prior to moving onto analysis of outcomes. Outcomes were analysed by user characteristics (e.g. demographics, ability, problem faced) and/or organisational factors: perceived expertise of the IAA advisor, and whether the information was easy to understand and relevant. Throughout this analysis, an assessment was made as to how far the different, single focus, questions could be bought together to serve as proxy outcome measures: e.g., good practice within any organisation, individual perception of ‘being in control’ etc. Finally, we bring the empirical work together to discuss the effectiveness of the outcome tool and the developments that needed to be undertaken: the type, extent of questions and administration.

2 Methods

2.1 Exploratory phase

The objective of the first exploratory phase was to investigate the acceptability, plausibility and feasibility of developing outcome measures. Three activities were carried out: a literature review, consultation phase and follow-up field work.

Literature review

The literature review identified key publications and research data around outcomes, allowing us to identify relevant concepts and develop a model of IAA services outcomes (see Figure 2). We draw on the models and concepts in this report, but the details are reported elsewhere (see Netten and Forder 2008).

Consultation phase

The consultation phase involved a series of semi-structured interviews (telephone and face-to-face) with key informants: 'experts' within the IAA environment (see Appendix 1). The topic guide was designed to identify how outcomes were conceptualised and defined, and the approaches and barriers to measurement in practice. This incorporated organisational and service aims, identification of vulnerable groups, conceptualisation and definition of outcomes, approaches to outcome measurement as well as any perceived barriers to such assessment (see Windle et al 2009). To cover the reach and activity of IAA services (see Figure 3), purposive sampling – which is a subjective rather than random approach to recruiting informants – was undertaken. Individuals within organisations are selected by the researchers because of the information and insights they can bring to the research (Gobo 2004). National IAA organisations were contacted, and key informants (in the main, strategic managers) were invited to take part in the research. In total 15 interviews were undertaken; they lasted between 35 and 90 minutes, and were tape recorded and thematically analysed (Huberman and Miles 1998).

Documentary analysis

Alongside this consultation phase was a collation and analysis of existing commissioner or organisation driven accreditation and regulation guidelines to which the IAA services responded. Each key informant interviewed was asked about the type and extent of existing measurement and available tools. The research team then requested copies of any outcome measures. From these documents 'concepts' were identified (Berg 1989) and tested across the different documentation.

Field work

Drawing on analysis from the previous activities, two 'field-work' sites were identified that would allow further exploration, assessment and validation of the emerging outcomes through semi-structured interviews with strategic, operational staff and users. The sites were purposively selected to incorporate the necessary activity and reach. Summary information is given in Table 1 below.

Table 1: Summary of field work sites

	Field work organisation: Drop in advice centre	Field work organisation: Telephone advice line
Operational area	Services a large conurbation in South-East England (pop 29,879)	England and Wales
Number of clients *per annum*	• 8,500*	• New service
Client access	• Website • Face-to-face 'drop-in' • Planned meetings for specialist advice and case-work	• Website • Two-tier telephone advice line. • Tier 1, initial enquiries and signposting • Tier 2, specialist enquiries
Reach (information areas or subjects)	• Education • Financial • Housing • Employment • Immigration, nationality, asylum • Health and community care	• Health and community care • Financial • Housing
Activity (information delivery and level of contact with client)	• Self-help information • Assisted information • General help • General help and case-work	• Self-help information • Assisted information • General help
Number of staff	• Bureau managers (2) • Supervisors (4) • Generalist advisors (11) • Specialist advisors (11)	• Team leaders (4) • Tier 1 staff (3) • Tier 2 staff (12)

*Source: Annual Report of fieldwork organisation 2008/9.

A total of 19 telephone or face-to-face interviews were carried out with operational staff. All were tape recorded and thematically analysed.

A separate topic guide was developed for service users. This covered their expectation of the service, perceived benefits or outcomes, and barriers to service use or actions (see Appendix 2). Recruiting users for this field work stage was a challenge. The process of recruitment, necessarily through IAA advisors, has been fully described in the interim report (see Windle et al 2009). This created one barrier early in the project. Some IAA advisors found it difficult to raise the subject of the research project following any contact owing to the perceived vulnerability of clients – taking on a gate-keeper role. Others felt it sat uneasily with their primary focus of advice giving. A further 'barrier' was the extent of contact that the user had had with the service: where it was a one-off, five-minute telephone conversation resulting in them receiving an information leaflet, they found it difficult to envisage what help they could offer to the research team, other than to say they had asked for the information and this had been posted to them. Conversely, where users were receiving longer-term case-work support (e.g. for a debt or housing problem) their lives were often chaotic. Participating in research was thought to be too much to ask them to take on, given the other difficulties they were facing. Recruiting users to take part in research took over six months, with only 10 users actually being interviewed. (Again, the interviews were carried out either by telephone or face-to-face, and were tape recorded and thematically analysed.) The difficulty in recruiting users is a fundamental problem across IAA services and mirrors the experiences of IAA organisations. As Section 3 indicates, many IAA organisations are only able to achieve a response rate of between 3% and 15% in self-completion surveys.

2.2 Development, cognitive testing, piloting and analysis of the outcomes tool

Development of the outcomes tool

The outcomes tool was developed from analysis of the exploratory phase. A goal of the MOPSU project was to minimise the burden of data collection and analysis for service users, providers, commissioners and regulators. Within the area of IAA, the tool needed to be relevant to individuals who had taken part in a brief intervention as well as those who had perhaps worked with an IAA advisor over a number of months. This juxtaposition of low-burden (concise, simple) and wide applicability presented challenges to the goal of robust measurement of outcomes.

The outcome tool (see Appendix 3), 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 (see Figure 4)

Figure 4: Example of four-level Likert-type scale

How did you feel before you contacted the service?

I didn't feel at all worried or concerned ☐

I was somewhat worried or concerned ☐

I was very worried or concerned ☐

I was extremely worried or concerned ☐

Further discussion of the rationale behind each of the different questions is given below (see section 3.3).

Testing the tool

Cognitive interviews were used to assess how individuals understood and interpreted each question. Cognitive testing is a technique to bring to the surface how individuals are interpreting the particular questions: 'their comprehension, recall, decisions and judgement and response processes' (Willis 2005: 6). Verbal probes are used to enable individuals to talk through their understanding of the question, any meaning it might hold for them and how they might respond. Such testing can help to assess whether the theoretical concepts and empirical findings used to develop the questions have construct validity: that is, how well the developed measure or question conforms to theoretical expectations. The process was also designed to explore the ease (or otherwise) individuals would have in completing the questionnaire if administered in different ways, such as through telephone interviewing or self-completion.

A total of 26 cognitive interviews were carried out. Twenty-three of the interviewees were drawn from four organisations selected to ensure a range of reach and activity was included (see Table 2). These interviews were carried out face to face and at a place and time convenient to the interviewee. A further three cognitive interviews were carried out by telephone with 'expert users' who sat on a user, carer and patient involvement in research group (based at the London School of Economics).

Table 2: Organisations from which interviewees were drawn

	Reach	Activity	User Profile
Carers organisation	• Housing • Financial • Health and community care	• Assisted information	• Aged over 65
Autistic trust	• Education • Health and community care	• Assisted information • General help • General help with case work	• Families of/ children/adults with diagnosis of autism
Older people's charity	• Financial • Housing • Health and community care • Education	• Assisted information • General help	• Aged 60 and over
Parents organisation	• Education • Financial	• Assisted information • General help • Specialist help	• Parents/families of disabled children

The interviews served an iterative process; the questions were refined during the fieldwork period and changes were made to the tool. The Likert scales were extended to include four rather than three items as individuals argued that the nature of information and advice – idiopathic and nuanced – should be recognised through a wider choice of response. Changes were also made through the insertion of extra questions or items. For example, an extra question was added to the outcomes tool on the barriers users experienced following the information and advice received. Similarly, within that question, an option was added to ensure that personal psychological and emotional barriers could be recorded: 'I didn't have the energy or time to follow up the information I was given (I was overwhelmed at the time).' Such changes were further tested and redesigned until participants felt that the questions had resonance with their experience of IAA services.

Within the cognitive interviews, supplementary questions were asked concerning facilitators or barriers to different modes of administration. The majority of interviewees argued that a face-to-face interview would be more appropriate. The perceived complexity of the interview (represented by the number of questions and items) limited how long these could be held in the memory while on the telephone; and those with literacy difficulties argued they would be unable to self-complete any tool. To ensure these concerns could be explored further, piloting of the completed tool included face-to-face, telephone and self-completion.

Piloting

Seven organisations agreed to pilot the outcome tool (see Table 3).

Table 3: Organisations involved in the piloting of the outcomes tool

	Reach	Activity	User Profile
Drop-in advice centre	• Education • Financial • Housing • Employment • Immigration, nationality, asylum • Health and community care	• Assisted information • General help • General help with case work	• Full adult population
Older people's charity	• Financial • Housing • Health and community care • Education	• Assisted information • General hep	• Aged 60 and over
Young people's service	• Education • Financial • Housing • Employment • Health & community care	• Assisted information • General help	• Aged 13 – 19 (completion only by those aged 18 plus)
Autistic trust	• Education • Health and community care	• Assisted information • General help • General help with case work • Specialist help	• Families of/children/adults with diagnosis of autism
Parents organisation (disabled children)	• Education • Financial	• Assisted information • General help	• Parents/families of disabled children
Parents organisation (additional educational needs)	• Education	• Assisted information • General help • General help with case work • Specialist help	• Parents/families of children with additional educational needs
Learning disabled charity	• Education • Financial • Housing • Employment • Immigration, nationality, asylum • Health and community care	• Assisted information • General help • General help with case work	• Learning disabled children/adults and their families

Two organisations agreed to face-to-face contacts with their clients, one to telephone interviews and self-completion tools, while the other four, citing valid concerns around IAA advisor capacity and user confidentiality, would only allow for information packs to be left at the organisation to be picked up by users if they wished to participate. All modes of the process of recruitment had their limitations.

In recruiting users for face-to-face interviews within the drop-in advice centre, the method the most convenient for the organisation was that researchers could only recruit in the waiting room. Users were approached to ask if they would be willing to participate and, if so, following their contact with the IAA advisor met with the researcher to complete the outcomes tool through a structured interview. This very brief gap between advice received and outcomes recorded limited the sensitivity of any tool focused on recording short and intermediate outcomes. Efforts were made to mitigate this through changing the wording of the questions. For example, instead of asking the user whether the ‘advice had been followed’, users were asked ‘do you intend to follow the advice you were given’.

The face-to-face structured interviews were organised more easily in the second organisation (the older people’s charity). Following contact with the organisation, the names of those users who consented to take part in the wider project were sent to the research team. The researcher contacted them to arrange a convenient time and place, and a total of 28 face-to-face interviews were carried out.

Five organisations agreed to recruit by offering their members ‘research packs’ containing an invitation letter, summary of the research, outcome tool and self-addressed envelope. Thirty packs were sent to each organisation (n=150). Discussions were held with IAA managers and advisors about distribution. However, again, there was anecdotal evidence that the IAA advisors felt that discussion of the research project sat uneasily with their roles, and this limited the number of packs handed out to users. In total, 48 questionnaires were returned from the organisations, a 32% response rate. No follow-ups were possible as the organisations did not feel it was appropriate to forward the names of individuals to the research team. However, despite the lack of follow-ups (St Leger et al 1997), the response rate was relatively respectable when compared to other such data collections.

For the telephone interviews, an email was forwarded to the manager of the parents’ organisation who then circulated this to the membership list. Individuals who were interested in participating were invited to contact the researchers. Three people volunteered and were interviewed. The percentage response rate is not known as we were not told the total membership numbers.

The mode of recruitment necessary in the drop-in advice centre, the lack of contact with users - at one remove - and the absence of follow-ups are all understandable limitations working within this challenging field. Such constraints may have affected the type of individual that participated. For example, prior research has shown that those users unhappy with their situation, health, quality of life and the type of information received are more likely to complete an outcomes tool or be interviewed (Windle et al 2009a). The analysis of the tool ensured such bias was explored (see section 4). Nevertheless, this research project was working in an embryonic field, concentrating on exploratory development. Bias, although needing to be identified, does not necessarily affect the outcomes. Rather, it is a useful finding, enabling appropriate further tool development and guidance around administration.

Analysis of the outcome tool

The number of responses (79) to the questionnaire limited the type and extent of analysis that could be carried out. Only univariate (frequencies, descriptive) and bivariate (cross-tabulations, chi-square, analysis of variance and t-tests) statistical techniques could be used. Reliability (Cronbach's alpha) and factor analysis was used to explore how well (or otherwise) the outcome tool measured a unidimensional latent construct: that is, did the outcomes tool form a single scale? For many of the questions included, the reliability 'score' would be low as the outcomes tool had not been intended as a single scale. Rather, each question had been developed to explore separately user circumstance, capability, their experience of the IAA encounter and outcomes. Nevertheless, it was hoped that some questions would have some underlying construct (or linked meaning) to allow further 'compound' indicators to be developed. Three indicators were derived from the questionnaire items, measuring social isolation, user self-perception of being in control and IAA organisational good practice. These are discussed further in section 3.3.

Given the small sample, the assumed lack of randomness in the sample selection and the likely bias because of the low response rate, statistically firm conclusions cannot be drawn from the data. Nevertheless, the data does provide some helpful insights into people's views and experiences of IAA services.

2.3 Ethical permission

Ethical permission to conduct the research was received from the University of Kent ethics committee. Two proposals were submitted: the first covered the exploratory stage of the consultation and cognitive interviews, and the second sought permission for wider piloting of the outcomes tool.

3 Exploratory phase: development of the outcomes tool

3.1 Introduction

There is a lack of research or experience within practice in measuring outcomes in IAA services, previous work focusing primarily on processes and outputs (see Netten and Forder 2008). The absence of outcome tools that could be built on or adapted determined the focus of the initial exploratory phase. In this section we first discuss the themes emerging from the consultation phase, documentary analysis and field work. We then describe the structure of and rationale behind the development of the outcomes tool.

3.2 Themes and outcomes from the development phases

3.2.1 Consultation and field work phase: key informants

A total of 34 key informants were interviewed using a topic guide developed from the literature review (see Section 2). 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.

‘Vulnerability’ was measured according to characteristics and level of need of users. Certain groups were always highlighted: older people, recent immigrants, and those from BME communities. Not all individuals within such groups were considered vulnerable *per se*. Rather, any perceived vulnerability was compounded by individual difficulties around communication (language or literacy), physical or learning disabilities and/or mental health problems leading to social exclusion or isolation, increasing the likelihood of deprivation and decreasing access to services and support.

> ‘Some groups are more vulnerable. I suppose, in relation to the calls we get, an example might be a person that is house-bound, with little social contact in a rural area and they need someone to visit them because they’ve got a form to complete and the nearest service is 50 miles away’ (KI_DS300033)
>
> ‘Mental health, learning disability, dementia: vulnerability is a lot to do with the level of power people have and all these groups have little or indeed no power’ (KI_DS300010)

Such vulnerability was seen as affecting how users first presented to the organisation. For most IAA organisations, the majority of clients accessed the service at a crisis point rather than for any planned information seeking. Such crises were not limited to the problem or issue that the client was facing (such as bankruptcy) but rather compounded by previous unsuccessful attempts to find the information: the lack of any prior pathway worsening an already serious situation.

> ‘By and large users present at crisis point and, that’s not just personal crisis but if they’ve hit blocks in the system as well which they can’t get through, so in a sense it is a double crisis. So

> they're desperate for some kind of support or help, and they're finding the system not working for them' (KI_DS300012)
>
> 'The majority of clients present at crisis when they finally get to [our service]. There is a pathway for users; they start off asking around friends and family, perhaps go onto the internet, but when things are not resolved then they come to us. And the problem of waiting is that often the issues are far worse' (KI_DS30007)

Respondents were clear and concise in discussing the aims and processes of the service, but when the interview moved onto outcomes and their measurement, few were able to clearly outline outcomes, while others conceptualised outputs as outcomes (see Figure 2 for more information on the distinction between outputs and outcomes).

> 'Outcomes, what do I see as outcomes? I'm sorry, I don't think I can help you with that' (FW_DS300033)
>
> 'Short term outcomes, that's satisfying their basic needs, food, housing, shelter, clothes and ensuring access to crisis loans' (KI_DS300035)

In part, such confusion arose owing to the huge range of individuals attending their service, some users simply wanting a leaflet, others having a one-off face-to-face contact while still others needing on-going support through case-work. This temporal dimension around user contact, the time taken with the client, the level of IAA advisor input appeared to affect the conceptualisation of outcomes.

> 'For short-term outcomes, the client comes in with a number of debts which are quite straightforward. We provide them with a series of self-help letters, they go away, do it and they're closed then. Another example of a short-term outcome is that of a mortgage hearing where they go and they're repossessed or they're not, that's a short-term outcome. A medium term outcome is a situation where we've had to negotiate with a creditor; perhaps there's a debt that is out of date and it involves a lot of work three or four months down the line. The long-term outcome is one where they are still in debt and still coming in five years on, that's a long-term outcome' (FW_DS300015)

Despite such initial difficulty, prompts and further discussion enabled some clarity as to the type and extent of outcomes. Using the model of short, intermediate and long-term outcomes as a focus (see Figure 2), all key informants identified an increase in knowledge as one short-term outcome. Through attending the IAA service, users should know more about their particular problem and what actions were available to take should they so choose. Similarly, empowerment of the user was perceived as a key immediate outcome. Empowerment can incorporate helping an individual or group to improve their decision-making ability, take control of their circumstances to achieve specific goals (Braye and Preston-Shoot 1995), and to 'have more control over their lives' (Shardlow 2002: 38). Placing this within the context of IAA services, users should be able to see that they have the ability to undertake the action, and such understanding should feed into their future capacity. This common view is illustrated well through the following quote:

> ‘What you always hope when you give people advice on a particular subject, there’s a learning, an increase in understanding the rights and responsibilities so that you hope that, and it doesn’t always work like this, but some people will be able to tackle the next issue because they tackled this one’ (KI_DS30008)

Other key informants perceived a short-term outcome to be ‘peace of mind’, or the reduction of stress or anxiety. To distil what was meant further and place this somewhat ‘fuzzy’ concept in an outcomes framework, respondents were asked how they defined ‘peace of mind’. From their responses, peace of mind was perceived as part of but more than simply empowerment or knowledge. Peace of mind incorporated validation of the client through appropriate ‘listening’, and was also seen as enabling the user to understand that taking action to deal with their problem was possible. Nevertheless, it could be argued that if clients are to perceive a level of validation, they are also likely to be empowered. Similarly, if users saw that they had options and choices, they could also act – part of the overall constructs of knowledge and empowerment. As such, ‘peace of mind’ was subsumed into these two constructs.

Intermediate outcomes were seen as, relatively simply, orientated toward some form of achievement. The client or user undertook a particular action to begin to resolve their problem, or they were able to access the particular service that they needed.

> ‘An intermediate outcome would be achieving a short-term goal, which could be anything from getting their medication changed because of an unfortunate side-effect, to getting a better level of disabled living allowance or obtaining their travel insurance: something where they’ve moved their problem on a bit’ (KI_DS30005).

Some key informants were able to identify long-term outcomes – ‘quality of life, health, financial stability’ (FW_ DS300029) – all of which were based on the necessary prior actions. If the individual was able to learn more about their problem, be able to act on this and achieve a result, then long-term outcomes would emerge.

> ‘Short-term benefit should lead to long-term benefit. For example, a short-term outcome could be as simple as an increase in benefit but, extrapolating from this, if you look at a change in benefit as a base-line issue, then it could make a huge difference to somebody’s life through by reducing anxiety and thereby improving health, allowing purchase of other services thereby improving health and quality of life, and simply allowing the individual more financial stability’ (FW_DS30009)

To begin to refine definitions and understanding of outcomes, key informants were asked if they felt that there were outcomes that had a higher ‘weighting’ than others. For example, was ensuring an increase in knowledge more important in any IAA intervention than empowering the client to act. Perhaps, not surprisingly, few of the respondents felt able to differentiate: ‘I’m not quite sure that there has been a huge amount of sophisticated thinking about this’ (KI_DS300010). The process of IAA was perceived as a holistic endeavour; it was only with knowledge could individuals think of acting, but only through building confidence – empowerment – could actions be undertaken.

Where respondents were able to differentiate outcomes was in discussion around how users would weight outcomes. It was recognised by most IAA service staff that, for users, the main focus of any contact and wished for outcomes was the fundamental resolution of any problem. Although IAA advisors may be focusing their service on knowledge and empowerment – hoping to put in building blocks to support the longer-term aims of, for example, financial stability and social inclusion – the user focus is to ‘sort out the problem’.

> ‘I suspect if you’re in crises you just see your problem being solved on an immediate basis and your situation being improved. Having a better economic state just helps everybody. Getting advice on education, training is about being part of society. But, if you come here in a crisis, your biggest thing is about getting out of that crises’ (KI_DS300008).
>
> ‘Clients would always give greater weight to those outcomes that get their problem solved. So sometimes those issues around empowerment – they’re outcomes that the advocacy service may want more than the client’ (KI_DS300010)

Definitions and understanding of outcomes and their importance were present, if not universal across the services. However, few of the organisations identified measuring outcomes either as a one-off exercise or as part of their overall quality and assurance framework. Where this was in place, outcomes were collected only as part of specialised project work rather than within the core IAA services. These findings were supported by those quality and assurance measures collated as part of the documentary analysis exercise: without exception these incorporated either metrics (numbers seen, ethnicity, age-range) or ‘satisfaction’ questions. There seemed to be three barriers to such measurement: demands from commissioners; capacity and resources; and client base.

Where performance data was demanded by funders, this was output rather than outcome data, the former perceived as allowing tangible ‘evidence’ and enabling far simpler comparisons across organisations.

> ‘Say you have service A and service B, they both say that they’ll provide the service, but they are very different organisations. How do you really benchmark one against another? So therefore funders will use the information that they can benchmark and that is output information: how many hours, what are you going to do, where are going to do it, how many people are you going to see. And you can understand it, as this enables them, in their eyes to compare ‘like-with-like’ and the rest is quite difficult. (KI_DS300007)

Moving from external to internal demands, organisational resources and capacity limited how far outcome data could be developed, administered and analysed. Those organisations offering IAA services are often small voluntary sector services, reliant on numerous small short-term grants and staffed by volunteers, their primary focus the provision of appropriate, timely information and support. This difficult ‘balancing’ act in ensuring all roles were undertaken was recognised by many of those interviewed.

> ‘You have to be very careful, you don’t want the emphasis to shift from what you do to how you do it. You know, we’ve always got to put the client first, and if you get involved in too much ancillary type work, it could be at the expense of your clients’ (FW_DS00019)

> ‘We’ve been so understaffed for so long and so many people are calling [our telephone advice line], and it’s one of my bugbears, we employ people to work on the help-line and we employ them because they are passionate about helping people and because of that passion, evaluation comes second and those workers know that if they do the evaluation part of the work, then they can’t answer the next three calls and that’s what they want to focus on’ (KI_DS300015)

Nevertheless, for other organisations, although recognising capacity as perhaps a valid argument, this in itself had become an excuse not to measure outcomes appropriately: ‘”Oh, there’s too much paperwork, oh, we haven’t got the time” - we must get past these excuses’ (KI_DS300010). They argued that such measurement was possible if it was built into people’s work programmes, ensuring cultural change.

The final barrier to outcomes measurement was that of the client base. Across IAA 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 sent. 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. The users themselves may have low or high levels of vulnerability and problems of social exclusion and physical, learning and communication disabilities. Such diverse activity and clients led to recognisable challenges in designing a robust tool, identifying how best this could be administered (e.g., self-completion, telephone interview, face-to-face) and appropriately analysed. IAA advisors and managers reported that, even when tools were circulated to users, the response rate was negligible, 2-15%, affecting how far the data could be analysed. That there was a desire to move from measuring outputs to outcomes was unquestionable: all service providers agreed that they wanted to explore outcomes and to be able to follow-up their client base.

3.2.2 Consultation and field work phase: users

A sample of 10 service users was interviewed during the consultation and field-work phase. The difficulty of recruitment has been discussed above (see Section 2). Nevertheless, despite such a small sample, their views were invaluable in enabling an understanding of their perception of ‘outcomes’ from any IAA encounter. The themes that emerged from the data were similar to those of the key informants, although, as perhaps would be expected, users’ understanding and conceptualisation of outcomes was limited, and none perceived outcomes as a linear process – short, medium or long-term.

Mirroring the IAA advisor responses, all users spoke of their levels of anxiety – due to a specific ‘crisis’ or an on-going complex problem (such as obtaining a continuing care grant) – prior to contacting the IAA organisation. However, where there was a slight difference in any findings was in the users’ articulation of what they wanted from the service. For some, resolution of the problem was indeed the driving force behind contact.

> ‘Before I went, I thought basically that all my problems would be solved. The help I needed I would get from there, or if they couldn’t actually do it they would put me in contact with an organisation that could help me’ (User_DS300041).

For others, however, the outcomes wanted were somewhat more nuanced: a more discursive encounter that would enable an exploration of those options available.

> ‘I was looking for help and guidance in an area I wasn’t having much success in and I was really hoping that we could go through some of the options and get some hard information around an area that I didn’t really know’ (User_DS300044).

Such nuances around outcomes did not just include discussion of overall options. Some users identified their need for IAA advisors to validate their approach or feelings: ‘The main thing I got from it was to keep pursuing it in the way that I was doing and providing the necessary documents in support of the evidence’ (User_DS300053). Others, that the use of the information given enabled them a voice in statutory processes and procedures: in short, empowerment.

Users measured the success of the encounter through whether they were able to get what they had envisaged they needed. If users were looking for a discussion of options, they universally reported a successful encounter. Where more proactive help was wanted – completion of forms or paperwork owing to problems with literacy – less success was reported.

> ‘If I was to say it was a waste of time, that wouldn’t be the right thing. They did help me in a certain aspect through finding the forms on the internet for me, but they didn’t help me with what I wanted done. It was a waste of two hours because they didn’t help me fill in the forms. They’re very good at giving you the advice and finding sources of information, but then it’s basically, that’s all we can help you with. So, for me, the problem is still on-going and I still need to find someone to help me with the form’ (User_DS300018)

Discussion with users showed that they considered an ‘effective’ encounter one that led to a reduction in anxiety. However, such reduction was not linked to the IAA encounter per se, but rather whether the problem was resolved or not. Users stated that they had known more following the encounter, but that, in the words of one user, the real ‘stress buster was the resolution of the problem; my wife and I felt that we could go away on holiday and not worry anymore’ (User_DS300044).

3.3 Structure of the outcomes tool and question rationale

The consultation phase and field work allowed for the identification of key outcomes (see Table 4).

Table 4: Summary of outcomes drawn from the consultation and field work phases

Outcome level	User	Key informant
Short-term	• Reduction in anxiety • Increased knowledge • Resolving the problem	• The 'phew' factor (peace of mind, reduction in anxiety/worry) • Increased knowledge • Increased empowerment
Intermediate	Users did not see outcomes in a 'linear' way	• Services accessed • Action undertaken
Long-term		• Improved problem solving • Improved ability to navigate the system • Improved health/financial stability • Social Inclusion

Analysis also enabled further insight into those factors that could affect outcomes: for example, the level of need or vulnerability of the user, the level of anxiety being brought to any 'meeting', the dissonance between what the user wanted from the IAA service and what it was possible to provide. In bringing these together, an initial outcomes tool was designed and cognitively tested across a sample of 26 users (see section 2 above). Following such testing, the final tool incorporated three areas: the IAA encounter, outcomes and demographics.

3.3.1 IAA encounter

Eight questions were included to assess the user experience and pathway. Ranging from how the user felt prior to contacting the service, via the type of help they wanted and whether they had sought information from other different areas, those key factors identified by IAA service providers and users within the exploratory phase were incorporated.

3.3.2 Outcomes

In exploring outcomes, the decision was made to include only short-term and intermediate outcomes. The difficulties of recruitment, the range of reach and activity, and the low response rate reported by IAA services around internal satisfaction and outcome instrumentation, all combined to dictate that any outcomes tool should be concise and targeted. To include long-term outcomes (even if only through inference) a far greater number of questions would have been needed, affecting likely response rates. An individual having a 3 – 5 minute telephone conversation and leaflet would be very unlikely to complete a 20-page questionnaire. The short-term outcomes were measured through two questions exploring levels of knowledge and empowerment:

- *Following your contact with the service, how much more do you know now?*
- *'How would you feel if you faced a similar situation in the future?'*

Intermediate outcomes were perceived by IAA service providers as encompassing some form of action, moving toward resolution of the problem. The number of issues being faced by individual users and the range and activity of IAA organisations meant that targeted questions around specific problem resolution could not be used. For example, it would not have been appropriate or useful to have a list of questions incorporating benefit applications made, housing repossessions fought, debt arrangements made with creditors and so on, particularly given much of this information is collected by IAA services as part of their wider contract with commissioners. Similarly, for many users, the issue for which they sought information and advice was often part of the whole, rather than a single problem. It was therefore necessary to develop and test two more general questions. It was theorised that if users received the help they wanted and chose to act (or indeed not act) then there might be some movement toward problem resolution. The two questions finally included were:

- *'Did you get the help you wanted?'*
- *'What happened as a result of your contact with the service?'*

The final outcome included was the 'counter-factual' question of user actions in the absence of IAA services. The cross-sectional nature of the outcomes tool did not allow for any pre and post measurement. The only way to gain some insight into the difference made to individuals through attending and receiving IAA was to ask how far they felt they would have been able to take forward their problem if such services had not been in place. The final question used was:

- *'If you didn't get the help that you did from the information and advice service, how confident would you be to take forward the issue?'*

The word 'issue' was used as some users did not see their enquiry as part of a problem or difficulty – they were simply searching for information.

3.3.3 Demographics

User characteristics are likely to facilitate or undermine the benefit or outcomes from any IAA encounter. To measure the level of 'vulnerability', six demographic questions were incorporated: age, ethnicity, whether the user lived alone, ability to deal with paperwork/forms, overall quality of life and postcode. As we have discussed, age and ethnicity do not necessarily confer 'vulnerability'. Nevertheless, when combined with other characteristics (communication difficulties, deprivation and physical or learning disabilities), users are likely to be more vulnerable within the IAA encounter and further work by themselves and the advisor will be necessary over a longer time-frame. Such further work will include a building of trust between the user and adviser, an understanding by the users as to any available solutions to their problem and encouragement to act on their problem (empowerment) before the outcomes can be achieved.

To measure communication difficulties (language or literacy), two indicators of abilities in 'Instruments of Activities of Daily Living' (IADLs) were included within the outcomes tool:

- *'Do you deal with your finances and paperwork – for example, paying bills, writing letters – by yourself?'*
- *'Do you feel able to fill in forms by yourself without help from anyone else? '*

It was important to find a means of reflecting deprivation as prior research has clearly demonstrated that, unless mitigated, psycho-social determinants (income, health-related behaviours, social exclusion and so on) will affect service use throughout the life course (see Marmot and Wilkinson 1999). It has been demonstrated that despite the importance of information and advice services for this group to ensure equity of access and knowledge, benefits or outcomes are less tangible. An evaluation of information prescriptions (IPs) – aimed at signposting individuals with long-term care conditions to services or better management of their conditions – identified that ' fewer users living in disadvantaged areas found IPs useful as those living in more affluent areas' (OMP 2008: 7). It is unlikely that such experiences of this group are limited to a particular initiative. Direct measures are not easily incorporated in the limited type of tool being tested. Instead, service users were asked to indicate their postcodes which were then calculated at the lower layer super output area (LSOA) level (ODPM 2004) to indicate the level of deprivation in the area in which they lived.

Ideally, to measure levels of disability and/or existing mental health problems, we would have included validated tools: either Activities of Daily Living (ADLs) or the GHQ12 (a measure of psychological health). However, such scales would have lengthened the tool substantially, probably leading to greater non-response. Instead, users were asked to indicate their overall levels of quality of life across a seven-item scale ranging from 'my life is so good it could not be better' to 'my life is so bad it could not be worse' (Bowling 1995). This is likely to be associated with levels of anxiety and other aspects of physical and mental wellbeing that might affect the reporting of outcomes.

3.3.4 'Proxy indicators'

Three key concepts were identified from the literature (see Netten and Forder 2008) and the exploratory interviews with service providers and users (see above) that were acknowledged as likely to influence the effectiveness of the users' encounter with any IAA service. These were social isolation, user perceptions of 'being in-control', and levels of IAA good practice. We have previously discussed the need to ensure any tool was easy to complete, low-burden and relevant to a wide range of service users. Such demands by necessity placed constraints around the number and type of questions or existing scales that could be included within any outcome tool. An exploration was made as to whether the indicators of 'social isolation', 'in-control' and 'IAA good practice' could be built from existing questions. In doing so, prior literature was consulted to identify those questions that could be brought together to perhaps serve as one of the constructs, and further testing of reliability was carried out through measures of statistical reliability (Chronbach's alpha) and factor analysis.

If users are to know about services, be able to access these and act on any information and advice, they need to have a level of social inclusion (DWP 2005). There are scales and measures available that can 'score' levels of inclusion: 'the extent to which people are able to participate fully in the institutions of society' (see Berman and Phillips 2000). Again, such scales could not be used within a concise standardised questionnaire owing to their length. A proxy indicator of 'social isolation' was therefore developed from the three questions of: living alone, age and quality of life. The latter was included as prior analysis of this question had demonstrated that, where individuals reported their quality of life as bad, very bad or so bad it could not be worse, differences in levels of functional ability were observed: for example, levels of physical impairment being associated with social isolation as a result of lack of ability to move outdoors independently (Glendinning et al 2008).

The second proxy indicator developed was that of 'being in control' A multidimensional concept, it includes the ability to make choices, plan what may be wanted from a particular service, the capacity to identify the most appropriate service and use any interaction in the most appropriate way, taking forward the information received to some level of resolution. A sense of 'being in- control' has been argued to be a 'pivotal contributor to a wide variety of behaviours and to both physical and mental well-being, essential elements of quality of life' (Lachman and Prenda Firth 2004: 320). Many scales have been developed to measure 'mastery': internal (self efficacy) and external (responsiveness of environment) control (see Bandura 1997, Brim et al 2004). Nevertheless, these were initially constructed for US citizens and are often couched in language that is not easily accessible within the UK. Similarly, many of the scales include work status, irrelevant to many service users owing to levels of disability or age (e.g., Pearlin and Schooler 1978). Finally, all of the scales consist of 12 or more questions, necessarily lengthening any questionnaire which in turn could increase non-response rates (de Vaus 2002).

Five models were developed to assess whether questions could be grouped to 'proxy' an assessment of individual perception of internal or external control. The sample size did not allow for complex multivariate analyses and, as a result, the models were developed drawing on previous research, examination of correlated variables (e.g, see Lachman and Prenda Firth 2004) and further testing. Two models seemed to indicate some sense of 'mastery' (see Figure 5), with the only change between them that of the age of the individual included in the proxy indicator. This latter was included as prior research has indicated that those individuals living in the least deprived areas are 18 years older when accessing high-level health and social care services than their counterparts in the most deprived areas (see Windle et al 2009a). Nevertheless, within the overarching analysis, Model 1 provided better outcomes.

Figure 5: Variables selected to proxy 'in control'

Model 1

- User completed the tool by themselves (Completion = 1)
- The user 'always' or 'usually' dealt with forms (Forms <=2)
- Age was less or equal to 66 (Age <=66)
- Users lived in least deprived areas (as measured through IMD rank) (IMD Quartiles >=3)

Model 2

- User completed the tool by themselves
- The user 'always' or 'usually' dealt with forms
- Age was less or equal to 75
- Users lived in least deprived areas (as measured through IMD rank)

The final proxy indicator developed was that of 'organisational good practice'. It can be argued that if users perceive that the IAA advisor has a high level of expertise, that the information received was given in such a way that it was easy to understand and helpful or relevant, they would be able to move forward more appropriately, with any 'movement' impacting on outcomes. A proxy indicator of 'good practice' was constructed from the following three questions:

- 'How would you rate the knowledge of the person who gave you the information and advice?'
- 'Was the information or advice you received easy to understand?'
- 'Overall, how helpful has the information and advice you have received been'?

It must be recognised that this analysis is at a very formative stage. The proxy indicators are crude. Similarly, developing such constructs using such a small, no doubt biased and 'skewed' sample, cannot provide immediate guidance on how far different concepts can be extrapolated from a simple questionnaire. Nevertheless, such exploration does begin to provide limited indications of what it might be possible to do following analysis of a larger survey. The analysis using such proxy indicators is reported in the next section (see section 4), but care needs to be taken in any interpretation given the embryonic nature of the questions and concepts, as well as the limited survey numbers.

4 Results

4.1 Introduction

We start by describing the characteristics of respondents. The short and intermediate outcomes are then explored in relation to these characteristics.

4.2 User characteristics

Seventy-nine users in seven organisations completed questionnaires (see Table 3) in three different ways: self-completion (61%, 48), researcher administered face-to-face interviews (35%, 28) and telephone interviews (4%, 3).

The mean age of participants was 56 (median 51, standard deviation 21 years), ranging from 17 to 91, reflecting the range of reach and activity across the different organisations. Almost half of the sample (45%) were aged 60 and over, just over a quarter (26%) were under 40, while almost a third (30%) were aged between 40 and 59 (see Table 5).

Table 5: Age range of the sample

Age Range	% (n)
Aged up to 29	10% (8)
Aged 30 - 39	16% (13)
Aged 40 - 49	21% (17)
Aged 50 - 59	9% (7)
Aged 60 - 69	9% (7)
Aged 70 - 79	14% (11)
Aged 80 and over	20% (16)
Total	100% (79)

Over two-thirds (70%, 55) of those users completing the questionnaire were women. Perhaps surprisingly, given the gender distribution in the general population, women formed a higher proportion of younger people in the sample. For users aged 60 and over, the ratio of men to women is 1:1.5 compared to 1:3 in the younger age groups.

It could be argued that more women than men were able to complete the questionnaire. However, such response rates are far more likely to reflect the gender differences in service use. More women than men make use of projects or interventions (see Glendinning et al 2008). Similarly, given the gender division in caring responsibilities and roles, women may have a greater need for information and advice.

One way of exploring the impact of over-arching deprivation is through the Index of Multiple Deprivation (IMD).[3] From Table 6 below, it can be seen that almost half of the sample (45%, 36) are in the lowest two quartiles, with a quarter of the sample living in the most deprived areas.

Table 6: Lower Layer Super Output Area (LSOA) by number of respondents

LSOA quartile	% (n)
Quartile 1 (Most deprived)	25% (20)
Quartile 2	20% (16)
Quartile 3	36% (28)
Quartile 4 (Least deprived)	11% (9)
Totals	92% (73)

Those users aged 60 and over were more likely to live in less deprived areas: 68% (21) lived in areas in quartiles 3 and 4, compared with 48% (16) of those under the age of 60. There were no differences by age for any other indicators of vulnerability: abilities in 'Instrumental Activities of Daily Living' (IADLs) and personal circumstances (such as living alone, needing help with completion of the questionnaire and so on).

Previous research has shown that living alone in combination with ageing heightens risk factors, leading to higher service use, potentially resulting in demand for greater input from information and advice services (Cove et al 2006, Bentley and Meyer 2004, Victor et al 2002). Similarly, the combination of ageing and solo living can have an impact on integration within the community (Davidson 2004). In our small sample, almost a third of individuals (32%, 25) lived alone. Of these, over two-thirds (68%, 17) were aged 60 and over (see Table 7)

Table 7: Lone living status by age range

Age Range	Lone living status		Totals
	Don't live alone	Live alone	
Aged up to 59	68% (36)	32% (8)	56% (44)
Aged 60 and above	32% (17)	68% (17)	44% (34)
Totals	100% (53)	100% (25)	100% (78)

Fisher's Exact Test, p =0.004 (2 sided)

The majority of the sample (58%, 46) stated that the quality of their life ranged from good to so good it could not be better, fewer than one in 10 (8%, 6) that it ranged from bad to so bad it could not be worse and, over a third (34%, 27) agreed that their QoL was 'alright' (see Table 8).

---

[3] Scores represent the overall measure of deprivation in any local authority area and are calculated using the following criteria: income deprivation, employment deprivation, health deprivation and disability, education, skills and training deprivation, barriers to housing and services, living environment deprivation and crime. Within the outcome tool, user postcodes were calculated at the lower layer super output area (LSOA) level (ODPM 2004). There are 34,378 LSOAs in England. The most deprived LSOA is given a rank of 1 and the least deprived a rank of 34,378 (Noble et al 2008).

Table 8: Self-reported quality of life of respondents

Quality of life	%, n
So good it could not be better	5% (4)
Very good	24% (19)
Good	29% (23)
Alright	34% (27)
Bad	4% (3)
Very bad	3% (2)
So bad it could not be worse	1% (1)

4.3 Ease or difficulty in questionnaire completion

It has been discussed previously that one of the key aims of the questionnaire development was to ensure that any tool was clear and easy to complete. It would seem that of those individuals who carried out self-completion (46), only 7 (5%) reported needing further help. Assistance, not surprisingly, depended on the age of the individual: almost a third of older individuals (30%, n=7) completed the questionnaire with help from family or friends or with one of the local service team (see Table 9).

Table 9: Age Range by Type of questionnaire completion

Age Range	Type of questionnaire completion			Totals (%, n)
	Self-completion (%, n)	Help from family/friends (%, n)	Help from local service team (%, n)	
Aged up to 59	100% (23)	0% (0)	0% (0)	100% (23)
Aged 60 and over	69% (16)	22% (5)	9% (2)	100% (23)

$X^2 = 8.256, df = 2, p = 0.016$

Help was also sought to complete the questionnaire (again, not surprisingly) where individuals reported some or great difficulty in 'completing forms'. Half (7) of this group reported that they had sought help from family/friends or a member of the service team (see Table 10).

Table 10: Able to complete forms by type of questionnaire completion

Form completion	Type of questionnaire completion			Totals (%, n)
	Self-completion (%, n)	Help from family/friends (%, n)	Help from local service team (%, n)	
No or few difficulties	100% (31)	0% (0)	0% (0)	100% (31)
Some or great difficulties	50% (7)	36% (5)	14% (2)	100% (14)
Totals	85% (38)	11% (5)	4% (2)	100% (45)

X^2 = 19.492, df = 2, p =0.00

Further assistance was given only for those individuals 60 and over who reported some or great difficulty with completing forms (see Table 11).

Table 11: Age range and difficulties in completing forms by questionnaire completion

Age Range	Form completion	Type of questionnaire completion			Totals (%, n)
		Self-completion (%, n)	Help from family/friends (%, n)	Help from local service team (%, n)	
Aged up to 59	No or few difficulties	100% (20)	0% (0)	0% (0)	100% (20)
	Some or great difficulties	100% (2)	0% (0)	0% (0)	100% (2)
Aged 60 and over	No or few difficulties	100% (11)	0% (0)	0% (0)	100% (11)
	Some or great difficulties	42% (5)	42% (5)	17% (2)	100% [4](12)
	Totals	84% (38)	11% (5)	4% (2)	100% (45)

$X^2 = 9.224$, df = 2, p =0.01

4.4 IAA encounter

4.4.1 Nature of the problem

From the consultation phase, field work and cognitive interviews carried out to support the tool development, it became clear that few individuals phone or visit an information and advice service to discuss a single issue.

> 'There is also a lot of work about communication and exploring the emotional side, particularly on the phone. Three conversations down the line, you really know what's going on, what the issues are and it's only at that time that they can actually understand what they need to do' (FW_DS300013)

The question on the nature of the problem was designed to be multiple-response ensuring full activity could be captured (see Table 12). Each user perceived their issue to concern more than one problem, with an average of 1.65: slightly higher than that reported by one of our field work sites (see Table 1), who identified 1.4 'problems' per user. Health was the single most frequent issue mentioned by half the sample, with a fifth to a quarter of users needing guidance on social services, debt, housing and education. It should be noted that the IAA services included in the testing phase of the outcomes tool may have skewed the focus of information need: two organisations provided IAA for children with disabilities (learning and physical), a third focused on partnership with parents in the education systems, while the fourth (of six), was solely focused toward providing advice on education and employment.

---

[4] Percentage figures may add up to over 100% owing to rounding.

Table 12: General nature of the problem

General nature of problem	% (n)
Health	50% (33)
Social services	24% (16)
Debt	24% (16)
Housing	20% (13)
Education	20% (13)
Legal rights	17% (11)
Employment	10% (7)
Totals	165% (109)

Analysis was carried out to explore if the nature of the problem was specific to certain groups. For example, was the type of advice sought affected by the individuals' age, deprivation levels, solo living, sex or overall perceived quality of life?

The age of the user was found to be associated with the type of problem for which help was being sought. There were indications, perhaps not surprisingly, that those aged 60 and over were more likely to seek help on housing problems and social services, and less likely to seek information and advice around finance/debt, employment and education (Table 13).

Table 13: Problem by Age Range

Problem	Age Range		Totals
	Aged up to 59	Aged 60 and over	
Problem concerns housing	14% (6)	21% (7)	100% (76)
Problem concerns social services	16% (7)	27% (9)	100% (76)
Problem concerns finance/debt	38% (12)	12% (4)	100% (76)
Problem concerns employment*	16% (7)	0% (0)	100% (76)
Problem concerns education**	30% (13)	0% (0)	100% (76)

**Fisher's Exact Test, p=0.017 (2 sided); **Fisher's Exact Test, p<0.0005, (2 sided).*

The level of IADLs could be argued to have an effect on help-seeking behaviours. If an individual is unable to deal with paperwork or benefit forms, information on benefits or specific interventions may be sought, along with support to complete documents. There was some suggestion (albeit non-significant) that those individuals who reported limited capability with forms were more likely to seek information and advice on social care (see Table 14).

Table 14: Able to deal with forms by Problem concerns social services

Age Range	Problem concerns Social Services		Totals
	No	Yes	
Always/Usually deal with forms	83% (42)	17% (9)	100% (51)
Sometimes/Never deal with forms	71% (17)	29% (7)	100% (24)
Totals	79% (59)	21% (16)	100% (75)

Fisher's Exact Test, p=0.35 (2 sided, ns).

One counter-intuitive finding was that users from the more affluent areas were more likely to seek information and advice about social services (see Table 15). However, this is likely to reflect concerns about people's own or their relatives' care needs as they grow older. Over two-thirds of the sample of those aged 60 and above lived in less deprived areas.

Table 15: Levels of deprivation by Problem concerns social services

Levels of deprivation	Problem concerns Social Services		Totals
	No	Yes	
First (most deprived) and second quartile	91% (31)	8% (3)	100% (34)
Third and fourth (least deprived) quartile	69% (25)	31% (11)	100% (36)
Totals	80% (56)	20% (14)	100% (70)

Fisher's Exact Test, p=0.035 (2 sided)

As the question allowed multiple responses, further analysis was carried out to identify interactions among the dependent as well as the independent variables. This confirmed the bivariate analysis, 'age' being the only characteristic associated with the type of problem. Those in the younger age groups concentrated their enquiries on employment (*F=6.25, p=0.015*) and education (*F = 13.923, p = 0.000*).

The IAA services included in the testing phase of the outcomes tool may have skewed the focus of information need: two organisations provided IAA for children with disabilities (learning and physical), a third focused on partnership with parents in the education system, while the fourth (of six) was solely focused toward providing advice on education and employment.

In exploring the efficacy of the question, of the 79 respondents there were only three non-responses. It may have been that they did not feel that the above categories covered their problem and, indeed, two of the three did add comments within the 'other' category: 'Day to day living with an ADHD child', 'supporting a dependent with a disability'. The latter comment could be covered through the addition of a 'Rights of Carers' option. For the former, it would seem that the issue ranged across all aspects and the respondent may have felt ticking all boxes to be futile. The reliability and rigour of this (and other questions) is discussed below (see Section 5).

4.4.2 Levels of anxiety

From the qualitative work (see section 3), the experience of most organisations is that ‘people generally present at the point of crisis when it’s difficult for the advisor to help’ (KI08_DS300020). Such a state of mind will have an impact on outcomes, at least in the short term. Likely reactions to any crises are concern and worry. If these are manageable and correct information is given and acted upon, there is likely to be short-term relief: the ‘phew’ factor. Nevertheless, if concern has become embedded within the individuals’ life, then further effort –on the part of both the client and advice worker – is required to achieve outcomes.

> ‘I think a short-term outcome is a mixture of peace of mind, control; it’s having someone as a sounding board, to verbalise what’s going on, because often what you’re talking about is really sensitive and there may be extreme feelings of guilt, anger that need to be explored and brought out; once that has been done there can be a forward movement’. (FW_DS00019).

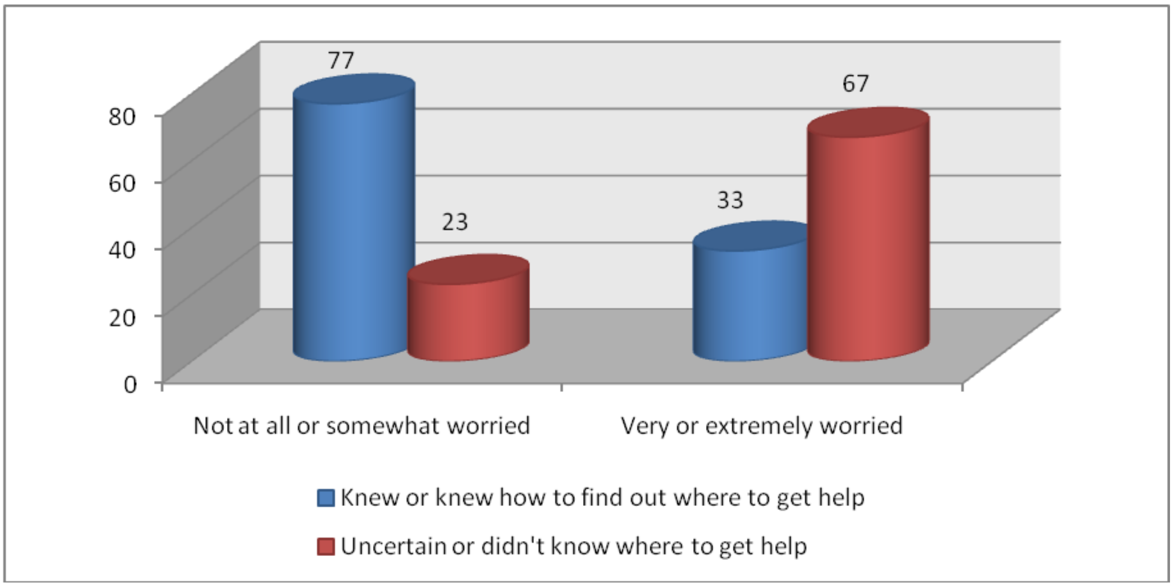
To attempt to capture the levels of crises presented by clients, participants were asked to indicate how they had felt prior to contacting the service. Over three-quarters of the sample (76%, 59) said that they had some concerns or worries prior to their visit; almost a fifth of the sample (18%, 14) were extremely worried and concerned, while only a quarter (24%, 18) had not been worried before contacting the service (see Table 16).

Table 16: Feelings prior to contact with the service

Feelings prior to service contact	% (n)
Extremely worried or concerned	18% (14)
Very worried or concerned	18% (14)
Somewhat worried or concerned	40% (31)
Not at all worried or concerned	24% (18)
Total	100% (79)

To assess those factors associated with anxiety, we examined age, levels of deprivation, ability to complete paperwork or forms, type of problem, and knowledge of where IAA could be sought. There was only one statistically significant association: where individuals were not sure or had no idea of where to go for help, their worries and concerns were higher (see Figure 6).

Figure 6: Knew where to get help wanted by feelings prior to service contact



This confirms the qualitative findings, the majority of informants and users indicating that the crisis at presentation was often due to lack of a clear pathway.

> 'Nearly every time users present at crisis point. Awareness of [IAA service] is very poor; individuals come here when everything else has gone wrong and they finally reach our service at the end of their tether, at crisis point'. (KI06_DS300010)

A multi-response question was included to identify if respondents had used different information sources: either other IAA services, friends or relatives, or searching the internet. Perhaps surprisingly, over half the sample (50%, 37) had only received information from the single organisation. Similarly, few individuals identified going to more than one source of information (1.07) (see Table 17).

Table 17: Use of other information

Information received from other areas	% (n)	% of cases
Information received from only this organisation	50% (37)	54%
Information received from friends/relatives	30% (22)	32%
Information sought/received from the internet	20% (15)	21%
Total	100% (79)	107%

There were no statistically significant findings between sources of information and levels of anxiety. The rationale behind this may be three-fold. The first is the type of services that allowed testing of the outcomes tool. Of the six services, four were specific to diagnoses and users would be unlikely to find other IAA services that could support their needs. Secondly, individuals were not asked whether this was their first contact with the service. If users already knew about the service, their worries or concerns would have been due to the problem itself, rather than their knowledge of where to get help. Finally, the ordering of the question may have had an impact on responses. The question was placed toward the end of the tool to give an indication of further, rather than prior, searching behaviours. The additions and changes to the tool that this part of the analysis suggests are discussed below (see section 5).

4.4.3 Type of help wanted from the service

It has been discussed previously that there was disparity for IAA staff between what they perceived their service outcomes to be and user perceptions. Key outcomes were empowerment and increased knowledge enabling independent action. In discussing what users wanted, many staff echoed the following statement:

> They either want a complete and utter solution to their problem and if they get that, they will be absolutely cock-a-hoop, or they want someone else to take the responsibility' (FW_DS30029).

From the analysis of the outcomes tool, it would seem that although the majority of users (52%) did wish for a discussion of choices and options through the provision of information and advice, a large proportion of the sample (48%, 38) wanted more proactive help (see Table 18).

Table 18: What type of help was wanted from the service?

What type of help was wanted?	% (n)
I wanted information and advice	52% (41)
I wanted to be told where I should go for help	20% (16)
I wanted help with my forms	18% (14)
I wanted someone to act on my behalf	10% (8)
Totals	100% (79)

It could be assumed that if individuals have answered positively to the last three options - I wanted to be told where to go, I wanted help with forms and I wanted someone to act on my behalf – they were looking for 'hands on' assistance rather than a discussion of options. Recoding this particular question and exploring this dichotomy it was found that five variables were associated with the type of help users identified as wanting. Perhaps unsurprisingly, the age of the user appeared to be associated with what help was wanted, although this was not statistically significant (see Table 19).

Table 19: Age range of user by Type of help wanted

Age range of user	What type of help was wanted?		Totals
	Information and advice	Proactive help	
Aged up to 59	60% (27)	40% (18)	100% (45)
Aged 60 and above	41% (14)	59% (20)	100% (34)
Totals	52% (41)	48% (38)	100% (79)

Fisher's Exact Test, p=0.11 (2 sided, ns).

The matter for which users were seeking IAA help affected how individuals wanted to discuss their problem. If the issue concerned employment, all users wanted information and advice rather than more proactive help (see Table 20)

Table 20: Problem concerns employment by What type of help was wanted from the service

Problem concerns employment	Information and advice	Proactive help	Totals
No	46% (32)	54% (37)	100% (69)
Yes	100% (7)	0% (0)	100% (7)
Totals	51% (39)	49% (37)	100% (76)

Fisher's Exact Test, p=0.012 (2 Sided)

If individuals had been very or extremely anxious prior to contacting the service they, not surprisingly, wanted someone else to act on their behalf (see Table 21).

Table 21: Feelings prior to contacting the service by type of help wanted

Feelings prior to contacting service	What type of help was wanted?		Totals
	Information and advice	Proactive help	
Not at all or somewhat worried	61% (30)	39% (19)	100% (49)
Very or extremely worried	36% (10)	64% (18)	100% (28)
Totals	52% (40)	48% (37)	100% (77)

Fisher's Exact Test, p =0.04 (2 sided)

Similarly, if there were difficulties with literacy or with form completion (IADLs), more proactive help was wanted. Of those users who did not deal with finances or paperwork, or dealt with these on an infrequent basis, almost three-quarters of the sample (71%, 17) wanted more proactive help (see Table 22). Where users found difficulty with form completion, almost the total sample (83%, 20) identified wanting more than simply 'passive' information and advice (see Table 23).

Table 22: Dealing with finances/paperwork by Type of help wanted

Do you deal with finances/paperwork by yourself?	What type of help was wanted?		Totals
	Information and advice	Proactive help	
Always/Usually deal with finances of paperwork	62% (34)	38% (21)	100% (55)
Sometimes/Never deal with finances or paperwork	29% (7)	71% (17)	100% (24)
Totals	52% (41)	48% (38)	100% (79)

Fisher's Exact Test, p =0.013 (2 sided)

Table 23: Able to fill in forms without help by Type of help wanted

Able to fill in forms without help	What type of help was wanted?		Totals
	Information and advice	Proactive help	
Always/Usually deal with forms	67% (36)	33% (18)	100% (54)
Sometimes/Never deal with forms	17% (4)	83% (20)	100% (24)
Totals	51% (40)	49% (38)	100% (78)

Fisher's Exact Test, p <0.001 (2 sided)

Along with the demographics and ability of users (IADLs), it is likely that the type of help wanted was influenced by the level of difficulty of the problem being faced. For example, users who were in severe debt and in the process of having their house repossessed were more likely to want 'hands-on' support than teenagers making an initial enquiry about types of employment within their area. No such question on perceived levels of difficulty was asked, in part owing to findings from the consultation phase that identified where individuals were seeking information, a problem perceived difficult at some level, has necessarily been identified. How difficult the problem is perceived to be will depend on many individual-level factors; for older people, exploring how to get help with shopping may be a daunting task and perceived as a 'crisis' while, conversely, individuals in severe debt do not necessarily perceive their problem as a difficulty. Moreover, if users have already visited a number of services with no outcome, they may wish for proactive help, rather than a discussion of options. Again, we did not record whether users had previous contact either with the organisation for which they were completing the tool, or the wider IAA community, given that this information is often recorded by the organisation as part of their reporting mechanism (we discuss in section 5 how the outcome tool could be merged with metric data).

4.5 Outcomes

4.5.1 Introduction

In adapting existing outcomes models (Saxton et al 2007), a triadic model was adopted incorporating short-, intermediate and long-term outcomes (Netten and Forder 2008). In the analysis, we used key questions from the outcome tool to proxy the different outcomes (e.g., knowledge, empowerment, action). Some of the outcomes were represented by a single question; for others, it was necessary to use a combination of questions (see Table 24). Within each of the outcome 'levels', two analyses were carried out. The first explored whether the outcome was affected by user characteristics (e.g demographics, ability, problem faced). The second covered organisational factors: perceived expertise of the IAA advisor, and whether the information was easy to understand and relevant. These three questions formed an internally reliable scale (Chronbach's Alpha=0.7) and were combined to form the proxy indicator of 'good practice' (see 3.3 above).

Table 24: Questions used to measure outcomes

Outcome level	Outcome	Question
Short-term	Knowledge	Following your contact with the service, how much more do you know now? • I know a great deal more • I know quite a lot more • I don't know any more • I am more confused now (than I was before)
	Empowerment	How would you feel if you faced a similar situation in the future? • Confident I would know what to do on my own • Confident I would know where to go for help • Not confident, I would only have some idea what to do • Not confident at all, I wouldn't know what to do
Intermediate	Actions (Problem resolution)	Did you get the help you wanted? • Yes, I got more help than I wanted • Yes, I got the help that I wanted • No, I got less help than I wanted • I did not get any help at all What happened as a result of your contact with the service? • I followed the advice I was given • I followed some of the advice I was given • I followed none of the advice I was given • I wasn't able to follow the advice

4.5.2 Short-term outcome: knowledge

The majority of the sample felt that they either knew a great deal or quite a lot more after their contact with the IAA service (see Table 25).

Table 25: Increase in 'knowledge' following contact with the intervention

Following contact with IAA, how much more does user know	% (n)
A great deal more	36% (28)
Quite a lot more	53% (42)
Don't know any more	10% (8)
Totals	78 (99%)

Nevertheless, are certain groups able to 'learn more' from such an intervention than others? In exploring the demographics of deprivation, sole-living and age, it was found that the latter two variables were associated with how far any increase in knowledge seemed to be achieved in the short term. For those users living alone, almost a quarter of the sample (24%, 6) stated that they either didn’t know any more, compared to 4% (2) of the sample who lived with family or friends (see Table 26).

Table 26: Living status by Increase in knowledge

	Levels of knowledge following intervention		Totals
	I know a great deal/quite a lot more	Don't know any more	
Live alone	76% (19)	24% (6)	100% (52)
Live with family/friends	96% (50)	4% (2)	100% (25)
Totals	90% (69)	10% (8)	100% (77)

Fisher’s Exact Test, p=0.012 (2 sided)

When exploring the impact of age, there were indications (not statistically significant) that those users aged 60 and over were less likely to have improved their knowledge, with almost a fifth (18%, 6) stating that they did not know any more following the intervention (see Table 27).

Table 27: Age by Increase in knowledge

Age Range	Increase in knowledge		Totals
	I know a great deal/quite a lot more	Don't know any more	
Aged up to 59	96% (42)	4% (2)	100% (44)
Aged 60 and above	82% (28)	18% (6)	100% (34)
Totals	90% (80)	10% (8)	100% (78)

Fisher’s Exact Test p= 0.073 (2 sided) (ns).

Bringing together these two variables, where individuals are aged 60 and over and live alone, almost a third of users (29%, 5) reported that they didn’t know anything more following their contact with the IAA service (see Table 28).

Table 28: Living alone and aged over 60 by Levels of knowledge following intervention

	Levels of Knowledge following interventions		Totals
	I know a great deal/quite a lot more	Don't know any more	
Do not live alone/not over 60	95% (58)	5% (3)	100% (61)
Live alone/over 60	70% (12)	29% (5)	100% (17)
Totals	90% (70)	10% (8)	100% (78)

Fisher’s Exact Test, p=0.011 (2 sided)

The type of information that users need is associated with increased (or otherwise) levels of knowledge. For example, if users are looking for help or assistance with a complex financial matter, what they take away may depend on their prior level of knowledge, the expertise of the IAA advisor and the organisational limitations on what help can be offered (e.g., help with paperwork/forms). It was found that there were indications, albeit non-significant, that users who attended for legal advice, were less likely to increase their level of knowledge (see Table 29). Care needs to be taken interpreting this finding as only one organisation (the drop in advice-centre – see Table 3) provided information and advice about this subject.

Table 29: Legal problem by Increase in knowledge

	Increase in knowledge		Totals
	I know a great deal/quite a lot more	Don't know any more	
Legal problem	73% (8)	27% (3)	100% (11)
Not legal problem	92% (59)	8% (5)	100% (64)
Totals	89% (67)	11% (8)	100% (75)

Fisher's Exact Test, p=0.08 (2 Sided) (ns).

In exploring the organisational factors, it would seem that there were some differences in the reported 'good practice' of the organisation (not statistically significant). The perceived expertise of the IAA advisor may affect outcomes, leaving a fifth of the sample not knowing any more (see Table 30).

Table 30: Perceived knowledge of IAA advisor by Increase in knowledge

Perceived knowledge of IAA advisor	Increase in knowledge		Totals
	I know a great deal/quite a lot more	Don't know any more	
IAA advisor knowledge excellent or very good	94% (58)	6% (4)	100% (62)
IAA advisor knowledge good or poor	80% (12)	20% (3)	100% (15)
Totals	91% (70)	9% (7)	100% (77)

Fisher's Exact Test, p=0.13 (2 sided).

There was an association between knowledge gained and the IAA service used. Almost three-quarters (74%, 20) of the sample from the drop-in advice centre (see Table 3) thought that their knowledge had increased, compared with 98% (50) across the other organisations (see Table 31). However, care needs to be taken in interpreting this finding as indicating a quality or process weakness. Such a finding may have been a consequence of administration type and time-frame. Within this organisation, all outcome tools were administered through a face-to-face structured interview which took place immediately after individuals had met with the advisor.

This immediacy may affect how far users can assess the information given and their perceptions on the expertise of the IAA advisor. Similarly, it has been highlighted that the vast majority of those users seeking legal advice only attended this one organisation (see Table 29). As such, rather than evidence of a lack of 'good practice', what may be being seen here is the impact of different ways of completing the questionnaire: those doing so face-to-face feel able to be more critical and report lower levels of 'good practice'.

Table 31: Mode of administration by increase in knowledge

Mode of administration	Increase in knowledge		Totals
	I know a great deal/quite a lot more	Don't know any more	
Self-completion, Telephone Interview	98% (50)	2% (1)	100% (51)
Face-to-face (only Organisation A)	74% (20)	26% (7)	100% (27)
Totals	90% (70)	10% (8)	100% (78)

Fisher's Exact Test, p=0.002 (2 sided).

4.5.3 Short-term outcome: empowerment

The second short-term outcome measured was empowerment. To explore the extent that users felt 'empowered' through their contact with the service, they were asked 'How would you feel if you faced a similar situation in the future'. It was found that following contact with the service, most respondents (92%, 73) would know what to do or where to go for help. Fewer than one in ten individuals (8%, 6) remained unconfident (see Table 32).

Table 32: Facing a similar situation in the future

Facing a similar situation in the future	Percentage (n)
Confident I would know what to do on my own	13% (10)
Confident I would know where to go for help	79% (63)
Not confident, I would only have some idea of what to do	4% (3)
Not confident at all, I wouldn't know what to do	4% (3)
Total	100% (79)

Exploring the characteristics and circumstances of users (levels of anxiety prior to contact, sole living, age, and communication/literacy difficulties), a statistically significant association was only linked with previous levels of anxiety. Where users identified being very or extremely worried prior to contact with the service, almost a fifth (18%, 5) would not be confident in facing a similar situation in the future (see Table 33).

Table 33: Feelings prior to service contact by Confidence in facing a similar situation in the future

Feelings prior to service contact	Facing a similar situation in the future (%, n)		Totals
	Confident would know what to do or where to go	Not confident would only have some or no idea	
Not at all/somewhat worried	98% (48)	2% (1)	100% (49)
Very or extremely worried	82% (23	18% (5)	100% (28)
Totals	92% (71)	8% (6)	100% (77)

We identified above (see 3.3) that proxy indicators were developed to explore social isolation and perceptions of control. Owing to the small numbers of individuals in the survey, it was not possible to use regression or multi-level modelling to explore the strengths and weaknesses of the different associations. Rather we relied on theoretical development and univariate analysis (ANOVAs, t-tests), with the result that the constructs developed are necessarily crude. Any identification of these samples was similarly limited by the small number of respondents. Nevertheless, there does seem to be some indication that the constructs developed would work if a larger sample were available. For example, in exploring the developed construct of social isolation, a third of the sample identified as socially isolated (33%, 2) would not be confident if they faced a similar situation in the future (see Table 34).

Table 34: Social Isolation by Facing a similarly situation in the future

Social Isolation	Facing a similar situation in the future (%, n)		Totals
	Confident would know what to do or where to go	Not confident would only have some or no idea	
Not social isolated	95% (69)	5% (4)	100% (73)
Socially isolated	67% (4)	33% (2)	100% (6)
Totals	92% (73)	8% (6)	100% (79)

Fisher's Exact Test, p=0.063, (2 sided), (ns)

In contrast, those individuals for whom there may be a perception of being 'in control', all indicated (100%, 11) that, following contact with the service, they would be confident in any future action (see Table 35), although this is not statistically significant.

Table 35: Perception of control by Facing a similar situation in the future

Perception of 'control'	Facing a similar situation in the future (%, n)		Totals
	Confident would know what to do or where to go	Not confident would only have some or no idea	
Not in control	92% (61)	8% (5)	100% (66)
In control	100% (11)	0% (0)	100% (11)
Totals	93% (72)	6% (5)	100% (77)

Fisher's Exact Test, p=0.54 (2 sided) (ns).

For the organisation to help empower users, the information given should be relevant, understandable, based on the expertise of the IAA advisor and increase user knowledge. Not surprisingly, where users did not find the information easy to understand (see Table 36) or relevant (see Table 37), they were less confident of knowing what to do.

Table 36: Information understandable by Confidence in facing a future similar situation

Information understandable	Facing a similar situation in the future (%, n)		Totals
	Confident would know what to do or where to go	Not confident would only have some or no idea	
Information very/easy to understand	97% (61)	3% (2)	100% (63)
Information fairly easy/ difficult to understand	75% (12)	25% (4)	100% (16)
Totals	92% (73)	8% (6)	100% (79)

Fisher's Exact Test, p=0.014 (2 sided)

Table 37: Information helpful by Confidence in facing a future similar situation

Information helpful	Facing a similar situation in the future (%, n)		Totals
	Confident would know what to do or where to go	Not confident would only have some or no idea	
Information extremely/ very helpful	99% (64)	1% (1)	100% (65)
Information fairly/not helpful	64% (9)	36% (5)	100% (14)
Totals	92% (73)	8% (6)	100% (79)

Fisher's Exact Test, p=0.036 (2 sided)

For users it could be argued that as such factors were likely to affect the resolution of their problem; perceptions around future actions would be less positive.

4.5.4 Intermediate outcomes: introduction

Intermediate outcomes are reflected in actions, e.g., the benefits claimed, services accessed or debts repaid. In short, there would be resolution of at least part of any presenting problem. The difficulty of constructing questions reflecting these has been discussed (see 3.3 above).

4.5.5 Intermediate outcomes: received the help wanted

From the qualitative analysis (see section 3), it would seem (not surprisingly) that where users were unable to get the help they wanted, their problem remained unresolved. However, this qualitative finding was not reflected in the response to the outcome tool. A staggering 92% (73) of the sample said that they either got more help or the help they wanted (see Table 38).

Table 38: Did the user get the help wanted?

Did user get help wanted?	% (n)
More help than wanted	31% (25)
Got the help wanted	61% (48)
Got less help than I wanted	5% (4)
Didn't get any help at all	1% (1)
Total	98% (78)

As one indicator of possible problem resolution, it would seem that almost all of the sample could have chosen to move forward. Nevertheless, as with other outcomes, opportunities for action could be negated through user capability or circumstances and organisational practice.

There were indications that the type of problem may be associated with receipt of help wanted. Information sought on health and social services (see Table 39 and Table 40) was more likely to be judged successful, while in the more complex areas of concern such as housing and legal advice users were less likely to move forward to act upon their issue (Table 41 and Table 42).

Table 39: Problem concerned health by Received help wanted

Problem concerns 'Health'	Received help wanted		Totals
	Got more help or help wanted	Got less help or no help	
No	88% (38)	12% (5)	100% (43)
Yes	100% (32)	0% (0)	100% (11)
Totals	93% (70)	7% (5)	100% (75)

Fisher's Exact Test, p=0.067 (2 sided, ns).

Table 40: Problem concerned social services by Received help wanted

Problem concerns ‘Social Services’	Received help wanted		Totals
	Got more help or help wanted	Got less help or no help	
No	92%(55)	8% (5)	100% (60)
Yes	100% (15)	0% (0)	100% (15)
Totals	93% (70)	7% (5)	100% (75)

Fisher’s Exact Test , p=0.57 (2 sided, ns).

Table 41: Problem concerned legal rights by Received help wanted

Problem concerns ‘Legal rights’	Received help wanted		Totals
	Got more help or help wanted	Got less help or no help	
No	95% (61)	5% (3)	100% (64)
Yes	82% (9)	18% (2)	100% (11)
Totals	93% (70)	7% (5)	100% (75)

Fisher’s Exact Test, p=0.15 (2 Sided, ns).

Table 42: Problem concerned housing by Received help wanted

Problem concerns ‘Housing’	Received help wanted		Totals
	Got more help or help wanted	Got less help or no help	
No	95% (59)	5% (3)	100% (62)
Yes	84% (11)	16% (2)	100% (13)
Totals	93% (70)	7% (5)	100% (75)

Fisher’s Exact Test, p=0.20 (2 sided, ns).

In looking at whether individuals received the help they wanted and the levels of ‘good practice’, it was found that where users perceived that the advisors did not have the necessary expertise, they were less likely to receive the help they wanted. Within our very small sample, differences between the groups were seen, with a quarter of the sample (24%, 4) receiving less or no help following contact (see Table 43).

Table 43: Knowledge of advisor by User got help wanted

How did user rate knowledge of the advisor	User got the help wanted		Totals
	Got more help or help wanted	Got less or no help	
Advisor knowledge excellent or very good	100% (61)	0% (0)	100% (61)
Advisor knowledge good or poor	75% (12)	25% (4)	100% (16
Totals	95% (73)	5% (2)	100% (77)

Fisher's Exact Test 0.001, 2 sided

4.5.6 Intermediate outcomes: Individual actions

If a user is to take action, the first stage is to receive the necessary help. The second stage is to follow the advice given by the service should it be appropriate. Over three-quarters of the sample 80% (63) indicated that they followed the advice, almost a fifth (19%, 15) that they followed some of the advice and only one individual stated they didn't use any of the information (Table 44).

Table 44: What happened as a result of user contact with service

Result of contact with service	% (n)
I followed the advice I was given	80% (63)
I followed some of the advice I was given	19% (15)
I followed none of the advice I was given	1 (1%)
I wasn't able to follow the advice I was given	0% (0)
Total	100% (79)

Any action will be affected by a number of factors. Those users who indicated that they followed none of the advice or were unable to follow the advice were asked to respond to a filter question, stating whether lack of action was due to: not agreeing or understanding the information, not having the energy or time to follow up or, that the information led to a 'dead-end'. Only one individual within our sample would have been directed to this question and, s/he decided not to respond. Such a lack of completion may have been because the options did not feel relevant, that they did not wish to admit a lack of understanding or they simply did not wish to be critical of the service.

Nevertheless, a number of factors could still limit action. The advice given could have been of poor quality or irrelevant. Alternatively, the user's individual situation (communication, learning or physical disabilities) or their levels of expectation may have restricted how far they were able to follow the advice given. In exploring the first barrier, advisor expertise, easily understood information and user increased knowledge were included within the analysis; none was statistically significant. Not surprisingly, what was associated with user actions was that of information relevance; if the user perceived the information to be helpful, 85% of the sample followed the advice (see Table 45)

Table 45: Information helpful by Followed advice

Information and advice helpful	Advice followed		Totals
	Followed advice	Followed some/none of the advice	
Information extremely/very helpful	85% (55)	15% (10)	100% (65)
Information fairly/not helpful	57% (8)	43% (6)	100% (14)
Totals	78% (63)	20% (16)	100% (79)

Fisher's Exact Test p=0.031 (2sided)

Even if the advice received is perceived to be of high quality and relevant, users life circumstances may undermine an individual's ability to follow the information and advice. The only statistically significant finding was counter-intuitive: those individuals who identified themselves as able to deal with forms were less likely to follow some or none of the advice given (see Table 46).

Table 46: User feels able to deal with forms by Advice followed

User feels able to deal with forms	Advice followed		Totals
	Followed advice	Followed some/none of the advice	
Always/Usually deal with forms	74% (40)	26% (15)	100% (54)
Sometimes/Never deal with forms	96% (23)	4% (1)	100% (24)
Totals	81% (63)	19% (15)	100% (78)

Fisher's Exact Test p=0.029 (2 sided)

Such a finding perhaps suggests that those users who are more 'able', can use the process (meeting or telephone call) more appropriately and integrate information received more effectively – exercising choice and judgement about information received. However, this may not be about ability *per se*, but rather the individual perception of 'feeling in control' both across their wider life as well as within the specific situation for which they are seeking advice.

In exploring the proxy indicator of 'in control' (see 3.3), there was an association with users' assessment of the value of the information given, perhaps building their own pathway. An analysis of variance of control and assement of the value of the advice was significant (F=5.792, df=1, p=0.019). For users who were more in control, half the sample (50%, 4) followed some or none of the advice compared to 16% of those less likely to report control (see Table 47).

Table 47: In control by Advice followed

'In control'	Advice followed		Totals
	Followed advice	Followed some/none of the advice	
Not in 'in control' proxy	84% (58)	16% (11)	100% (69)
In control' proxy	50% (4)	50% (4)	100% (8)
Totals	80% (62)	20% (15)	100% (77)

Fisher's Exact Test, p=0.042 (2 Sided).

Checks were carried out to ensure that where users chose to follow some or none of the advice, this was not because the information was unhelpful. No one user within the 'in-control' group identified that the information received was only fairly or not helpful.

Using the 'good practice' indicator (IAA level of expertise, information easy to understand and relevant) and bringing together the two variables of help wanted and whether the individual followed advice, it was found that where good practice was perceived, individuals were far more likely to get the help they wanted and to follow the advice (see Table 48).

Table 48: 'Good practice' construct by Action taken

'Good practice'	Action Taken (help wanted and followed advice)		Totals
	Didn't get help wanted or didn't follow advice	Got help wanted and followed advice	
Not in 'good practice' proxy	20% (6)	80% (24)	100% (30)
In 'good practice' proxy	0% (0)	100% (48)	100% (48)
Totals	8% (6)	82% (72)	100% (78)

Fisher's Exact Test, p=0.002, (2 sided).

4.6 Absence of service

We identified above that 92% of our sample stated they received the help they wanted, 90% that they knew a great deal more and 80% that the information was easy to understand. In exploring outcomes, 90% reported increasing their level of knowledge, while 92% reported that they would know what to do if faced with a similar situation in the future. Before we attribute this to the service, we need to explore what would have happened in its absence. In reporting user actions in the absence of the service, almost half the sample (49%, 49) stated that they would have known what to do, or been able to find out what to do, even if they had not received information and advice (see Table 49).

Table 49: How confident would the user be in knowing what to do in the absence of services?

In the absence of the service	% (n)
Confident I would know what to do	6% (5)
Confident I could find out what to do	43% (34)
Not confident I could find out what to do	27% (21)
Not confident at all, I wouldn't know what to do	21% (17)
Total	97% (77)

Exploring such findings, it would seem that user circumstances have some impact. There was some indication (although not statistically significant) that those aged 60 and over are more likely to know what to do/where to go than their younger counterparts (see Table 50).

Table 50: Age range by absence of services

Age Range	In the absence of services		Totals
	Confident know/find out what to do	Not confident could find out/not know at all	
Aged up to 59	42% (10)	58% (25)	100% (43)
Aged 60 and above	62% (21)	38% (13)	100% (34)
Totals	51% (39)	38% (13)	100% (34)

Fisher's Exact Test, p=0.10 (2 sided, ns)

Such findings may be 'skewed' by the levels of deprivation. When 'deprivation alone' is explored, the findings demonstrate a 10% difference between those in the most deprived areas as compared with those in the more 'affluent' wards (see Table 51).

Table 51: IMD quartiles by Confidence in the absence of services

IMD Quartiles	In the absence of services		Totals
	Confident know/find out what to do	Not confident could find out/not know at all	
First and second quartile (more deprived)	43% (15)	57% (20)	100% (35)
Third and fourth quartile (least deprived)	53% (19)	47% (17)	100% (36)
Totals	48% (34)	52% (37)	100% (71)

Fisher's Exact Test, p=0.47 (2 sided, ns)

However, when the age range is included, of those aged 60 and above and living in the least deprived areas, over two thirds (70%, 14) (Fisher's Exact Test, p=0.014, 2 sided) were confident that they would know what to do or where to find out the necessary information. No statistically significant associations were found with other service user characteristics (sole-living, social isolation).

There was some suggestion that those who were very or extremely worried were more likely to rely on the IAA service, although the association was not statistically significant (see Table 52).

Table 52: Feelings prior to service contact by Confidence in absence of service

Feelings prior to service contact	In the absence of services		Totals
	Confident know/find out what to do	Not confident could find out/not know at all	
Not at all/somewhat worried	56% (27)	44% (21)	100% (48)
Very/extremely worried	41% (11)	59% (16)	100% (27)
Totals	51% (38)	50% (37)	100% (75)

Fisher's Exact Test, p=0.23 (2 sided, ns).

Exploring whether the capability of users through IADLs is associated with their level of confidence in the absence of services, there was an indication that if users had difficulties with paperwork/finances (see Table 53) and forms (see Table 54), then they would be less confident in the absence of any service.

Table 53: Deal with paperwork/finances by Confidence in the absence of services.

Deal with paperwork/finances	In the absence of services		Totals
	Confident know/find out what to do	Not confident could find out/not know at all	
Always/usually deal with paperwork/finances	55% (29)	45% (24)	100% (53)
Sometimes/never deal with paperwork/finances	42% (10)	58% (14)	100% (24)
Totals	51% (39)	49% (38)	100% (77)

Fisher's Exact Test, p=0.33 (2 sided, ns)

Table 54: Able to complete forms by Confidence in absence of services

Able to complete forms	In the absence of services		Totals
	Confident know/ find out what to do	Not confident could find out/not know at all	
Always/usually deal with forms	53% (28)	47% (25)	100% (53)
Sometimes/never deal with forms	42% (10)	58% (14)	100% (24)
Totals	**51% (39)**	**49% (38)**	**100% (77)**

Fisher's Exact Test, p=0.62 (2 sided, ns)

Organisational 'good' practice had some effect, albeit in some cases counter-intuitive. When the IAA advisor expertise was seen as either good or poor, almost two thirds of the sample (63%, 10) stated that they would know what to do if they hadn't received any help (see Table 55)

Table 55: IAA Advisor knowledge by Confidence in the absence of services

IAA advisor knowledge	In the absence of services		Totals
	Confident know/find out what to do	Not confident could find out/not know at all	
Advisor knowledge excellent/very good	47% (28)	53% (32)	100% (60)
Advisor knowledge good/poor	63% (10)	37% (6)	100% (16)
Totals	50% (38)	50% (38)	100% (76)

Fisher's Exact Test, p=0. 39 (2 sided, ns).

Similarly, if users perceived the information received as unhelpful (fairly or not helpful), they were also more likely to report a level of confidence about acting in the absence of services (see Table 56).

Table 56: Helpfulness of information by Confidence in the absence of services.

Helpfulness of information (relevance)	In the absence of services		Totals
	Confident know/find out what to do	Not confident could find out/not know at all	
Information extremely/very helpful	44% (28)	56% (35)	100% (63)
Information fairly/not helpful	79% (11)	21% (2)	100% (14)
Totals	51% (39)	49% (38)	100% (77)

Fisher's Exact Test, p=0.036 (2 sided)

It is only in the question around whether the user received the help they wanted that the likely expected pattern of responses is found (see Table 57).

Table 57: Receipt of help wanted by absence of services

Help wanted	In the absence of services		Totals
	Confident know/find out what to do	Not confident could find out/not know at all	
Got more help or help wanted	52% (37)	48% (34)	100% (71)
Got less or no help wanted	40% (2)	60% (3)	100% (5)
Totals	51% (39)	49% (37)	100% (76)

Fisher's Exact Test, p=0.67 (2 sided, ns).

It may be that such findings were partly due to the actions users carried out following their 'unsuccessful' visit with the IAA advisor. For example, if users perceived the IAA advisor as 'inexpert' and the information received as not helpful (or relevant), then they would need to search further to resolve their problem. They are reporting their levels of confidence in the light of this experience. Such an argument is supported when the use of other services is explored. If individuals had only received information from the organisation on which they were basing their responses, 57% (16) of the sample would not be confident they would know what to do if such a service had not been received. This is in contrast to the situation seen where information had been more widely sought through friends/relatives or the internet (see Table 58) .

Table 58: Absence of services by Use of other information sources

Absence of services	Use of other information sources			Totals
	Information received from only this organisation	Information received friends/relatives	Information sought/received from internet	
Confident know/ find out what to do	43% (16)	59% (13)	57% (8)	52% (35)
Not confident could find out/not know at all	57% (21) (2)	41% (9)	43% (6)	48% (33)
Totals	54% (37)	32% (22)	21% (14)	100% (68)

5 Discussion

5.1 Introduction

The IAA research was at a much earlier stage of development than the other MOPSU research (on adult social care homes, low-level services and early years). The development of any tool that enables measurement of outcomes rather than inputs and process is a challenge. It was never a possibility within the time-frame of this research project and within the extremely diverse and embryonic area of IAA service outcomes to develop, test and refine an outcomes tool resulting in a 'ready-to-go' tool that could be immediately used by practitioners. Nevertheless, progress has been achieved. Initial outcomes were identified through interviews with IAA managers, operational staff, national informants and users, enabling the dissonance between staff and user perceived outcomes to be made transparent. 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. Given the complexity of this area – the reach and activity of the services themselves, as well as any tool –further work needs to be carried out if commissioners are to have access to data that can inform important commissioning decisions.

5.2 Measuring value: valid and reliable 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 (see

Figure 7 below). 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.

Figure 7: Effective questions measuring short-term outcomes

Following your contact with the service, how much more do you know now?

I know a great deal more ☐

I know quite a lot more ☐

I don't know any more ☐

I am more confused now (than I was before) ☐

How would you feel if you faced a similar situation in the future?

Confident I would know what to do on my own ☐

Confident I would know where to go for help ☐

Not confident, I would only have some idea what to do ☐

Not confident at all, I wouldn't know what to do ☐

From the literature and key informant interviews, we theorised that if users received the help they wanted from the IAA service and chose to act (or indeed not to act) then there would be some movement toward problem resolution – an intermediate outcome. Two questions enabled a measurement of those groups that took steps toward resolution as well as those individuals for whom such progress was more difficult (see

Figure 8 below).

Figure 8: Effective questions measuring intermediate outcomes.

Did you get the help you wanted?

Yes, I got more help than I wanted ☐

Yes, I got the help that I wanted ☐

No, I got less help than I wanted ☐

No, I did not get any help at all ☐

What happened as a result of your contact with the service?

I followed the advice I was given ☐

I followed some of the advice I was given ☐

I followed none of the advice I was given ☐

I wasn’t able to follow the advice ☐

It is within this area that an appropriate ‘synergy’ of IAA service process and output data could be employed. Within the consultation and field-work interviews, it was clear that client contact was, in the main, recorded on various computer systems and used both for internal quality assurance and reports to commissioners. For many IAA services, this was limited to metrics: ‘Number of people that we have seen, their ages, where they lived, how many came from minority ethnic groups and what kinds of issues did you help them with’ (KI_DS300010). However, for others that held contracts with, for example, the Legal Services Commission, their reporting requirement was more sophisticated, demanding outcomes of housing repossessions, amount of debt claimed and so on. Such objective data could be usefully matched at the micro level, using the subjective user responses from the outcomes tool to explore how users perceive their movement toward problem resolution.

Demographic data was included to assess how far user circumstances were associated with outcomes. It also enabled an initial exploration as to whether there were specific groups for whom the work necessary to achieve outcomes would be more difficult, allowing initial understanding of where higher value within any IAA service could be attributed. Three questions worked well, allowing separation of ‘population’ groups and feeding into the further developed proxy indicators. The two IADL questions (difficulties in completing paperwork and/or dealing with forms) demonstrated an underlying construct and, as such, could be reduced to including the single question of Do you feel able to fill in forms by yourself, without help from anyone else’. The question around living alone enabled identification of those at risk of achieving lower outcomes while providing one of the questions that led to the early development of the proxy indicator - social isolation. Figure 9 below details these effective questions

Figure 9: Effective demographic questions and IADLs

How old are you? (Please specify in years) ☐

If you know your postcode, please could you give this in the box provided? ☐

Do you live on your own? Yes ☐ No ☐

Do you deal with finances and paperwork – for example, paying bills, writing letters – by yourself?

Always ☐	Sometimes ☐
Usually ☐	Never ☐

Do you feel able to fill in forms by yourself, without help from anyone else?

Always ☐	Sometimes ☐
Usually ☐	Never ☐

In beginning to think about and structure the proxy indicators, there was a level of frustration within the analysis. The small sample meant that no multivariate analysis could be undertaken, limiting how far the proxy indicators could be developed and refined. Nevertheless, although at this stage of development these are a somewhat 'crude' measure, those indicators of social isolation and good practice seemed to provide a way of further detailing and separating out the outcomes of IAA services for particular groups. Those questions needed to form such indicators and further test outcomes – sole living, quality of life, age, level of knowledge of IAA advisor, information easy to understand and relevant – should be included within any tool (see Figure 10 and Figure 11). However, further testing and refinement need to be undertaken to ensure that the concepts developed are valid and reliable.

Figure 10: Effective questions to include assessing social isolation

Do you live on your own? Yes ☐ No ☐

Thinking about the good and bad things that make up your quality of life, how would you rate the quality of your life as a whole?
(*Please tick the box next to the answer that best describes your quality of life*).

So good, it could not be better ☐
Very good ☐
Good ☐
Alright ☐
Bad ☐
Very bad ☐
So bad, it could not be worse ☐

How old are you? (Please specify in years) ☐

Figure 11: Effective questions to include assessing IAA 'good practice'

How would you rate the knowledge of the person who gave you the information or advice?

Excellent ☐	Very good ☐
Good ☐	Poor ☐

Was the information or advice you received easy to understand?

Extremely easy ☐	Very easy ☐
Fairly easy ☐	Difficult ☐

Overall, how helpful has the information and advice you have received been?

Extremely helpful ☐ Very helpful ☐
Fairly helpful ☐ Not helpful ☐

The proxy that perhaps was least successful was 'Being in–control'. Hypothesised to be an important factor in assessing those groups for whom delivery of outcomes could be 'easier', it worked well within some analysis. When other questions were included within any analysis, some counter-intuitive findings were seen. Such findings may have been valid. Further testing of such an important proxy needs to be undertaken and additions made to any model.

The full questionnaire can be found in Appendix 3, providing details of all those questions included within the testing phase.

5.3 Recruitment of users and administration of the outcomes instrument

The difficulties in recruiting users to complete the questionnaire were discussed at length within the interim report (see Windle et al 2009) and further explored above (see 2.2). Such experiences mirror those found by IAA organisations. Collection of data needs to be a systematic exercise. Nevertheless, there are a number of techniques and approaches that could be used to support and encourage users to report their experiences – none of which is new or particularly complicated.

It is argued that first managers need to work with IAA operational staff to enable some movement of culture change around collecting evaluation data. For many staff, their focus is on providing information and support, not collecting data. However, within any document detailing operational roles and responsibilities, an evaluative function could be included. That is, the importance of evaluating outcomes would be embedded within the job description. Operational staff could be provided with support and time to follow-up a limited sample of those users that had attended within a particular time frame. Such a sample could be temporal (e.g., all those individuals who attended during a particular week) or purposive, (e.g., all individuals from a particular black and minority ethnic community). Further support to operational staff to recruit users could be through the provision of a 'script' to be used following their intervention, with operational staff emphasising the importance of such data collection to any user. It is recognised that some staff feel this to be outside their role. However, if such actions are made part of the 'normal' practice rather than a separate exercise, it is likely that individuals will become more comfortable with the process.

Within this research, the administration of the outcomes tool was carried out through self-completion and structured face-to-face and telephone interviews. From the analysis there was little indication of differences by administration type, partly owing to the small sample. However, it was clear from measurement of IADLs that we were reaching few individuals with communication difficulties: fewer than one in ten reported that they never dealt with forms or paperwork. Similarly, the outcomes from the question on ethnicity showed overwhelmingly that such a tool, or perhaps our sample IAA services, failed to reach those individuals from ethnic minorities - only one individual (of 79) came from a minority group. Conversely, over one in ten individuals (12%) were drawn from the most deprived areas, with over a third (35%) from the second most deprived quartile. Where individuals were self-completing questionnaires, few reported needing help from their family or a member of the service team.

Given such outcomes, if IAA services are to take forward any further developed tool, there needs to be a choice in administration. Commonsense suggests that those who do not have English as their first language, or have learning, physical or cognitive difficulties could not self-complete any tool. The process of recruitment and administration would therefore need to include the following steps. Those IAA staff providing advice in the first instance could discuss with the service user the outcomes tool, the rationale behind such collection (using any provided script) and the method of administration (self-completion, telephone, face-to-face) with which the user would be most comfortable. If the user feels able to be part of the data collection, either a simple form could be completed on their behalf or data entered into any client recording system. If a self-completion tool is deemed appropriate by both parties, this could be simply given to the individual with a self-addressed envelope. An identification code will need to be given to each questionnaire matching the organisation's client record. An appropriate identification code allows a reminder to be sent out but, more importantly, ensures that the metric and any outcome data kept by the organisation can be merged with the outcomes data – allowing 'added-value'.

If a telephone or face-to-face interview is considered appropriate, it will be necessary for either a colleague or external individual to undertake the administration to ensure a lack of bias. For example, if the IAA advisor responsible for providing the advice then carries out the telephone or face-to-face interview, that user may find it difficult to report negative experiences (Hogg 1999). Such a type of data collection is extremely resource-intensive. The user will need to be contacted and the interview arranged at a convenient time and place. If such data collection is being undertaken by the organisation, the responsible member of staff will have carried out at least two conversations prior to meeting with the user and will then have to travel to the user's home to carry out the interview. Management recognition of such time will be necessary. More importantly, to ensure that such an exercise is worthwhile, appropriate planning and rationale as to the sample to be included within any data collection exercise should be undertaken.

It is perhaps in the areas of sampling and analysis that further resource questions – knowledge, capacity and funding – have to be addressed. For many of the small voluntary organisations responsible for IAA provision, few will be aware of the different types of sampling necessary to provide robust outcomes. Advice on appropriate sampling could be drawn from their national 'umbrella organisation': for example, in the case of local Age Concerns, contact could be made with the national Age UK office. Alternatively, local research units could be approached, either those based within local universities or the national research development services. For example, the National Institute of Health Research (NIHR) funds a network of research design services (RDS) within the ten English regions (see http://www.nihr-ccf.org.uk/site/programmes/rds/default.cfm): each of these local RDS units provides expert advice on research design and methodology.

Advice on analysis could similarly be sought from the above national and local organisations. However, it will be necessary for an individual with the appropriate knowledge to undertake reporting from any adopted outcomes tool. Funding from commissioners will need to be made available. If commissioners wish to target funding appropriately and efficiently, collection of outcomes is a core exercise and small amounts of further monies will need to be made available within any core or project funding.

5.4 The single outcome tool

The range and activity of the selected piloted sites was broad. The use of a single standardised outcome tool raises concerns as to whether the full range of activity was captured. The analysis of the consultation and field work interviews, the demonstrable difficulties in user recruitment, all give indications that those attending the IAA service within the higher levels of activity - general or specialised case-work – may not have completed the tool. A single tool was always a compromise, having to be concise enough to encourage completion, short enough to be relevant to those having a one-off telephone conversation or receiving written information, while allowing questions to be included that could measure higher levels of activity (see Figure 3). Such a compromise led to the exclusion of 'Activities of Daily Living' (ADLs) that would enable robust measurement of need, and one or two questions that could highlight the level and extent of support being provided. Either inclusion would have been off-putting to those receiving a simple leaflet as they may well perceive such questions as irrelevant to their situation, leading to a belief that the tool was not directed toward them.

It was encouraging that there was good distribution across the key demographics (age, deprivation), those variables exploring the IAA encounter (anxiety prior to attendance, nature of the problem etc) and IADLs, indicating that the range and perhaps activity may have been incorporated within the sample. Nevertheless, if IAA outcomes are to be developed and refined, the activity of IAA services may need to be separated. We would recommend that any further work could include the development of two outcome tools. Covering the core outcomes, the first needs to be directed toward 'assisted information' and 'general help', while the second (needing to include ADLs and measures of psychological well-being e.g., GHQ12), directed towards the often complex areas of 'general and specialist help with case-work' (see Figure 3). Further testing and refinement of each tool could then be appropriately undertaken.

5.5 Future development in measuring IAA outcomes

In assessing how this research should be taken forward, there are five further key areas of development, incorporating wider policy requirements as well as the more micro-level research recommendations.

- Recognition by policy makers, commissioners and providers that outcome data needs to be reported.
- The development of any outcomes tool needs to incorporate links between data regularly collected by IAA services.

- Further development of the outcomes tool needs to include those questions that infer long-term outcomes (e.g., changes in quality of life, financial stability etc., following the intervention).
- The developed tool needs to be further tested with vulnerable and 'hard-to-reach' users.
- Any adapted tool needs to be administered across a far larger sample.

The consultation and field-work interviews demonstrated that neither strategic, senior nor operational staff were able to conceptualise and identify outcomes without significant prompting and explanation of the model, perhaps a response to commissioners' on-going demands for output data.

> 'So what you will normally see in a monitoring report is – "we worked with 150 people of whom seven were from ethnic minority groups. We dealt with 74 housing enquires, 12 benefits and 3 problems of suspected abuse". And that will basically be about as sophisticated as monitoring gets at this stage in the game and that's probably true across the country' (KI_DS300010).

Such limited focus is not just seen within local IAA services. A recent national publication detailed governmental strategy around IAA services, and the process and focus these should be undertaking. Guidance on the type, recording and measurement of outcomes are omitted (see Williams et al 2009). If the measurement of outcomes within this area is to be managed appropriately, there needs to be a national recognition that value of such services cannot be demonstrated unless there is first a culture shift toward an acceptance and implementation of core outcome measures.

In including within the outcome tool the IAA encounter, outcomes and demographics, there was some overlap between the output data collected by the IAA services. In any development, it will be necessary to work further with the selected services to assess how far there can be a synergy between already collected data –embedded within local practice– and the outcome tool. For example, can any 'self-completion' tool be sent out with a generated unique identifier and, following return, populated with the outputs recorded within any client monitoring system? Testing this was not possible within the parameters of this research project. It should be included within any development to ensure subjective and objective measures can be correlated.

The limitations of the outcomes tool, the compromise necessary to ensure inclusion of the broad reach and activity of the IAA services, and the low-burden design have been discussed above. Following analysis and reporting it has become clear that further additions will be necessary to any outcomes tool. Along with the inclusion of ADLs and psychological well being measures (see 5.4), further outcome measures need to be incorporated. The concentration on short and intermediate outcomes was successful. If an outcomes tool is to be truly 'fit for purpose', then long-term outcomes need to be inferred. Questions need to be included that can demonstrate, for example, positive changes in quality of life and financial stability. Such measures also need to be designed to allow a cross-sectional questionnaire administration – capacity and mode of service delivery negating before and after data collection.

The outcomes tool was tested across a number of IAA services, enabling an inclusion of range and activity. However, we do not know whether the most vulnerable and hard-to-reach users were included within the pilot. Further testing is needed to explore administration with specific groups: those with mental health problems, learning difficulties and those from ethnic minority communities, particular new immigrants.

Finally, in looking at the administration, any adapted tool needs to be administered across a far larger sample. The numbers within this research are simply not enough to state categorically that we have successful measured short-term and intermediate outcomes.

5.6 An outcomes-based approach

This project, set up to test whether outcomes could be measured within this extremely complex field, demonstrated that nebulous outcome models could be conceptualised, low-burden tools developed and a reasonable response rate achieved (32%) when compared against the response rate achieved by local IAA services (3% – 15%). Some of the included questions and developed proxy indicators were more successful than others. If further development can be undertaken alongside national and local IAA services, it is likely that more effective measurement can be achieved. How far such an approach can be taken will depend on the extent that national and local commissioning decisions become based on such measures, rather than continuing with the safe, tangible comparators of output numbers.

6 References

Bandura, A. (1997) *Self-Efficacy: The Exercise of Control*, Freeman, New York.

Baxter, K., Glendinning, C. and Clarke, S. (2006) *Scoping Review on Access to Information about Social Care Services,* Social Policy Research Unit, University of York, York.

Bentley, J. and Meyer, J. (2004) Repeat attendance by older people at accident and emergency departments, *Journal of Advanced Nursing*, 48, 2, 149-156.

Berg, B.L. (1989) An introduction to Content Analysis, in B.L. Berg (ed.) *Qualitative Research Methods for the Social Sciences*, Allyan & Bacon.

Berman, Y. and Phillips, D. (2000) Indicators of social quality and social exclusion at national and community level, *Social Indicators Research*, 50, 329-350.

Bowling, A. (1995) *Measuring Disease*, Open University Press, Buckingham.

Braye, S. and Preston-Shoot, M. (2001) Social work practice and accountability, in L.A. Cull and J. Roche (eds) *The Law and Social Work: Contemporary Issues for Practice*, Palgrave Macmillan, Basingstoke.

Brim, O. G., Ryff, C. and Kessler, R.C. (2004) The MIDUS Survey: An Overview, in O.G. Brim, C. Ryff and R.C. Kessler (eds) *How Healthy Are We? A National Study of Wellbeing at Mid-Life*, University of Chicago Press, Chicago.

Caiels, J., Forder, J., Malley, J., Netten, A. and Windle, K. (2009) Measuring the outcomes of low-level services: Final Report, PSSRU Discussion Paper 2699, Personal Social Services Research Unit, University of Kent, Canterbury.

Cove, J., Dickinson, A., Wagland, R., Widiatmoko, D. and Windle, K. (2006) *An Audit of Older People's Use of Accident & Emergency Services*, University of Hertfordshire, Hatfield.

Care Quality Commission (2010) *The State of Health Care and Adult Social Care in England: Key Themes and Quality of Services in 2009*, Care Quality Commission, London.

Davidson, K. (2002) Gender differences in new partnership choices and constraints for older widows and widowers, *Ageing International*, 27, 4, 43–60.

De Vaus, D.A. (2002) *Surveys in Social Research* (Fifth Edition), Routledge, London.

Department of Health (2006) *Our Health, Our Care, Our Say: A New Direction for Community Services*, Department of Health, London.

Department of Health (2007) *Who Produces Health and Social Care Information?* Department of Health, London.

Department of Work and Pensions (2005) *Opportunity Age – Meeting the Challenges of Ageing in the 21st Century*, Department of Work and Pensions, London.

Forder, J., Netten, A., Caiels, J., Smith, J. and Malley, J. (2007) Measuring outcomes in social care: Conceptual development in empirical design, PSSRU Discussion Paper 2422, Personal Social Services Research Unit, University of Kent, Canterbury.

Glendinning, C. (2008) *Evaluation of the Individual Budgets Pilot Programme – Final Report*, Social Policy Research Unit, University of York.

Gobo, G. (2004) Sampling, representativeness and generalizability, in C. Seale, G. Gobo, J.F. Gubrium and D. Silverman (eds) *Qualitative Research Practice*, Sage Publications, London.

HM Government (2007) *Putting People First: A Shared Vision and Commitment to the Transformation of Adult Social Care*, HMSO, London.

Hogg, C. (1999) *Patients, Power & Politics: From Patients to Clients*, Sage Publications, London.

Huberman, A.M. and Miles, M.B. (1998) Data management and analysis methods, in N.K. Denzin and Y.S. Lincoln (eds) *Collecting and Interpreting Qualitative* Materials, Sage Publications, London.

Lachman, M.E. and Prenda Frith, K.M. (2004) The adaptive feeling of control during mid-life, in O.G. Brim, C. Ryff and R.C. Kessler (eds) *How Healthy Are We? A National Study of Wellbeing at Mid-Life*, University of Chicago Press, Chicago.

Marmot, M. and Wilkinson, R. (eds) (1999) *Social Determinants of Health,* Oxford University Press, Oxford.

Netten, A. and Forder, .J (2008) Measuring the outputs of information and advice services: Initial report, PSSRU Discussion Paper 2543/2, Personal Social Services Research Unit, University of Kent, Canterbury.

Noble, M., McLennan, D., Wilkinson, K., Whitworth, A., Barnes, H. and Dibben, C. (2008) *The English Indices of Deprivation 2007*, Communities and Local Government, London.

OMP (2008) *Evaluation of Information Prescriptions: Final Report to the Department of Health*, Office of Public Management, London.

Perlin, L. and Schooler, C. (1998) The structure of coping, *Journal of Health and Social Behaviour*, 19, 2–21.

Saxton, M.I., Naumer, C.M. and Fisher, K.E. (2007) 2-1-1 Information Services: outcomes, assessment, benefit-cost analysis and policy issues, *Government Information Quarterly*, 24, 1, 186-215.

Shardlow, S.M. (2002) Values, ethics and social work, in R. Adams, L. Dominelli and M. Payne (eds) *Social Work: Themes, Issues and Critical Debates*, Palgrave in association with the Open University, Basingstoke.

St Leger, A.S., Schneiden, H. and Walsworth-Bell, J.P. (1997) *Evaluating Health Services' Effectiveness*, Open University Press, Buckingham.

Victor, C., Scrambler, S., Shaha, S., Cook, D., Harris, T., Rink, E. and de Wilde, S. (2002) Has loneliness among older people increased? An investigation into variations between cohorts, *Ageing & Society*, 22, 585-597.

Williams, C., Harris, J., Hind, T. and Uppal, S. (2009) *Transforming Adult Social Care: Access to Information, Advice and Advocacy*, IDeA, London.

Willis, G.B. (2005) *Cognitive Interviewing: A Tool for Improving Questionnaire Design*, Sage Publications, London.

Windle, K., Netten, A., Caiels, J. and Masrani, R. (2009) Measuring the outputs of information and advice services: progress report, PSSRU Discussion Paper 2635, Personal Social Services Research Unit, University of Kent, Canterbury.

Windle, K., Wagland, R., Forder, J., D'Amico, F., Janssen, D. and Wistow, G. (2009a) National Evaluation of Partnerships for Older People Projects: Final Report, Personal Social Services Research Unit, University of Kent, Canterbury.

Appendix one

Interview schedule - Key informants

Introduction to key informant interview

- **Who we are:** PSSRU at Kent
- **What this research is about:** we are designing a survey about people’s experiences of using information and advice services that can help and support them. The project we are involved in is concerned with people’s quality of life and the impact and value added of services for users.
- **Consent./anonymity/recording:** Everything you say is confidential and will remain anonymous. With your permission we would like to record the discussion for detail and clarity. Recordings will be confidential to the research team.
- **What we are going to do in the interview:** run through a number of broad questions to cover certain themes to talk about what people use services for and how (and in what ways) services help them. We also want to ask about current ways of measuring the impact of services.
- **Open structure:** Also please feel free to mention anything you think is important related to the subject theme or that you think we may have missed in talking about the provision of information and advice services.

Interview Schedule for Key informants
Information and Advice Services

- **Could you start by saying a bit about the service that is provided by your organisation?**
    - **What kind contact do you have with users?** (e.g. telephone; face to face etc)
    - **How much contact do have with users in a 'typical single case'**

- **What level of involvement do you have with users in a typical case?**
    - **Dispense advice only**
    - **Advice with continual contact with user until resolution / completion of case.**
    - **Advice, continual contact with user until case complete, advocacy for user** (e.g. represent at tribunal etc)
    - **At what point do users present?** (crisis point or general advice for later etc)

- **What are the need levels of people who use the service?**
    - **Is there a spectrum e.g. low to high needs?**
    - **To what degree?**
    - **Does this present any issues for service provision?** (e.g. impact on the methods and formats in which you deliver information? Or users having advocates (family etc) to speak on their behalf)

- **Would you say that any users come from particularly 'vulnerable groups'?**
    - **How would you categorise these groups?**
    - **Are some 'more vulnerable' than others?**
    - **In what ways are they more vulnerable**
    - **Which ones?**

- **What would you say is the aim of the information and advice service that you are involved in?**
    - **Provision of information in a timely way**
    - **Exploring with the individual what they need/ want?**

- **What are the overarching benefits/outcomes for people who access the service?**
- **What would you perceive as the short, intermediate and long term outcomes for service users?**
    - **Can these be defined?**
        - **Short: e.g. peace of mind; empowerment; knowledge**
        - **Intermediate: e.g. claim benefits; access services; repay debts**
        - **Long term: quality of life; health; financial stability**

- **What do you think that users themselves most value (in terms of what they gain) about using the information and advice service?**
    - **Key aspects of services from user perspective?**

- **In terms of outcomes for users, what outcomes do you think have a higher weight (are more important) than others (key outcomes)?**
    - **For example do you perceive 'empowerment' as a greater impact as an outcome than that of specific service knowledge?**
    - **Do you think this is different for users? For example they may value 'peace of mind' more overall?**

- **What is the current approach to quality and outcome measurement in terms of assessing the impact of the service?**
    - **What do commissioners currently use to guide funding decisions?** (For example accreditation documents)**.**
    - **How are services currently evaluated?**

- **Do you feel there are any barriers to providing good quality information and advice services?**
    - **Barriers for users**
    - **Barriers for measuring impact of services?**

Appendix two

Interview schedule – Outcomes for service users

Introduction to service user interview

- **Who we are:** PSSRU at Kent
- **What this research is about:** we are designing a survey about people's experiences of using information and advice services that can help and support them. The project we are involved in is concerned with people's quality of life and the impact and value added of services for users.
- **Consent./anonymity/recording:** Everything you say is confidential and will remain anonymous. With your permission we would like to record the discussion for detail and clarity. Recordings will be confidential to the research team.
- **What we are going to do in the interview:** run through a number of broad questions to talk about your experience of the information and advice service(s) you have used and what sort of impact this has had on your life.
- **Open structure:** Also please feel free to mention anything you think is important related to the subject theme or that you think we may have missed in talking about the provision of information and advice services.

Interview Schedule for Service User
Information and Advice Services

Expectation of the service

- **Could you start by saying a bit about the service that you have used or had contact with?**
    - **What *type* of contact did you have with the service?** (e.g. telephone; face to face etc)
    - **How much contact did you have overall?** (e.g. from start to finish of issue/problem; just got some advice and then dealt with it yourself; picked up leaflets etc)
    - **How long was/were the contacts that you had (in each session)**

- **What kind of help did you expect to get from [the service] *before* you used it?** (provision of information; hands on help)
    - **How did your actual experience match this expectation?** (different, better, worse?) – how/why?
    - **Did you get what you wanted?**
        - **If yes, how did this happen?**
        - **If no, why not?**

Benefit / Outcome of accessing the service

- **How would you describe your overall experience of the service?**
    - **How did you feel before using/accessing the service?**
    - **How did you feel after using/accessing the service?**
    - **How does that compare to how you feel now?**
        - **Is it different? If so how? And why do you think that is?**

- **How did the service help you?** (take action on your behalf; advise you of options; provide you with information; tell you where else to go to get help (Signposting) etc)

- **What do you feel you gain(ed) from using the service?**
    - Information about something, knowledge, peace of mind, sense of justice/ that something can be done?
    - Obtain benefit, start repaying debt, access a service that you couldn't or didn't know about before?
    - feel better about yourself, feel more healthy, feel more stable or able to cope?

- **Did any of these mean more to you than any of the others?**

    - **Did anything in particular make you feel better about your situation?**

- **What aspect(s) of your life do you feel the service has helped you with or changed (either directly or indirectly)?** (finance; family/ relationships; stress; mental or physical health; overall quality of life)

- **How do you feel about *the way* that you were helped?**
    - Did you still feel in control overall? [empowered]
    - Did they ‘take over’ and do things for you?
        - What did you want the service to do

Barriers

- **Did you have any difficulties in accessing or using the service?**
    - (Language, mobility, opening times, other communication e.g. letters etc)

- **Was there anything about using or accessing the service that you think could have made things easier for you?**
    - In terms of gaining access to the service? (finding out that it existed, where it was, how you could use it / get to speak to someone)
    - In terms of meeting your objective (in what you wanted to achieve)
        - (speed, timeliness of when you went i.e. could/should have gone earlier rather than crisis point?)

Appendix three

Outcomes tool

Office use only
Org_ID: ____

PSSRU
University of Kent

Measuring the Outputs of Information and Advice Services

This questionnaire is about your experiences and views of the information and advice services that you use. The aim of this project is to identify a way of measuring and monitoring the value of information and advice services through exploring the experiences and perceptions of people who use these services. The findings from the study will be used to help to decide how to develop services in the future. All Information you give will be anonymised and kept confidential. Please take your time when filling it in and try to answer all questions.

1. How is this Questionnaire being completed? [Please tick one]

☐ I am completing this questionnaire myself

☐ I am completing this questionnaire with help from a member of my family/a friend

☐ I am completing this questionnaire with one of my local service team

2. Did the general nature of your problem concern (Tick all that apply)

☐ Health
☐ Education
☐ Housing
☐ Finance/Debt
☐ Social Services
☐ Employment
☐ Legal Rights
☐ Other [Please specify]

3. How did you feel before you contacted the service?

☐ I didn't feel at all worried or concerned

☐ I was somewhat worried or concerned

☐ I was very worried or concerned

☐ I was extremely worried or concerned

4. Did you know where to go to get the help you wanted?

☐ Yes, I knew where to go

☐ I knew how to find out where I should go

☐ I wasn’t sure where I should go

☐ I had no idea where I should go

5. What type of help did you want to get from the service

☐ I wanted to be given information and/or advice

☐ I wanted to be told where I should go for help

☐ I wanted help with forms

☐ I wanted someone to act on my behalf

6. How would you rate the knowledge of the person who gave you the information or advice?

☐ Excellent	☐ Very Good
☐ Good	☐ Poor

7. **Was the information or advice you received easy to Understand?**

☐ Extremely easy
☐ Fairly easy
☐ Very easy
☐ Difficult

8. **What happened as a result of your contact with the service?**

☐ I followed the advice I was given [Now go to question 10]

☐ I followed some of the advice I was given [Now go to question 10]

☐ I followed none of the advice I was given [Now go to question 9]

☐ I wasn’t able to follow the advice I was given [Now go to question 9]

9. **What prevented you from following the information or advice you received?**

☐ I didn’t agree with the information or advice I was given

☐ I didn’t understand the information or advice I was given

☐ I didn’t have the energy or time to follow up the information I was given (I was overwhelmed at the time)

☐ I tried to follow the advice but it led me nowhere

10. Did you get the help you wanted?

☐ Yes, I got more help than I wanted

☐ No, I got less help than I wanted

☐ Yes, I got the help that I wanted

☐ I did not get any help at all

11. Did you get any information from anyone else? (Tick all that apply)

☐ No, only this organisation

☐ Yes, friends/ relatives

☐ Yes, the internet

☐ Yes, elsewhere [Please Specify]

12. How would you feel if you faced a similar situation in the future?

☐ Confident I would know what to do on my own

☐ Confident I would know where to go for help

☐ Not confident, I would only have some idea what to do

☐ Not confident at all, I wouldn't know what to do

13. Following your contact with the service, how much more do you know now?

- ☐ I know a great deal more
- ☐ I know quite a lot more
- ☐ I don’t know any more
- ☐ I am more confused now [than I was before]

14. Overall, how helpful has the information and advice you have received been?

- ☐ Extremely helpful
- ☐ Very helpful
- ☐ Fairly helpful
- ☐ Not helpful

15. If you didn’t get the help that you did from the information and advice service how confident would you feel to take forward the issue?

- ☐ Confident I would know what to do
- ☐ Confident I could find out what to do
- ☐ Not-confident I could find out what to do, I would only have some idea
- ☐ Not confident at all, I wouldn’t know what to do

16. Thinking about the good and bad things that make up your quality of life, how would you rate the quality of your life as a whole?

☐ So good, it could not be better

☐ Very good

☐ Good

☐ Alright

☐ Bad

☐ Very bad

☐ So bad, it could not be worse

17. Are you Male or Female?

☐ Male

☐ Female

18. How old are you? [please specify in years]

☐

19. Do you deal with your finances and paperwork – for example, paying bills, writing letters – by yourself?

☐ Always ☐ Sometimes

☐ Usually ☐ Never

20. Do you feel able to fill in forms by yourself, without help from anyone else?

☐ Always ☐ Sometimes

☐ Usually ☐ Never

21. If you know your postcode, would you write it below

My post code is

☐

22. Do you live on your own?

☐ Yes

☐ No

23. What ethnic group do you consider yourself to belong to? [Please tick one]

☐ White
☐ Chinese
☐ Indian
☐ Black Caribbean
☐ Black other
☐ Black African
☐ Pakistani
☐ Bangladeshi
☐ None of these

Thank you again for your time.

Please return the questionnaire to the PSSRU in the pre-paid envelope provided.

Personal Social Services Research Unit
University of Kent
Canterbury
Kent CT2 7NF
Tel: 01227 824545
Email: e.welch@kent.ac.uk

Appendix four

Participant information sheet (face to face user interview)

Participant Information Sheet
Information and Advice services research study
Interview

You are being invited to take part in a research study by taking part in a telephone interview about your experiences and views on the information and advice service that you have used. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. You can ask us if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

The aim of the study is to explore the experiences and views of people who use or have contact with information and advice services. The findings from the study will be used to help to decide how to develop services in the future.

Why have I been chosen?

You have been chosen because you are a user of an information and advice service. We are very interested to find out about your views and experiences of this.

Do I have to take part?

It is up to you to decide whether or not to take part. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect your relationship with any of the services that you use or have contact with.

What will happen to me if I take part?

You will take part in an informal interview with a researcher about your experiences of information and advice services. The questions will predominantly be about how important these services are to you and how services affect your life. We would also like you to sign and return a consent form provided by the researcher.

Will my taking part in this study be kept confidential?

Yes, all details will be kept confidential. Only researchers working on the study will have access to the information that is collected.

Who may I contact for further information?

If you would like more information about the research before you decide whether or not you would like to take part, please call Lizzie Welch on 01227 824545 or email e.welch@kent.ac.uk

Thank you for your interest in this research.

Appendix five

Consent form (face to face user interview)

PSSRU
University of Kent

CONSENT FORM
Interview

Title of Project: Information and Advice Services

Name of Researcher:

I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions. ☑

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my legal rights being affected. ☑

I understand that with my permission the interview will be audio-taped. ☑

I agree to take part in the above study. ☑

Your Name ____________________

Date ____________

Signature ____________________