Ministry of Justice

Evaluation of Integrated Advice Hubs in Primary Healthcare Settings

Technical Appendix

IFF Research and York Health Economics Consortium

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1. Introduction

In 2019, the Ministry of Justice (MoJ) published the Legal Support Action Plan (the 'Action Plan'), which outlines the department's vision for legal support. As part of the Action Plan, the MoJ committed to test and evaluate the provision of holistic legal support hubs, to generate evidence on how this approach can more effectively support earlier resolution of a person's legal problems.

To this end, a Feasibility Study was commissioned by the MoJ to assesses how a robust evaluation of Health-Justice Partnerships (HJPs) could be conducted. Published alongside the Feasibility Study on Evaluation of Integrated Advice Hubs in Primary Healthcare, this Technical Appendix provides further information on:

- Chapter 2: The design considerations informing the recommended 'before' and 'after' impact evaluation method including the strengths and weaknesses of options for collecting data, types of indicators that could be considered, the risks and limitations of implementing this method and the measurement framework for the recommended approach.
- Chapter 3: The summary of interviews proposed for the process evaluation including the types of audiences to involve, the risks and limitations of implementing this method and the measurement framework for the recommended approach.
- Chapter 4: The planned approach for the economic evaluation including examples of the types of data required to conduct the analysis, the risks and limitations of implementing this method and the measurement framework for the recommended approach.
- Chapter 5: The data quality and ethical considerations the evaluation will incorporate, including actions taken for ethical approval.

This Technical Appendix offers insight into how HJPs can be evaluated in a robust and consistent manner, including the methodological design considerations that are needed to inform such an evaluation.

2. Impact evaluation approach

2.1 Overall approach

The robustness of different evaluation approaches can be measured based on the Maryland Scientific Methods Scale[1]. At the top of this scale (Level five = most robust) would be an **RCT**, which is **not believed to be feasible** for this evaluation as:

- It would require GPs and others in primary care to identify people with a legal need – likely to be health-harming – but then *not* to refer these people on to access advice; and
- For co-located drop-in services, it would require some self-referring clients to be turned away from receiving help.

Neither of these options feel desirable due to the ethical concerns of turning away clients seeking support and the additional burden placed on advice and healthcare staff.

Level four is a quasi-experimental approach whereby there would be a 'natural' control group in the way the service is provided (for example, certain groups excluded from being able to access advice). Due to a lack of power over the way advice is delivered, this is not an available option.

The most robust evaluation option available is at Level three. This would mean:

- **Collecting 'before' and 'after' data from beneficiaries** receiving support from each HJP.
- **Comparing this with data collected from a counterfactual group** who are also experiencing legal needs but who have not had access to the HJPs.

This is best done through two surveys of HJP clients – an online survey at baseline, distributed by advice hubs and collecting consent for re-contact, and an online and

[1] The Maryland Scientific Methods Scale (SMS) | What Works Centre for Local Economic Growth (whatworksgrowth.org)

telephone survey at follow-up – alongside two surveys of a counterfactual group, identified from the general public through an online panel that is matched to the treatment group. The first step of matching the counterfactual group to the advice hub clients will be during the recruitment period, when counterfactual participants will be screened to ensure that they are facing similar legal issues to the advice hub clients (more details on the legal needs below). The second step will be during analysis when propensity score matching will be used – please see the 'propensity score matching' section below for the principles of propensity score matching for further technical detail.

To ensure accessibility, HJP clients should be able to opt to complete the baseline survey by telephone if they prefer, although it is expected that the majority of advice hub clients will be comfortable using an online platform. To further improve access for clients who are not digitally confident, HJPs could be asked if they are willing to pass on a flyer advertising both the telephone and online channels to clients at the point of advice.

Overall, there are around 5,200 individuals supported across all 11 HJPs within a year (based on 2021 data; see Table 3 below). The evaluation will aim to recruit as many as possible of these clients, accepting that not all clients will be willing or able to take part in the evaluation, that there will be a level of attrition between the pre and post surveys, and that the evaluation itself is subject to budget and timing constraints.

A key aim of the evaluation is to determine whether there has been a statistically significant difference in outcomes since the client received advice. Table 1 below maps out the percentage point difference needed to be able to tell whether a difference in outcomes is statistically significant, for different pre-and post-samples. This assumes that one-in-three individuals recruited at the start of the evaluation (i.e., in the pre-survey) also take part three months later (in the post-survey). This assumption takes into account that individuals are likely to be going through stressful experiences and often lead difficult lives and therefore may not all be willing or able to take part three months later. This response rate will be maximised using incentives, developing engaging and appropriate research materials and respondent communications and allowing sufficient time for survey completion.

Table 1: Degrees of difference required for statistical significance

Difference required to be statistically significant	**Option 1: With base size of (pre) n=1200/(post) n=400**	**Option 2: With base size of (pre) n=600/(post) n=200**	**Option 3: With base size of (pre) n=450/(post) n=150**
For findings at around 50% mark	5.7pp	8pp	9.2pp
For findings at 75%/25%	5.2pp	7.4pp	8.6pp
For findings at 90%/10%	3.8pp	5.6pp	6.6pp

Clearly, in terms of sample sizes, larger volumes are better as it means that smaller differences can be identified as significant. However, this has resource and timing implications. The Feasibility Study revealed a relatively low level of footfall through the participating HJPs meaning that recruitment for the treatment group could take a long period of time. It is anticipated that it could take close to two years (23 months) to recruit 1,200 HJP clients for the treatment group, which exceeds project time and budget constraints.

On balance, Option 2 (aiming for 600 surveys in the treatment group at baseline) seems appropriate. This is likely to achieve a balance between what is feasible in terms of recruitment within the timescales but will not require an extremely large percentage point difference in order to determine a statistically significant finding. This would then give a sample size of 200 surveys in the treatment group at follow-up. For the counterfactual group, it will be possible to recruit 1,200 baseline participants within the project timeline, which will then result in around 400 participants in the counterfactual group at follow-up. This will help to improve the identification of statistically significant differences between the groups and also provide scope to better match the counterfactual group to the treatment group.

With a base size of 200 for the treatment group, it will only be feasible to look at outcomes at an overall level in the impact evaluation, rather than being able to look at the extent to which outcomes were achieved for each of the three operating models identified in Chapter 4 of the Feasibility Study.

Propensity score matching

Propensity score matching (PSM) seeks to address the risk of selection bias, by finding a comparator group of cases with a similar likelihood of experiencing the same treatment, based on a number of observable covariates. There are four steps in PSM:

1. **Estimate the propensity score** – use regression models, controlling for all of the covariates in the treatment group, to derive a likelihood an individual received the treatment. The covariates to be matched on should be explored in more depth during the impact evaluation development, but could include age, sex, ethnicity, Indices of Multiple Deprivation (IMD), employment status, long-term health conditions and type of legal problem. This gives a propensity score that can be used to find individuals in a comparator population with a similar likelihood of receiving the same treatment (if it were available).

2. **Match** – find individuals that have a similar likelihood (or propensity) of experiencing the treatment, so they can be matched to form a more convincing comparator group. An algorithm is used to find matched subjects in the comparator population.

3. **Evaluate the quality of matching** – the goal of matching is to achieve a balance between the treatment group and comparator group on observable traits. Statistical tests (e.g., comparing means (t-test); percent bias reduction, graphical comparisons) are used to test how similar the treatment group and matched group are.

4. **Evaluate outcomes** – compare means of samples, run a regression on the matched controlling unbalanced covariates.

For further technical detail on PSM, including the advantages and disadvantages, please see below.

Propensity Score Matching – Technical detail

The impact evaluation will utilise 'propensity score matching' (PSM) which seeks to address the risk of selection bias, by finding a comparator group of cases with a similar likelihood of experiencing the same treatment, based on a number of observable covariates.

PSM relies on there being individual patient data (IPD) available for both arms of the study. If constraints in the study data collection are encountered, and only aggregate data are available for one of the study arms, we would use indirect treatment comparisons (ITC) methods to derive a comparative population. For example, matched adjusted indirect comparison (MAIC) applies weighting to the available IPD in one group, such that the patient characteristics match that of the aggregate data in the other group, thereby creating a weighted average population. An alternative method would be a simulated treatment comparison (STC), which uses regression based adjustments to derive a treatment effect using the IPD, adjusted for baseline characteristics. The same regression model is then applied to the aggregate data, to derive a simulated treatment effect.

One disadvantage of PSM is that whilst it seeks to reduce the bias due to confounding variables, it can only account for observed (and observable) covariates and therefore any hidden bias due to latent variables may remain after matching. The covariates to be matched on should be considered in detail and include protected characteristics as well as any additional known variables that influence the experience of legal problems (such as the type of legal problem), but awareness should be shown in final reporting that there may be some hidden bias due to latent unobserved variables.

Another disadvantage of PSM is that it requires large samples in order to provide high quality matches, with substantial overlap between treatment and control groups. Ideally, the counterfactual group would be larger than double the intervention group (to provide more selection opportunities for close matches) but these sample sizes are somewhat fixed due to project timing and budget. It is felt that these sample sizes should provide adequate matches, but these matches will be evaluated using statistical tests and any limitations will be shown in the final reporting.

2.2 Collection of 'before' and 'after' data from HJP clients

Establishing a baseline

When?

While 'before' data could be collected at the point of referral from the healthcare professional, this would add a step into the referral process which might negatively impact upon the number of referrals taken up. Therefore, it is recommended to gather baseline data shortly after individuals have contact with the advice provider at the HJP.

What?

It is important to have demographic information and advice type at baseline to be able to target a follow-up sample accordingly (and check for non-response bias). More detailed information on the issue they face would also be valuable to collect if possible while recall levels are high. Finally, current mental and physical health will be important to capture so that the evaluator can observe any change in these measures before and after contact with the hubs.

How? Management information or survey?

While both approaches have their strengths and weaknesses as detailed in Table 2 below, **using an online survey rather than management information is recommended** to establish a baseline among hub clients.

Whilst some management information about clients, their legal problems, the advice provided and some outcomes are collected by hubs, this information is not uniform or consistently available from all sites. A baseline survey allows data and informed consent for participation in a follow-up interview to be captured in a systematic way. In addition to

providing detailed information about the study, what participation involves and how data will be collected, processed and stored, a helpline and email address on the welcome screen of the online survey/email invite/flyer is recommended so further reassurances can be given to hub clients as necessary. If the participant opts for a telephone survey this same information will be shared verbally at the start of the survey so they can then make a fully informed decision about taking part. Offering an incentive to participating clients would also help to mitigate against a low response rate.

Continual monitoring of the survey data is recommended to ensure responses from a broad range of demographic profiles are collected, including from clients who belong to minority groups. If needed, the evaluator should ask the advice hubs to explicitly refer clients from low-responding groups.

Table 2: Strengths and weaknesses of possible approaches to collecting baseline data.

	Strengths	Weaknesses
Management information	This information has already been collected by the HJPs, reducing the research burden on clients and the overall demands of the evaluation. Sites have confirmed that they are willing to share anonymised data for the evaluation.	This data are not widely collected and is inconsistent across sites: • Demographic information and type of advice provided is collected by all Citizens Advice (CA) in an inconsistent manner. • Central England Law Centre also collect demographics and advice provided, but it is unlikely to map exactly to the CA data. • Some, but not all, CA sites collect further information such as the Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) [2]scale for mental health, occupation and (for around 20% of clients) income profile. They do not collect data on all the outcomes within the ToC.

[2] About WEMWBS (warwick.ac.uk)

	Strengths	Weaknesses
Survey	A baseline survey will enable more **comprehensive and consistent information across all advice hubs** to be captured. Obtaining consent for participation in the evaluation through advice hubs sending out an online survey link to clients means it can be systematised, with all relevant information provided in written form. For the minority who opt to complete the survey over the phone the same information about the study will be shared by the interviewer and then verbal consent will be acquired before starting the survey. Disseminating the link to the online survey and handing out flyers could fit easily into current working practices as it is very common in CA centres to hand out information and send follow-up information over email and would not rely on individual advisors having to use appointment time to talk through the study.	It is not possible to get to a 'true' baseline as contact will be after the first appointment so some information will need to be collected retrospectively. There is a risk that sample sizes will not be achieved if response rate is low. An online/telephone survey may not be appropriate for some client groups.

Anticipated volumes of advice hub clients and timeframes

The anticipated volumes of advice hub clients will determine how long it will take to obtain sufficient sample for the baseline. Including all of the 11 HJPs (outlined in Table 5 of Feasibility Study) in the impact evaluation is recommended, even where only 9 are included in the process evaluation, to maximise achievable base sizes. It is possible that

additional HJPs who were not able to take part in the Feasibility Study due to capacity restraints will be eligible and able to participate in the impact evaluation, disseminating online invites and flyers. If so, it is advised to include these HJPs in the baseline recruitment efforts to boost sample size. The evaluator should aim for a sample size of 600 total at baseline.

It is hard to estimate what proportion of clients come through HJPs at present because this information is not collected in a wholly centralised or consistent manner. For Citizen's Advice (CA), there are two ways in which these clients can be identified:

- Those with physically co-located services can be identified by CA Head Office. Those without co-located services, would need to be identified by route of referral into the service. This information is held locally (if at all) and would require liaison with local advice hubs to pass the data to CA Head Office to compile for the evaluator.

- A marker could be added on to the CA dataset to require all CA to identify clients of interest.

These routes are not fool proof as they both rely on multiple advisors recording information accurately and systematically. However, on balance, adding a marker to identify clients of interest on a 'best attempt' basis will be beneficial.

While there were around 68,500 clients who sought advice at the 11 HJPs of interest in 2021, there were far fewer that can be identified as having received advice through the link with a healthcare provider.

Table 3: Estimated volumes of advice hub clients.

Head	Source	Number of clients which sought advice from the advice centre
CA Blackpool	Central data[3]	1,204
CA North East Derbyshire	Central data	537
CA Warrington	Central data	151
CA Milton Keynes	Central data	75
CA Central Dorset	Local estimate	350 (72 recognised centrally)
CA Wandsworth	Local estimate	810
CA Broxtowe	Local estimate	200
CA Solihull	Unknown at this time	-
CA Arun and Chichester	Unknown at this time	-
CA County Durham	Unknown at this time	-
Central England Law Centre	Unknown at this time	-
Total (for 7 hubs)		**3,327**

The above table shows that for the seven hubs where there is an indication of annual clients, there were c.3,327 clients in 2021. Extrapolating this to all 11 advice hubs to include in the evaluation, there are around 5,200 individuals supported across all 11 advice hubs within a year. However, these figures are based on 2021 figures when Covid-19 will have impacted attendance. The cost of living crisis is also likely to see client volumes increase substantially. Against this, staff constraints are likely to limit the number of clients that can be seen.

Utilising the 2021 figures, assuming around 12% of clients would opt-in to the baseline survey[4], this would mean around 630 clients a year. To achieve the desired base size of 600 advice hub clients would therefore take a period of just less than 12 months. It may be

[3] Data held centrally by Citizens Advice Head Office.

[4] The estimated 12% response rate is based on feedback from central Citizens Advice about the average responses rates for their own client feedback surveys.

quicker than this if use of the advice hubs increases as Covid-19 restrictions have been lifted or if other eligible advice hubs are willing to participate in the evaluation. This will be closely monitored over the first few months of fieldwork and timings can be adjusted as necessary. The proposed evaluation will also look to maximise participation in the baseline survey through measures such as incentives and reminder emails where possible.

'After' data: follow-up surveys

In order to collect 'after' data at an appropriate point, a **survey of advice hub clients** will be most appropriate. While some data are collected by advice hubs on outcomes, this is neither consistent nor comprehensive enough for the impact and economic evaluations.

When?

The anticipated timeframes for legal issue outcomes can vary considerably from just a few weeks to 12 months or more, depending on the issue. An appropriate time between baseline and follow-up will therefore be somewhere between the two extremes at about 6 months. However, this will need to be reduced in order to ensure the data are collected within the project deadlines. A shorter follow-up period of three months may mean that not all legal issues will have been resolved, however it is expected that participants will be able to talk about some outcomes (such as their mental health) and any expected outcomes. The timing of the process evaluation will permit a 6 month time lapse between initial and follow-up interviews so detailed qualitative data will be captured through this element of the evaluation. Permission to re-contact will be asked for, so that the MoJ has the option to follow-up at a later date once the project has ended and explore any longer-term outcomes. One further consideration for the delay between surveys will be to ensure that our follow-up survey is differentiated from the CA feedback survey which may be sent at a similar time– about three months after first contact – as such, a follow up of four months should be considered.

As clients will be opting into the research over a period of several months, the follow-up survey will need to mirror this by operating on a rolling basis, with new sample loaded in monthly.

How?

In common with the baseline, an online survey is recommended, which also allows participants to opt-in to completing over the telephone if they are more comfortable with this approach. Clients could also be asked at baseline to share their telephone numbers if they are willing to do so. This would allow some telephone follow-up in order to maximise response rates, as online response rates are typically much lower.

As with the baseline survey, offering an incentive to participating clients, and ensuring they are able to ask questions about the research and their involvement in a number of ways would help to mitigate any risks related to a low response rate.

2.3 Designing and obtaining a counterfactual group

To check whether any change seen between 'before' and 'after' can be attributed to contact with HJPs, it is necessary to compare any change noted with what change would have happened in the absence of the advice hub (a 'difference in difference' approach to establishing the advice hub's impact). To see what would have happened in the absence of contact with an HJP, requires the identification of a counterfactual group, as close as possible to the characteristics of hub clients.

Possibilities for establishing this group, with their accompanying strengths and weaknesses are shown in Table 4 below.

Table 4: Options for establishing a counterfactual.

	Strengths	Weaknesses
A) **Individuals with legal needs who have approached advice hubs without an integrated health element i.e.,** replicate the 'before' and 'after' approach with a sample of individuals from other advice centres in the CA network.	Interested parties would find it easy to believe that this was a group similar to those receiving advice in all respects other than geographical location (and perhaps therefore demographics).	Local centres without a HJP would have to facilitate opt-in via an online survey. This adds some burden to hubs with little stake in the evaluation (and who did not volunteer to help) and so co-operation may be variable. This would only provide a sample of individuals who have accessed advice. It would be beneficial to compare with a broader sample

	Strengths	Weaknesses
		of people with a legal need (whether or not they go on to access advice) to explore whether the HJPs increase the proportions of /change the profile of those accessing advice.
B) **Individuals referred to the advice hubs but who do not take up the referral.**	Interested parties would find it easy to believe that this was a group similar to those receiving advice in all respects other than the fact that they took up the advice.	While consent to participate could theoretically be gained at point of referral, this may be a group with low levels of engagement, making participation in research unlikely. Numbers of drop-outs are also unknown and there is a risk that it would take a very long time to build up sufficient sample sizes.
C) **Free-finding a sample of individuals with a legal need (who have not necessarily approached an advice hub at all) and following them up to explore their circumstances/outcomes after the same amount of time as for beneficiaries.**	In order to do this, the evaluator would need to screen a general population sample to identify those with a legal need, for example through an online panel and/or Random Digit Dialling (RDD). The Legal Needs Survey and Legal Problem Resolution Surveys (see below) can be used to sense check the proportion of the counterfactual sample that has a legal need reflects that of the general population. No burden for advice hubs.	If the sample differed from clients substantially in terms of their needs and/or demographics, it could undermine the validity of the comparison group. To mitigate this, the evaluator should agree a definition of needs with MoJ, that aligns with the advice the HJPs provide. The evaluator could also use propensity score matching to match the demographics of advice hub clients.

On balance, **option C** where a counterfactual group is free-found from the general population is recommended. This is a practical option which does not increase the ask of HJPs, who have limited capacity to support the research.

Sourcing the counterfactual group from a combination of an online panel as well as a randomly-sourced telephone sample would be ideal. Using both approaches in tandem would help to mitigate any bias towards the digitally confident that might be expected in an online panel sample[5]. However, to fit within the budgetary parameters of the project, the evaluation could proceed with an online panel that is not supplemented with telephone sample. This means that the counterfactual group may be skewed towards those who are digitally confident and perhaps more capable of resolving their legal issues, potentially minimising the difference that advice hubs are making.

Ideally, the counterfactual group survey would be run over a number of months on a rolling basis to best match the advice hub clients survey. This would take account of contextual changes which could affect access to healthcare settings or advice services, such as a new Covid-19 wave or restrictions or the cost of living crisis etc. The provision of an incentive to participating clients would also help to mitigate any risks associated with contextual changes which could lead to a low response rate. However, running the counterfactual group survey on a rolling basis would increase the overall cost of this element of the research.

If the collection of counterfactual data can only be one-off due to budget restraints, asking about how any change in context are likely to have affected results through the qualitative interviews is recommended in order to position analysis and reporting accordingly.

[5] The telephone sample would be drawn from a combination of a Random Digit Dialling (RDD) sample and lifestyle databases. An RDD sample consists of phone numbers that have been randomly generated – this approach can be used to generate both landline and mobile telephone numbers. Lifestyle databases consist of individuals with phone numbers compiled from a range of different sources, to which it has been possible to match gender and age (e.g., through matching to the electoral roll). Having this demographic sample makes it possible to target people in the harder to reach groups, enabling the research to reach a more representative profile (by age and gender). Lifestyle databases are not as pure a sample source as RDD but blending the two approaches can achieve a balance between purism and pragmatism.

Estimating the incidence of legal need in the general population

The assumptions used to determine the best starting sample size for the counterfactual are based on the 2019 survey of the Legal Needs of Individuals in England and Wales, commissioned by the Law Society and the Legal Services Board (LSB)[6]. The survey asks about 34 different legal issues, grouped under 8 broad categories of legal needs:

- Rights of individuals
- Consumer problem
- Conveyancing/ residential
- Family
- Injury
- Property, construction and planning
- Employment, finance, welfare and benefits
- Wills, trusts and probate

Not all of these categories are relevant to the scope of this evaluation as not all issues are likely to be covered by HJPs (for example, buying or selling a house). As articulated within the ToC, the categories which feel most relevant are 'Employment, finance, welfare and benefits' and 'Property, construction and planning' (which largely equates to 'housing'), although parts of other categories may be relevant (for example immigration issues are picked up in the ToC under 'Obtaining other entitlements or rights).

The survey finds that six in 10 adults (64%) based in England and Wales experienced a legal issue in the last four years. While only 32% (those experiencing an employment, finance, welfare or benefit issue) had a similar issue to the beneficiaries of HJPs, it is likely that the true figure would be higher when adding in property issues and some of the other categories. A reasonable estimate might be around 45%.

[6] Legal needs of individuals in England and Wales report | The Law Society

A matched sample requires people *currently* experiencing a legal need to be identified. A reasonable estimate for this is around 10% (dividing the 45% incidence over four years by four).

The Legal Problem Resolution survey commissioned by MoJ in 2014-5 is another source that can be used to support the estimated incidence rate.[7] This survey found that almost a third of adults (32%) had experienced one or more civil (27%), administrative (10%) or family (1%) legal problems in the 18 months before interview. This is broken down further in Table 5 below.

[7] Legal problem and resolution survey 2014 to 2015 - GOV.UK (www.gov.uk)

Table 5: MoJ Legal Problem and Resolution Survey - Percentage of adults that have experienced a legal problem in the last 18 months by problem type.

Civil legal problems	**27%**
Purchasing goods and services.	8
Neighbours' anti-social behaviour.	8
Money excluding personal debt.	7
Personal debt.	5
Rented accommodation.	5
Accidents or medical negligence.	4
Owning or buying residential property.	2
Administrative legal problems	**10**
Employment.	6
State benefits.	3
Education.	2
Family legal problems	**1**
Unweighted base.	*10,058*

Not all sub-categories shown in Table 5 will be relevant (for example, purchasing goods and services) for HJPs. However, if some categories are excluded and the timeframe reduced from 18 months to current, an incidence rate of around 10% seems appropriate.

2.4 Outcomes and indicators

Table 6 gives an indication of the types of metrics that could be collected in the survey and initial thoughts on standardised scales that could be considered.

Table 6: Indicative outcome metrics.

Indicator	Measurement scales, including validated tools
Level of legal knowledge, skills and confidence.	To be developed.
Ability to identify a legal problem.	
Ability to seek appropriate advice for legal issues.	
Increased or restored benefits.	
Obtaining other entitlements or rights.	In receipt of immigration support.
Resolution of employment issues.	Increased job security, reasonable adjustments secured
Housing situation stabilised.	Possession action avoided, repairs made to rental property
Improved ability to manage finances.	To be developed.
Increased independence.	
Improved mental wellbeing, including reduced stress/anxiety.	WEMWBS, PHQ-9
Improved physical wellbeing, including diet, exercise, sleep.	SF-12 quality of life survey.
Better relationships with family and friends, isolation reduced.	UCLA loneliness scale.
Whether legal issues have escalated.	Whether court/tribunal proceedings have been initiated.
Reduced demand on wider public services.	Social care usage.
Reduced demand on the healthcare system.	Frequency of use of primary care services.

Although data can be collected on all these areas within the survey, it is likely that some indicators may require a longer time period to elapse before change can be meaningfully measured, such as reduced use of healthcare and wider public services, particularly as the project parameters limit longer term follow-up with clients. These indicators may need to be extrapolated for the economic evaluation from early indicators collected in the survey.

2.5 Risks and limitations

The recommended approach to the impact evaluation is the 'best fit' for the project parameters including budget and timeline and has limitations, as outlined in Table 7.

Table 7: Impact evaluation risks and limitations.

Limitations	Likelihood	Impact	Mitigations
There are no positive findings due to measurement difficulties. This could be detrimental to the advancement of HJPs. Tracking, measuring and attributing outcomes are particularly difficult in this context where clients have complex issues that can reoccur or repeat, meaning that their trajectory isn't linear, improvements may be marginal, and benefits are complex and diffused.	Medium.	High.	• Thorough review of the ToC and evaluation framework with input from MoJ stakeholders, sector experts and clients as part of the Feasibility Study to ensure it accurately represents the complexity of risks, outputs and impacts of HJPs; • Continually refer and review the ToC throughout the process and impact evaluations; • Ensure sufficient base sizes so that more outcome changes can be proved statistically significant; • Be clear and realistic about the measurable elements of the HJPs, carefully choosing outcome measures that are validated where possible; • Triangulate data collected in each stage of the project to ensure robust conclusions can be drawn; and • Be clear on any limitations of the approach in project reporting so that it is clear where measurement issues

Limitations	Likelihood	Impact	Mitigations
			may be responsible for no significant findings.
The baseline of the HJP client survey is primarily online and therefore is likely to have less reach among those not digitally literate.	Medium.	High.	There are several mitigating actions that can be introduced to appeal to those who are not comfortable or confident online, including incentives and allowing clients to opt-in to completing the survey over the phone. This could be communicated through the email invite or, if budget allows, through a flyer distributed by HJPs (assuming they are willing to do this). Recruitment of subjects for the online survey will need to continue for sufficient time until the required number of service users have consented to participate.[8] We are a corporate member of Disability Rights UK and our team have undertaken disability awareness training. In terms of the online survey, our template meets accessibility requirements. For example, it allows respondents to choose the font size.
Baseline survey does not meet reach a representative group of participants with a legal need.	Medium.	Low.	Survey responses will be staggered and will closely monitor key demographic variables including age and ethnicity of HJP clients and participants in the counterfactual group. If we are low in responses from a demographic group, we will request that hubs help us to target recruitment of these participants.

[8] Genn H, Beardon S. Law for health: Using free legal services to tackle the social determinants of health. University College London. 2021. [1]

Limitations	Likelihood	Impact	Mitigations
The evaluator will rely on the goodwill of advice hubs to administer the opt-in survey link and flyers and to mark up where clients are in scope of the evaluation (i.e. seen at a health setting or through a referral from integrated health services).	Medium.	High.	We will make every effort to reduce the burden on advice hubs for helping to facilitate this study. Advice hubs have volunteered to take part in the evaluation and re-iterated their willingness to help at the feasibility stage. Including a re-contact question on the baseline survey means that advice hubs will only have to enable consent once rather than for baseline, follow up and qualitative stages separately, which minimises the burden on their services. We will have a key liaison person delegated to communicating with each advice hub to ensure that any information shared is done in a joined-up way and that advice hubs are clear that they know who they contact if they have any questions. Time spent to build rapport with each hub has been costed for. The administration of the survey and identifying potential participants has been integrated into existing work practices for frontline advisors. Further, we will set out clear instructions for advice hubs in terms of what is required from them throughout the evaluation including timeframe – this will come in the form of a (visual) information sheet with named evaluator contact details
The numbers expected for the baseline survey are based on data currently available and estimated response rate.	Medium.	High.	These can be monitored as fieldwork progresses so if the sample is achieved faster or slower than estimated, fieldwork can be adjusted accordingly.

Limitations	Likelihood	Impact	Mitigations
			Recruitment of subjects for the online survey will need to continue for sufficient time until the required number of service users have consented to participate[9].
The incidence rate for current legal need in the population is an estimate only.	Medium.	Medium.	The estimate has been informed by existing evidence, including the Law Society and LSB's legal needs survey.
Drop out rates between baseline and follow-up surveys are estimates.	Medium.	High.	Attrition is a common problem in research. Providing incentives (Munoz-Laboy 2019 [6]) for participation in the follow-up, designing appropriate research materials and ways of engaging with respondents, and allowing sufficient time for follow-up (Emengo 2020 [5]), will help to ensure retention of participants, but this will be monitored.
Ethical constraints for the participants.	Medium.	Low.	IFF Research operates under the strict guidelines of the Market Research Society's Code of Conduct. Participants will be reminded of this obligation and our duty to guarantee confidentiality and anonymity before taking part in the survey. Information about the survey will be tailored to each audience (HJP clients and the counterfactual group); making sure they are accessible easily understood by each group. Evaluator contact details are shared in case the participant has any concerns about the evaluation at any stage.

[9] Genn H, Beardon S. Law for health: Using free legal services to tackle the social determinants of health. University College London. 2021.

Limitations	Likelihood	Impact	Mitigations
Ethical concerns with having a counterfactual group who does not receive advice.	Medium.	Low.	In the literature review, only one paper identified ethical issues around including a counterfactual group of patients who would not receive support (Benfer 2018 [7]). The authors of this observational study of five MLPs in Connecticut suggested that it may be possible to randomize “based on lack of capacity — for instance, some MLPs only have attorneys certain days of the week — or when legal services are not triaged based on greatest need”. For this study, we are free-finding participants who suit the control group criteria that already exist in the general public. We are denying participants the opportunity of gaining advice through an advice hub, although it should be noted that HJPs have limited resources and could not assist all citizens with a legal need.
Data management.	Medium.	Low.	All data will be stored securely on the IFF servers and deleted no longer than 12 months following completion of the survey. Participants have the right to have a copy of their responses, change their responses or withdraw from the research at any point. In the tailored information sheet they will be provided with links to where they can access more information about our data management processes.

2.6 Measuring impact

The below table sets out how impact can be measured via the evaluation. For each component of the Theory of Change (ToC) shown in Appendix A, the evaluation framework in the table below sets out suggested indicators to measure that component, along with data source and audience.

Table 8. Impact Evaluation Framework.

ToC Component	Indicator	Data Source	Audience
Inputs			
Community	Levels of awareness of the HJPs.	Impact evaluation (IE): Client survey.	Advice hub clients & counterfactual group. *Baseline.*
Activities			
This may include: providing information and explaining options, identifying further action the client can take, providing support with tasks (e.g. form filling), casework, negotiating with third parties or the other side to the dispute, representation and litigation, and referring to other sources of support and advice.	Types of advice or assistance is offered to the client?	IE: Client survey.	Advice hub clients & counterfactual group. *Baseline & follow up.*

ToC Component	Indicator	Data Source	Audience
Outputs (improved access to advice)			
Clients receive appropriate advice and assistance for their problem/s.	Degree to which the advice was appropriate for the situation.	IE: Client survey.	Advice hub clients & counterfactual group. *Baseline & follow up.*
	Actions taken from receiving advice.	IE: Client survey.	Advice hub clients & counterfactual group. *Baseline & follow up.*
Short-term Outcomes			
Improved capability/capacity			
People are equipped to take control of their legal problems, through improved legal knowledge, skills and confidence.	Client's level of legal knowledge, skills and confidence.	IE: Client survey.	Advice hub clients & counterfactual group. *Baseline & follow up.*
People are better able to recognise a legal problem in the future and seek appropriate support.	Client's ability to identify a legal problem.	IE: Client survey.	Advice hub clients & counterfactual group. *Baseline & follow up*
	Client's ability to seek appropriate advice for legal issues.	IE: Client survey.	Advice hub clients & counterfactual group. *Baseline & follow up.*
Reduced burden on healthcare professionals allowing them to spend more of their time focusing on health issues.	Reduced number of visits to healthcare professional.	IE: Client survey.	Advice hub clients & counterfactual group. *Baseline & follow up.*

ToC Component	Indicator	Data Source	Audience
Problem resolution			
People are able to tackle problems and resolve them swiftly.	Clients are able to recognise when an issue is a legal issue.	IE: Client survey.	Advice hub clients & counterfactual group. *Baseline & follow up.*
	Clients are able to resolve their legal issues promptly.	IE: Client survey.	Advice hub clients & counterfactual group. *Baseline & follow up.*
Increased or restored benefits.	Clients have increased access to benefits.	IE: Client survey.	Advice hub clients & counterfactual group. *Baseline & follow up.*
Debts reduced or managed.	Clients have been able to reduce debt or restructure debt so that payments are more manageable.	IE: Client survey.	Advice hub clients & counterfactual group. *Baseline & follow up.*
Employment issues resolved.	Client employment issues are resolved promptly.	IE: Client survey.	Advice hub clients & counterfactual group. *Baseline & follow up.*
Obtaining other entitlements or rights e.g., immigration help.	Client is on track/has gained access to other entitlements.	IE: Client survey.	Advice hub clients & counterfactual group. *Baseline & follow up.*
Housing situation stabilised, e.g., possession action avoided, repairs made to rental property.	Client has remedied/is in the process of remedying their poor housing situation.	IE: Client survey.	Advice hub clients & counterfactual group. *Baseline & follow up.*
Long-term Outcomes			
Improved socioeconomic situation for individuals			
Prevention of problem escalation and	Legal issue is dealt with more promptly than if no assistance was received through co-located advice hub.	IE: Client survey.	Advice hub clients. Baseline and counterfactual group. *Follow up*

ToC Component	Indicator	Data Source	Audience
problem clustering.			
Improved ability to manage finances.	Client is better able to manage personal finances.	IE: Client survey.	Advice hub clients & counterfactual group. *Baseline & follow up.*
Increased independence.	Client feels that they have more autonomy and control over their own life.	IE: Client survey.	Advice hub clients & counterfactual group. *Baseline & follow up.*
Improved mental wellbeing, including reduced stress/anxiety.	Client has improved mental wellbeing.	IE: Client survey.	Advice hub clients & counterfactual group. *Baseline & follow up.*
Improved physical wellbeing, including diet, exercise, sleep.	Client has physical mental wellbeing.	IE: Client survey.	Advice hub clients & counterfactual group. *Baseline & follow up.*
Better relationships with family and friends, isolation reduced.	Client feels that their interpersonal relationships have improved.	IE: Client survey.	Advice hub clients & counterfactual group. *Baseline & follow up.*
Assumptions			
Clients act on the advice given – Clients have the confidence and motivation to enact a solution.	Following the first advice hub appointment, the client understands what steps need to be taken next.	IE. Client survey.	Client group. *Baseline.*
	The client takes these steps within 6 months of their first advice session.	IE. Client survey.	Client group. *Follow up.*

3. Process evaluation approach

3.1 Overall approach

As discussed in Section 4.2 in the Feasibility Study, three broad models of HJP were identified:

- Model one: A co-located HJP that uses a structured consultation booking system and shares information.
- Model two. A co-located HJP that uses a consultation booking system.
- Model three. A HJP that is not physically co-located but does use a structured consultation booking system and shares information.

The process evaluation will need to conduct interviews with a range of audience types across the three models of HJPs, to gain an understanding of how they are delivered. Table 9 outlines the recommended interviews across the three models as part of the process evaluation.

Table 9: Summary of proposed interviews

Audience	Model 1: Physically co-located and involves a structured referral/consultation booking system and/or shares information (Three advice hubs).	Model 2: Physically co-located and involves a consultation booking system (Three advice hubs).	Model 3: Not physically co-located and involves a structured referral/consultation booking system and/or shares information (Three advice hubs).
Strategic staff in umbrella body organisations and commissioners.	**Two or three depth interviews.** (e.g., at CA and Law Centre head offices)		
HJP advice managers.	**Three depth interviews.**	**Three depth interviews.**	**Three depth interviews.**
Frontline advisors working in advice hubs.	**Three mini-groups.** (One per site, four to five people in each).	**Three mini-groups.** (One per site, four to five people in each).	**Thre mini-groups .** (One per site, four to five people in each).
Healthcare professionals that make referrals (GPs, nurses, link workers etc.)	**Five or six depth interviews.** (Two or three per site)	**Five or six depth interviews.** (Two or three per site)	**Five or six depth interviews.** (Two or three per site)
Advice hub clients.	**20 depth interviews** soon after referral, following c.10 of these up after c. six months	**20 depth interviews** soon after referral, following c.10 of these up after c. six months.	**20 depth interviews** soon after referral, following c.10 of these up after c. six months.

Interviews with HJP advice leads highlighted the important role that link workers and administrators play in terms of liaising with clients and referring them to both internal and external sources of support, so it is suggested that the evaluator secures a number of interviews with link workers and administrators in the process evaluation as well as healthcare professionals such as GPs and nurses. Including these healthcare professionals in the process evaluation will help to provide additional insight into how the advice hubs operate and how clients experience the referral process. The provision of incentives to participating healthcare professionals (and to clients) would help to mitigate the risk of achieving a low response level.

Table 10 gives an indication of how each of these audiences would be able to contribute to a detailed understanding of implementation and delivery of co-located advice hubs.

Table 10: Summary of audience types and related objectives

	Strategic staff & commissioners	Hub managers	Delivery staff	Healthcare professionals	Advice hub clients
How arrangements for HJPs are brokered.	✓	✓		✓	
How HJPs perform relative to 'standard' sites.	✓	✓			
How clients are identified as being suitable for the service/how the service is introduced.			✓	✓	
Training received to identify referrals.			✓	✓	
How referrals are made.			✓	✓	✓
Volumes and nature of referrals (including how this compares to capacity).		✓			
Nature of advice provided/received (including balance between advice provided 'on site' or elsewhere).			✓		✓

Extent of overlap between rights/legal needs and health needs and relationship between the two.			✓	✓	✓
Perceived added value of co-location? Does it bring more people to legal advice? Does it bring a different cohort of people/problems? Does it bring them earlier?	✓	✓			
Outcomes achieved for beneficiaries and what leads to these – immediately and in the longer-term.			✓	✓	✓
Whether any changes have been made to the delivery model over time and rationale for these.		✓		✓	
Key factors that determine the success of HJPs.	✓	✓	✓	✓	
Challenges in making co-delivery work and how they can be overcome.	✓	✓		✓	
Impact of Covid-19 on impact of advice hubs.	✓	✓	✓	✓	
Impact of the cost of living crisis on the impact of advice hubs.			✓	✓	

As advice hub leads and strategic staff have already been spoken to during the Feasibility Study, process evaluation interviews should focus on what, if anything, has changed since.

To reduce cost, most of these interviews could take place by phone or video-conference but it is advisable to allow some provision for conducting interviews face-to-face where this is easier for HJPs to facilitate.

In these interviews, techniques like exploratory questioning, journey mapping and creative approaches could be used to empower participants to actively take part in the research and to capture detailed views and experiences. All HJP clients should be offered a support

leaflet at the end of fieldwork, to re-iterate the purpose of the research and to signpost them to other people to speak to if the interview stirred up upsetting thoughts. Ensuring clients are able to ask questions about the research, their involvement and their data in a number of ways (e.g., by emailing the evaluator or MoJ) would also help to ensure the safety of participants.

The implementation of recruitment quotas and the continual monitoring of the sample profile is recommended to ensure the inclusion of participants from a broad range of demographic profiles, including from clients who belong to minority groups. If needed, the evaluator should ask the hubs to explicitly refer clients from low-responding groups.

3.2 Risks and limitations

The HJPs and the proposed evaluation take place within a constantly evolving environment. As a result, it is expected that there will be changes to the wider environment that necessitate adjustments to the evaluation.

Table 11 summarises the key risks in relation to the proposed approach to the process evaluation and any external risks. For each risk, the likelihood and impact of the risk has been indicated, as well as possible mitigating actions and relevant learnings from the Feasibility Study.

Table 11: Risks and limitations to the process evaluation

Limitation	Likelihood	Impact	Mitigations
Project specific risks			
Retention of HJP clients for longitudinal interviews proves difficult.	Medium.	High.	If the evaluator cannot secure follow-up interviews with all 10 of the participants interviewed at the beginning of the process evaluation, they could recruit additional participants who were

Limitation	Likelihood	Impact	Mitigations
Project specific risks			
			supported by the advice hubs during a similar time period to the original participants and ask a number of baseline questions at the beginning of the interview.
Significant translation services may be required.	Medium.	Low.	We are well placed to meet the linguistic needs of HJP clients. In our telephone centre, we have speakers of most minority UK languages, for example Bengali speakers (4), Urdu (19), Gujarati (2), Polish (5) and Punjabi (10), among others. Translation requirements have been costed into the evaluation.
Interviewing a range of HJP clients.	Medium.	Low.	We will closely monitor key demographic variables including age and ethnicity of HJP clients who take part in the qualitative interviews. If we are low in responses from a demographic group, we will invite these participants to take part in an interview in the first instance.

Limitation	Likelihood	Impact	Mitigations
Project specific risks			
Adjustments required to enable participants with disabilities to take part.	Medium.	Low.	We are a corporate member of Disability Rights UK and our team have undertaken disability awareness training. This means all staff conducting interviews as part of the process evaluation will have an understanding of possible adaptations needed for disabled clients. We will double check at recruitment stage for each individual's needs to enable their participation.
Ethical constraints for the participants.	Medium.	Low.	IFF Research operates under the strict guidelines of the Market Research Society's Code of Conduct. Participants will be reminded of this obligation and our duty to guarantee confidentiality, unless otherwise specified before taking part in any interview. Further, research materials are designed sensitively, and

Limitation	Likelihood	Impact	Mitigations
Project specific risks			
			participants are given the option to move on from distressing topics if necessary. Information sheets will be tailored to each audience; making sure they are accessible easily understood by each group. Evaluator contact details are shared in case the participant has any concerns about the evaluation at any stage. We signpost clients to appropriate services at end of interview if needed.
Advice hubs reluctant to take part.	Medium.	High.	Most sites have volunteered and willingness to participate was established during the Feasibility Study, however consent should be checked at each stage. We will have a key liaison person responsible for

Limitation	Likelihood	Impact	Mitigations
Project specific risks			
			communicating with each advice hub to ensure that any information shared is done in a joined-up way and that advice hubs are clear that they know who to contact if they have any questions. Time spent to build rapport with each hub has been costed for.
Difficulties engaging healthcare professionals with research as they are time-poor, particularly during the Covid-19 pandemic, and receive many research requests (e.g., from pharmaceutical companies).	Medium.	High.	Offer flexibility in interviewing times and video/telephone options – this worked well when arranging the interviews with advice hub leads during the Feasibility Study. Explain carefully context and value of research. Offer incentives for interviews. Explore obtaining input from less-researched healthcare workers (e.g., nurses, link workers, administrative staff) as well as GPs.

Limitation	Likelihood	Impact	Mitigations
Project specific risks			
External risks			
Covid-19 impacts on legal need and routes to resolution which has had a huge and constantly evolving impact on the social justice system, rights and entitlements and services that can be accessed for help.	Medium.	Medium.	Maintain positive working relationships with the HJPs will enable the evaluator to both formally and informally gain insight into the impact of Covid-19 on their service and clients.
Changes in local and national needs and priorities - this may include system changes such as an increase in social prescribing or the development of integrated care systems, wider funding and operational decisions at the hubs, the cost of living crisis and central government's agenda.	Medium.	Medium.	Stay abreast of national developments and how this may impact upon the advice provided and outcomes achieved. Regularly consider any local and national changes with the evaluation steering group. Where possible and relevant, explore any changes in qualitative interviews.

3.3 Measuring process

The below table sets out an approach for measuring HJP delivery. For each component of the ToC, the evaluation framework in the table below sets out suggested indicators to measure that component, along with data source and audience.

Table 12: Process Evaluation Framework.

ToC Component	Indicator	Data Source	Audience
Inputs			
Funding & service costs.	What are the current sources of funding.	Process evaluation (PE): Advice hub case studies	Strategic staff Advice hub leads.
Training for health professionals.	Whether training is provided for health professionals.	PE: Advice hub case studies.	Health professionals. Advice hub leads.
	Type of training provided.	PE: Advice hub case studies.	Health professionals. Advice hub leads.
	Degree to which community has influence over the way the co-located advice hub operates.	PE: Advice hub case studies.	Advice hub clients. Advice hub leads. Frontline workers.
Service delivery (i.e., referral) systems.	What methods of referral systems are used in each model of advice hub including technology/software used.	PE: Advice hub case studies.	Strategic staff. Health professionals. Frontline workers.
	What patient information is shared between the health and justice partners.	PE: Advice hub case studies.	Strategic staff. Health professionals. Frontline workers.
Activities			
Who: A not for profit advice agency (e.g. CA or a Law Centre) co-located or	Which advice agencies are delivering the legal advice service in the primary healthcare setting?	PE: Advice hub case studies.	Strategic staff.

ToC Component	Indicator	Data Source	Audience
partnered with a healthcare setting.			
How: Depending on the model, referrals may come from the healthcare provider or individuals may self-refer to the advice provider.	How is a client typically referred from the health to the justice partner? (incl. software/booking systems that are used). *Same as referral input.*	PE: Advice hub case studies.	Strategic staff. Advice hub leads. Health professionals. Frontline workers.
	What information about the patient is shared between the agencies, if any? *Same as referral input.*	PE: Advice hub case studies.	Strategic staff. Advice hub leads. Health professionals. Frontline workers.
What: Depending on the model and provider this may include: providing information and explaining options, identifying further action the client can take, providing support with tasks (e.g., form filling), casework, negotiating with third parties or the other side to the dispute, representation and litigation, and referring to other sources of support and advice.	Types of advice or assistance is offered to the client?	PE: Advice hub case studies.	Strategic staff. Advice hub leads. Frontline workers.
Outputs (improved access to advice			
Clients receive appropriate advice	Type of assistance received/given. *Same as assistance activity.*	PE: Advice hub case studies.	Strategic staff. Frontline workers. Advice hub clients.

ToC Component	Indicator	Data Source	Audience
and assistance for their problem/s.	Degree to which the advice was appropriate for the situation.	PE: Advice hub case studies.	Frontline workers. Advice hub clients.
	Actions taken from receiving advice.	PE: Advice hub case studies.	Advice hub clients.
Short-term Outcomes			
Improved capability/capacity			
Improves faith in the justice system.	Degree to which clients positively view the justice system and avenues for addressing legal needs.	PE: Advice hub case studies.	Advice hub clients.
Reduced burden on healthcare professionals allowing them to spend more of their time focusing on health issues.	How does the use of advice hubs impact on healthcare professionals' ability to focus on medical issues?	PE: Advice hub case studies.	Health professionals.
	Does the use of advice hubs reduce time spent writing up referral notes etc?	PE: Advice hub case studies.	Health professionals.
Problem resolution			
Increased or restored benefits.	Clients have increased access to benefits.	PE: Advice hub case studies.	Advice hub clients.
Debts reduced or managed.	Clients have been able to reduce debt or restructure debt so that payments are more manageable.	PE: Advice hub case studies.	Frontline workers. Advice hub clients.
Employment issues resolved.	Client employment issues are resolved promptly.	PE: Advice hub case studies.	Frontline workers.
Obtaining other entitlements or rights e.g., immigration help.	Client is on track/has gained access to other entitlements.	PE: Advice hub case studies.	Frontline workers.

ToC Component	Indicator	Data Source	Audience
Housing situation stabilised, e.g., possession action avoided, repairs made to rental property.	Client has remedied/is in the process of remedying their poor housing situation.	PE: Advice hub case studies.	Frontline workers.
Long-term Outcomes			
Improved socioeconomic situation for individuals			
Prevention of problem escalation and problem clustering.	Legal issue is dealt with more promptly than if no assistance was received through co-located advice hub.	PE: Advice hub case studies.	Frontline worker. Hub leads. Strategic staff.
Improved ability to manage finances.	Client is better able to manage personal finances.	PE: Advice hub case studies.	Frontline workers.
Reduced costs to Government and society			
Assumptions			
Working relationships - Healthcare and advice providers have strong, positive, collaborative working relationships, with clear processes for joint working and referrals.	Is the HJP positive and collaborative?	PE: Advice hub case studies.	Advice hub leads. Frontline advisors. Health professionals.
	Is there a clear process for referring clients between the health and justice partners? *Similar to referrals under inputs and activities.*	PE: Advice hub case studies.	Advice hub leads. Frontline advisors. Health professionals.
Ease of use and access - The service is easy to use for patients and staff, so	Referrals are made easily.	PE: Advice hub case studies.	Advice hub leads Frontline advisors Health professionals Advice hub clients

ToC Component	Indicator	Data Source	Audience
referrals are made and clients attend appointments. Clients can access these locations in the pandemic/post-pandemic world.	Proportion of missed appointments is low.	PE: Advice hub case studies.	Advice hub leads.
	Ease of accessing the advice hub.	PE: Advice hub case studies.	Advice hub clients.
Health professionals are able to identify when patients' issues have a legal dimension.	Ease with which health professional can identify legal issues when a client presents for a medical appointment.	PE: Advice hub case studies.	Health professionals. Frontline workers.

4. Economic evaluation approach

4.1 Overall approach

The economic evaluation should work alongside the process and impact evaluation to address the fourth objective of evaluation: "*Use the evidence related to the change in outcomes to determine the financial and economic benefits, including potential economic benefits to Government and wider society, to address RQ1, RQ2, RQ3".* The economic evaluation will consider the financial and economic costs and benefits of the intervention using the principles of HM Treasury Green Book, concerning appraisal and evaluation in central government, as well as the Magenta Book concerning complex evaluations. The evaluation will seek to quantify in economic terms:

- Changes in resource use in the justice and health and social care systems, as well as any other relevant government departments;
- Impacts on individuals relating to improved access to justice and resulting health benefits; and
- Wider societal benefits, such as the spillover effects of the creation of additional employment or getting people back to work.

The literature review found evidence to suggest that HJPs can help to resolve legal issues, resulting in benefits to individuals, the government and wider society. In turn this may lead to changes in the demand on other services, such as health, social care and other welfare services. The ToC provides a framework for how the inputs required to deliver these services link to the short term outcomes and longer term impacts associated with their implementation.

The key tasks of the economic evaluation are to identify, measure and value the incremental costs and outcomes associated with the interventions. On the basis of the Feasibility Study, a CBA approach will be adopted, consistent with advice in the Green and Magenta Books. CBA is a comparison of interventions and their consequences in which both costs and resulting benefits (health outcomes and others) are expressed in monetary

terms[10]. The benefit of this approach is that it allows costs and benefits to be appraised consistently, with financial values attached to costs and benefits. A true cost-effectiveness analysis, which evaluates the effectiveness of two or more treatments relative to their cost[11], has not been deemed feasible as it is unlikely that the evaluation will be able to identify and acquire sufficiently consistent data on a suitable comparator intervention. Rather, an approach which uses real world evaluation data to measure and value inputs and outcomes will complement the approach taken by the impact evaluation and identify real world consequences of the HJPs. The economic evaluation will operate in close proximity to the team managing the impact evaluation team as it will be necessary and agree reasonable counterfactual scenarios to quantify the incremental costs and benefits of these interventions. It is anticipated that this will make use of the data collected in user impact surveys. Where data are not available from the study sites, the literature review and expert elicitation will be used to understand the likely consequences of interventions. Any assumptions and uncertainties in the values obtained will be tested in sensitivity analysis and will be reported transparently within any outputs.

4.2 Economic protocol

In the initial stages of the evaluation, an economic analysis protocol will be developed and agreed with the MoJ project team. This should describe in detail the questions to be answered from an economic perspective including the high level and secondary level data required. It will also outline the modelling approach (design, functionality, inputs, assumptions, time horizon) and the analyses and sub analyses to be performed (including any analysis for inequalities), how results will be presented, and sensitivity analyses.

The protocol will include a detailed data specification, to identify the nature and source of data on costs and benefits, for both the intervention groups and for any agreed comparator group(s), in order to address the questions posed. The economic evaluation should link closely with the process and impact evaluations to ensure that the appropriate metrics are measured in a consistent way. Where data are to be obtained directly from project sites,

[10] Cost-Benefit Analysis [online]. (2016). York; York Health Economics Consortium; 2016. https://yhec.co.uk/glossary/cost-benefit-analysis/

[11] Cost-Effectiveness Analysis [online]. (2016). York; York Health Economics Consortium; 2016. https://yhec.co.uk/glossary/cost-effectiveness-analysis/

and/or service beneficiaries, the contractor should co-ordinate the data collection work with the other parts of the evaluation to reduce the burden on sites. For example, agreeing relevant content for case studies on HJP costs, content of client surveys and liaising on timing of survey work.

The set-up costs and ongoing running costs of HJPs should be included in the analysis and will be collected using a cost and resources survey. Using an agreed proforma, which will be piloted prior to deployment, information will be collected on the resources required to implement the interventions (e.g., project management, workforce, training,) and also information on the approach to managing the process (e.g., referral systems, data collection). It is currently envisaged that this will be undertaken with all participating HJPs and will be analysed based on the typology. This will require information on the budget allocated to the service and later on the actual expenditure on the service, so these may be compared. Using data agreed in the data specification, the healthcare resources used within the service (GP/practice time, advice worker time) for agreed patient cohorts can then be measured.

For the cost & resources survey, the information is shared with YHEC using a secure encrypted transfer method (providing the advice hubs use it as requested by YHEC) and will not be reported in an identified manner. The same method will be used for any further management information shared. No personal data or identifiable information will be requested from the advice hubs. All data will be aggregated. If data sharing agreements are required between the advice hubs and YHEC, these can be put in place.

Outputs and outcomes should be categorised into justice, health and social care and wider societal impacts. The primary outcomes will be the uptake of the health justice service and the impact on individuals, such as reported health outcomes and resolution of legal problems. Secondary outcomes will be use of primary care and other health and social care services and use of formal justice services (if available). The contractor should also consider any wider societal benefits such as the spillover effect of any additional employment created as a result of opening co-located advice hubs.

The Feasibility Study suggests that many HJPs record feedback from clients. All HJPs report having follow-up data on outcome or impact data (e.g. income gained, housing

situation stabilised, employment sustained) albeit not for all clients. Over half of the advice hubs interviewed reported having access to health outcomes. Some areas are specifically asked to collect data on, for example, anxiety and depression using the WEMWBS as an outcome measure. While this cannot be directly mapped to quality adjusted life years (QALYs), in order to put a value on the improved quality of life, it could potentially lend weight to the ToC assertion that HJPs contribute to improved mental wellbeing and reduced stress and anxiety[12].

Final questionnaires for clients after an issue has been dealt with ask outcomes such as whether the outcome was satisfactory, whether health and wellbeing has improved, and whether they are seeing the GP less often. Advice hubs are willing to share data where information governance allows, as most information is already anonymised. Generally, the HJPs do not have access to GP records, with the exception of two advice hubs which do. This enables access to data which may indicate improvements in health, such as reduction in medication, and fewer visits to the GP. These hubs will be asked to provide a sample of data to establish a base case scenario.

Based on this, client outcome data will be sought on the following:

- Reported health status.
- Value of benefits claimed.
- Use of healthcare services (e.g., GP, hospital).
- Use of social care services e.g., carer support.
- Resolution of legal/welfare problems.
- Use of legal services e.g., courts and tribunals.
- Income gained.
- Employment status.

[12] Johnson et al. Where's WALY?: A proof of concept study of the 'wellbeing adjusted life year' using secondary analysis of cross-sectional survey data. Health and Quality of Life Outcomes (2016) 14:126

An early draft of the data specification is shown below. This will be developed in more detail within the economic analysis protocol, and will include bespoke data acquisition methods, while also drawing upon metrics collected by the impact evaluation.

Table 13: Indicative data specification

Measure	Data required	Source of data/information	ToC indicator
Incremental resources required to mobilise and operate HJPs.	Workforce e.g., advice workers, GP practice time. Staff training. New systems e.g., IT infrastructure for referrals/data collection. Promotional materials. Project management.	Costs and resource survey. Advice hub case studies.	Activity related costs.
Justice, health and social care service use	Uptake of the health justice services offered.	HJP data systems. Literature evidence.	Outputs.
	Use of legal services e.g., courts and tribunals.	HJP data systems Literature evidence	Long-term outcomes.
	Use of healthcare services (e.g., GP, hospital).	Advice hub case studies. HJP data systems (with access to GP data). Expert elicitation.	Short- and long-term outcomes.
	Use of social care services e.g., carer support.	Literature evidence. Expert elicitation.	Short- and long-term outcomes
Impacts on individuals	Resolution of legal/welfare problems.	HJP data.	Short-term outcomes.
	Reported health status.	Client survey.	Long-term outcomes
	Income gained.	HJP data systems.	Short-term outcomes.

	Housing situation stabilised.	HJP data systems.	Short-term outcomes.
Wider societal benefits	Value of benefits claimed. Employment status.	HJP data systems.	Short-term outcomes.

Access to an early sample of data will be required to assess its suitability for analysis. Thereafter, an interim analysis of data gathered should be conducted and then again at the final stage of the evaluation. Appropriate time horizons for the different perspectives (justice, health and wider society) should be considered.

4.3 Economic analysis

The evaluator should calculate the incremental costs and value of incremental outcomes across the cohort of clients referred to the services, over an appropriate time horizon (to be agreed during the project mobilisation phase). Statistical analysis should be undertaken to test for the significance of any differences found in costs and outcomes between the intervention and comparator groups. Depending on the quality of the data generated, generalised linear mixed models can be developed in order to control for the impact of multiple confounding variables simultaneously on the outcome of interest, i.e., make statistical adjustments for any impact of imbalances between the two groups. Sub-analysis by HJP service model can also be included.

Reputable unit costs will be applied to the resources used by the service and in a counterfactual scenario, to determine the cost per case across the cohort. Examples of recognised sources of secondary data for these metrics are:

- Unit Costs of Health & Social Care[13].
- HES data[14].

[13] Jones K. and Burns, A (2021) Unit Costs of Health & Social Care 2021. Unit Costs of Health and Social Care. Personal Social Services Research Unit, Kent, UK. (Hospital based nurses).

[14] Hospital Episode Statistics, NHS Digital

- National Cost Collection[15].
- Greater Manchester Combined Authority Unit Cost Database[16].
- Legal aid statistics[17].
- DWP benefits statistics[18].
- Average weekly earnings (for productivity measures)[19].

Additionally, evidence from additional literature searching may also be used to provide input values for analysis, either where data are unavailable, or the value of outcomes is uncertain. This will be used to develop values for improved outcomes in terms of justice (e.g., increased income, improved housing or employments situations) and health (e.g., improvement in mental health conditions). In this event, literature evidence will be considered alongside any data available from HJPs, using average effect sizes across different studies, to inform plausible input values and ranges for sensitivity analysis.

The evaluator could develop an economic model using Microsoft Excel, since this is a format which can be easily shared among stakeholders. The 'results' section should contain a sensitivity analysis, to show which model inputs have the greatest impact on the results when varied within agreed ranges, and ideally allow the client to vary any inputs which are uncertain or may have a range of values in real world settings.

4.4 Risks and limitations

Table 14 summaries the key risks in relation to the proposed approach to the economic evaluation. For each risk, the likelihood and impact of the risk has been indicated, as well as possible mitigating actions and relevant learnings from the Feasibility Study.

[15] National Schedule of NHS Costs

[16] https://www.greatermanchester-ca.gov.uk/what-we-do/research/research-cost-benefit-analysis/

[17] https://data.justice.gov.uk/legalaid

[18] Department of Work & Pension, Benefits Statistics, available at: https://www.gov.uk/government/collections/dwp-statistical-summaries

[19]https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/earningsandworkinghours/datasets/averageweeklyearningsearn01

Table 14: Risks and limitations to the economic evaluation.

Risks	Likelihood	Impact	Mitigations
Data availability (inc for counterfactual group).	Medium.	High.	Obtaining an early sample of the data is advisable, to ensure that data extraction works as intended. Alternative approaches can be devised if required.
Burden of data collection on advice hubs.	Medium.	Medium.	Data collection methods will be designed in conjunction with MoJ, tested with a sample of HJPs and adjusted accordingly to reduce burden on sites. In the event of non-respondents (and hence limited data), sensitivity analysis will be performed to test potential uncertainty in values.
Lack of data on other service/resource use.	Medium.	Medium.	This may be a challenging due to the lack of co-ordinated data collection systems in this sector. The project should use the advice hubs which have access to primary care data systems as a base case scenario, which can be tested in sensitivity analysis. Sufficient time should be allowed to access the required data (particularly health service data), to avoid project delays.
Poor data quality.	Low-medium.	Medium.	Use only reputable sources of secondary data and perform

Risks	Likelihood	Impact	Mitigations
			scenario analysis to assess the impact of variation in the data values used in the analysis.
Longer term outcomes not measurable within the timeframe of the evaluation.	Medium.	Medium.	Seek specific literature evidence for evidence to link short term measurable outcomes to longer term outcomes.
Data management.	Low.	Medium.	Any data of a sensitive/confidential nature will be transferred using a secure encrypted transfer method and processed in a secure IT environment. All data will be aggregated and no information will be reported in an identifiable manner.

4.5 Measuring economic impact

The below table sets out how the economic impact of HJPs can be measured via the evaluation. For each component of the ToC, the evaluation framework in the table below sets out suggested indicators to measure that component, along with data source and audience.

Table 15. Economic Evaluation Framework.

ToC Component	Indicator	Data Source	Audience
Inputs			
Funding & service costs.	What are the current sources of funding? What are the costs of delivering the service?	Economic Evaluation (EE): Advice hub case studies. EE: Cost & resources survey.	Strategic staff. Advice hub leads. Advice hub leads.
Training for health professionals.	Whether training is provided for health professionals	EE: Advice case studies.	Health professionals. Advice hub leads.
Service delivery (i.e. referral) systems.	What resources are deployed within practices to implement new service/systems?	EE: Practice surveys	GP practice staff.
Short-term Outcomes			
Improved capability/capacity			
Reduced burden on healthcare professionals allowing them to spend more of their time focusing on health issues	Does the use of advice hubs reduce time spent writing up referral notes etc?	EE: Advice case studies.	Health professionals.
Problem resolution			
Increased or restored benefits.	Clients have increased access to benefits.	EE: Advice hub data systems.	Advice hub clients & comparison group *Baseline & follow uP*
Debts reduced or managed.	Clients have been able to reduce debt or restructure debt so that payments are more manageable.	EE: Advice hub data systems.	Advice hub clients & comparison group. *Baseline & follow up.*

ToC Component	Indicator	Data Source	Audience
Employment issues resolved.	Client employment issues are resolved promptly.	EE: Advice hub data systems.	Advice hub clients & comparison group. *Baseline & follow up.*
Obtaining other entitlements or rights e.g., immigration help.	Client is on track/has gained access to other entitlements	EE: Advice hub data systems.	Advice hub clients & comparison group *Baseline & follow up*
Housing situation stabilised, e.g., possession action avoided, repairs made to rental property.	Client has remedied/is in the process of remedying their poor housing situation.	EE: Advice hub data systems.	Advice hub clients & comparison group. *Baseline & follow up.*
Long-term Outcomes			
Improved socioeconomic situation for individuals			
Prevention of problem escalation and problem clustering.	Legal issue is dealt with more promptly than if no assistance was received through co-located hub.	EE: Advice hub data systems.	Advice hub clients Baseline and comparison group. *Follow up.*
Improved ability to manage finances	Client is better able to manage personal finances.	EE: Advice hub data systems.	Advice hub clients & comparison group. *Baseline & follow up.*
Improved mental wellbeing, including reduced stress/anxiety.	Client has improved mental wellbeing.	EE: Client survey.	Advice hub clients & comparison group. *Baseline & follow up.*
Improved physical wellbeing, including diet, exercise, sleep.	Client has physical mental wellbeing.	EE: Client survey.	Advice hub clients & comparison group. *Baseline & follow up.*

ToC Component	Indicator	Data Source	Audience
Reduced costs to Government and society			
Reduced demand on the formal justice system (courts and tribunals).	Use of legal services for problems amenable to welfare advice.	EE: Advice hub data systems, literature evidence.	Legal services staff.
Reduced demand on wider public services	Use of social care services. Increased productivity via changes in employment status.	EE: literature evidence and expert elicitation. Hub data systems, literature evidence.	Social care staff.
Reduced demand on the healthcare system.	Use of primary care services. Use of healthcare services for health-related problems.	EE: Hub data systems. Practice surveys. EE: literature evidence and expert elicitation.	GP practices. Health professionals. GP practices.

5. Quality assurance and ethics

Table 16 below details elements of the quality assurance (QA) plan for the process, impact, and economic evaluations.

Table 16. Quality Assurance Plan.

Project activity	Quality Assurance Milestone
Feasibility report.	Quality review prior to submission.
	Peer review of feasibility approach.
Economic analysis	Technical validation of models.
	Final review on quality of narrative.
Surveys	Survey programming.
	SPSS and table specifications.
	Coding of open-ended responses.
	Data quality inc. quick responses, illogical responses, outliers etc.
	Final data checks against raw data files.
	Propensity score matching checks
Interviews/groups	Review of draft interview scripts.
	Consistency check after initial interviews and random selection listened into.
	Sign off analysis framework.
	Qualitative interviews entered into analysis framework.
Reports	Development of report blueprint structure.
	Accessibility check.
	Figure check primary data sources.

Project activity	Quality Assurance Milestone
	Internal review of York submission and alignment to rest of report.
	Quality review prior to submission to MoJ.
	Check that all comments from MoJ and peer review have been acted on fully and appropriately.

QA is an important part of the data analysis and modelling process. All economic analyses will be subject to YHEC's internal analysis QA procedure, which includes sense-checking of the analysis plan, verification of the computational accuracy of the variables and analysis, and checks for transcription errors. The QA processes are completed by a member of staff with relevant expertise who is not involved in the analysis itself. Typically, the process will include:

i. Analysis plan sense-checking.

ii. Analysis verification of computed variables and final analysis.

iii. Transcription checks for 20% of reported analyses.

iv. Medical writer review of the final report.

For a model or calculator, the QA will involve checking the formulae to ensure that they are both correct and appropriately applied, using a standard checklist. The checklist includes a range of tests, including sense checks, for instance, changing certain inputs to zero and checking that the observed effect is as expected. For some research projects, additional checks are introduced, with appropriate adjustments to timescales and budget.

5.1 Ethical approval

The distinction between research and evaluation can be indistinct, particularly where study design and methods are similar - in this case, interviewing healthcare professionals and HJP clients as part of the process evaluation. The project team have taken advice from the Chair of the University of York Health Sciences' Research Governance Committee (HSRGC), with regard to any further requirements for ethical approval which may be

required. As noted above, this proposed service evaluation does include some methods, such as interviews with advice HJP clients, where there is the potential for interviews to create ethical issues or other risks for participants (e.g., identifying sensitive data or creating distress), which may warrant ethical approval. Furthermore, if there is a possibility of wishing to publish results in the future, journals might require some form of ethics review/approval. As such, the project team concluded that the evaluation plans should be submitted to the HSRGC for consideration in the first meeting of 2022. Ethical approval was granted by the HSRGC in May 2022, giving assurance that our research methods align with the principles of research ethics, as set out by the Government Social Research (GSR) unit and the Social Research Association's (SRA) Ethical Guidelines, set out below[20]:

- Principle 1: Research should have a clear user need and public benefit.
- Principle 2: Research should be based on sound research methods and protect against bias in the interpretation of findings.
- Principle 3: Research should adhere to data protection regulations and the secure handling of personal data.
- Principle 4: Participation in research should be based on specific and informed consent.
- Principle 5: Research should enable participation of the groups it seeks to represent.
- Principle 6: Research should be conducted in a manner that minimises personal and social harm.

After careful consideration, IFF Research and YHEC believe that the proposed evaluation does not require further ethical approval from the Health Research Authority (HRA). The HRA's online tool for determining whether a research project requires HRA or NHS ethical

[20] GSR professional guidance for ethics: 2021-GSR_Ethics_Guidance_v3.pdf (publishing.service.gov.uk) and SRA 2021 ethics guidance SRA Research Ethics guidance 2021.pdf (the-sra.org.uk)

approval produced inconclusive results[21]. Consequently, the project team contacted the HRA asking for further clarification. The HRA response indicated that service evaluations do not require HRA or NHS ethical approval. Specifically, the HRA stated that:

> *Where a project is considered to be non-research, e.g., solely audit or service/therapy evaluation, it will not be managed as research within the NHS/HSC or social care. Such projects do not require ethical review by an NHS/HSC or Social Care Research Ethics Committee or management permission through the NHS/HSC R&D office. Under these circumstances, there is no need to submit applications to the NHS Research Ethics Committee, NHS/HSC R&D office or HRA and HCRW Approval.*

While service evaluations do not require ethics approval, the distinction between research and evaluation can be indistinct, particularly where study design and methods are similar - in this case, interviewing healthcare professionals and advice hub clients. However, the HRA clarified that: *A REC review is not normally required for research involving NHS or social care staff recruited as research participants by virtue of their professional role.* The proposed interviews with healthcare professionals are scheduled to take place as part of the process evaluation. The interviews are focussed on trying to understand the logistics of how the HJP works in that primary healthcare care setting at a global level rather than focussing on the medical or personal issues raised by individual patients – which may pose more of an ethical risk than what is proposed.

Further recruitment for HJP clients will be done through the advice hubs rather than through the healthcare setting the advice hub is affiliated with. As a result, ethical concerns regarding the vulnerability of these participants will be addressed by the University of York' HSRGC (below).

The fact that individual patient records will not be accessed as part of the evaluation gives further reassurance that NHS ethics approval is not required. While the evaluation aims to obtain some information on patient journeys as part of the economic evaluation, this would be provided at an aggregate level by only two of the HJPs. Furthermore, the methods used for data sharing will follow strict good practice for information governance, to ensure all

[21] http://www.hra-decisiontools.org.uk/

sensitive data are protected during the transfer and processing for analysis. For the cost & resources survey, the information is shared with YHEC using a secure encrypted transfer method (providing the advice hubs use it as requested by YHEC) and will not be reported in an identifiable manner. The same method will be used for any management information. No personal data or identifiable information will be requested from the advice hubs. All data will be aggregated. If data sharing agreements are required between the advice hubs and YHEC, these can be put in place.

5.2 Ethical considerations

The research should be conducted in accordance with the principles of research ethics, as set out by the GSR unit and the SRA's Ethical Guidelines[22]. This evaluation will likely be engaging individuals who are experiencing complex, stressful and upsetting problems, and so research approaches will need to be sensitive to such issues. Key ethical concerns are covered as follows:

1. **Informed consent:** Participants must understand who is doing the research, its purpose, what data are being collected, whether and how the session is being recorded or observed, and how the results and their personal data will be used. They must also understand their participation is voluntary, and that they can stop or withdraw at any time. This information should be given both at the point of recruiting participants and reinforced immediately prior to participation – both verbally, and via an "information sheet".

2. **Ensuring accessibility of participation:** Ensure that participation is accessible to all those that the research is relevant for, and that the interview experience is a positive one for the participant is important. This includes ensuring appropriate design of materials, using researchers trained in interviewing vulnerable individuals, including disabled people and people with long-term health conditions, and ensuring individuals' specific needs are catered for. Clients whose first language is not English may wish to bring someone to translate for them, however the sensitive issues discussed may require the use of professional translators. All

[22] GSR professional guidance for ethics: 2021-GSR_Ethics_Guidance_v3.pdf (publishing.service.gov.uk) and SRA 2021 ethics guidance SRA Research Ethics guidance 2021.pdf (the-sra.org.uk)

online surveys will be digitally formatted so they can be accessed and read easily on a mobile phone and the option to opt for a telephone survey will be made available for advice hub clients.

During the Feasibility Study interviews, advice hub clients were asked what their preferred method of communication was for future interviews. The responses were mixed, with some preferring telephone and others Zoom/Microsoft Teams. As a result, an interviewing approach which can adapt to participants preferred style of communication is recommended. It is likely that when giving their communication preference, many advice hub clients were thinking of qualitative interviews in a similar style to the one they were participating in, hence the preference for 'talking' channels – this does not necessarily mean that online quantitative research would be ineffective with this group. Advice providers tend to send follow up information and forms via email after the first appointment with their clients which suggests the majority of clients are likely to be digitally literate, however the option for telephone administered surveys will be made available for those who prefer that. While it will not be possible to source through the counterfactual group through a combination of an online panel and RDD telephone sample the limitations of comparing the treatment group with a group recruited only through an online panel will be made explicit when reporting.

3. **Avoiding personal and social harm**: The Feasibility Study found that advice hub clients are likely to be experiencing sensitive and stressful situations, particularly given the dual components of legal and health concerns that they are dealing with. Guides and surveys should avoid antagonising their situation, ensuring that topics covered by the research are only as sensitive as absolutely necessary in order to meet the objectives. Researchers should also stress in advance, and during the interview or survey, that taking part is entirely voluntary and that no answer is mandatory.

A safeguarding policy should ensure that all project interviewers are equipped to:

- **Recognise** that a participant is being harmed or is at risk of harm or neglect. This is done by understanding and promoting safeguarding practice throughout the project.
- **Respond** appropriately to what you are being told or what you see that may be a safeguarding concern.
- **Report** concerns to the Project Directors as soon as possible as well as the appropriate authorities if needed.
- **Record** the situation, key information and steps taken. Be accurate and comprehensive.

Researchers should inform participants of the safeguarding disclosure policy during recruitment, in the confirmation email, and in the introduction to the discussion.

With most research being conducted remotely, Covid-19 does not present a high risk, although where face-to-face research does occur, researchers should be mindful of taking measures to reduce spread e.g., through choice of venue.

To reflect gratitude for the time that advice hub clients contribute towards this evaluation, thank you payments can be offered – for example a £5 incentive for taking part in the baseline and follow up interviews and £40 for participating in a qualitative interview. It is important to acknowledge the valuable contribution these vulnerable participants are making. It can be difficult to engage healthcare professionals with research as they are time-poor and receive many research requests (e.g., from pharmaceutical companies). A thank you of £75 for each of these interviews therefore feels appropriate and an interview length of no more than 45 minutes as well as offering flexibility in interviewing times and video/telephone options.

Protects individual confidentiality: In reporting all outputs should be anonymised to preserve participant confidentiality. Researchers should make it clear to advice hub clients that nothing they say will be passed back on a named basis to the HJP or to the MoJ. For stakeholder interviews, there may be some instances where it is helpful to link responses to a particular HJP – for example, to bring a case study to life. In these instances, permission should be collected from stakeholders to have their views attributed but also allow them to feedback additional information on an anonymous basis, so they still have a chance to speak fully and frankly.

The literature review found three papers which made note of ethical concerns over interaction and information sharing between medical and legal services. One paper simply noted that this was a concern (Fuller 2020 [4]). Two Australian papers evaluating the benefits of HJP services in Melbourne hospitals noted that social workers and lawyers had difficulty keeping each other updated in situations in which lawyers were bound by confidentiality (Inner Melbourne Community Legal, 2018 [2]; Inner Melbourne Community Legal, 2018 [3]). Only one paper addressed ethical issues around including a control group of patients who would not receive support (Benfer 2018 [7]). The authors of this observational study of five MLPs in Connecticut suggested that it may be possible to randomize “based on lack of capacity — for instance, some MLPs only have attorneys certain days of the week — or when legal services are not triaged based on greatest need.”

5.3 Data protection and security

In line with confidentiality requirements, it would be expected that an evaluator is registered with the Information Commissioner’s Office and accredited with **ISO27001**, the international standard for information security, as well as **Cyber Essentials** if possible. Data transfer and storage should both be secure. It is also important to be fully compliant with the requirements of the Data Protection Act and **GDPR**, with GDPR training given to all staff members.

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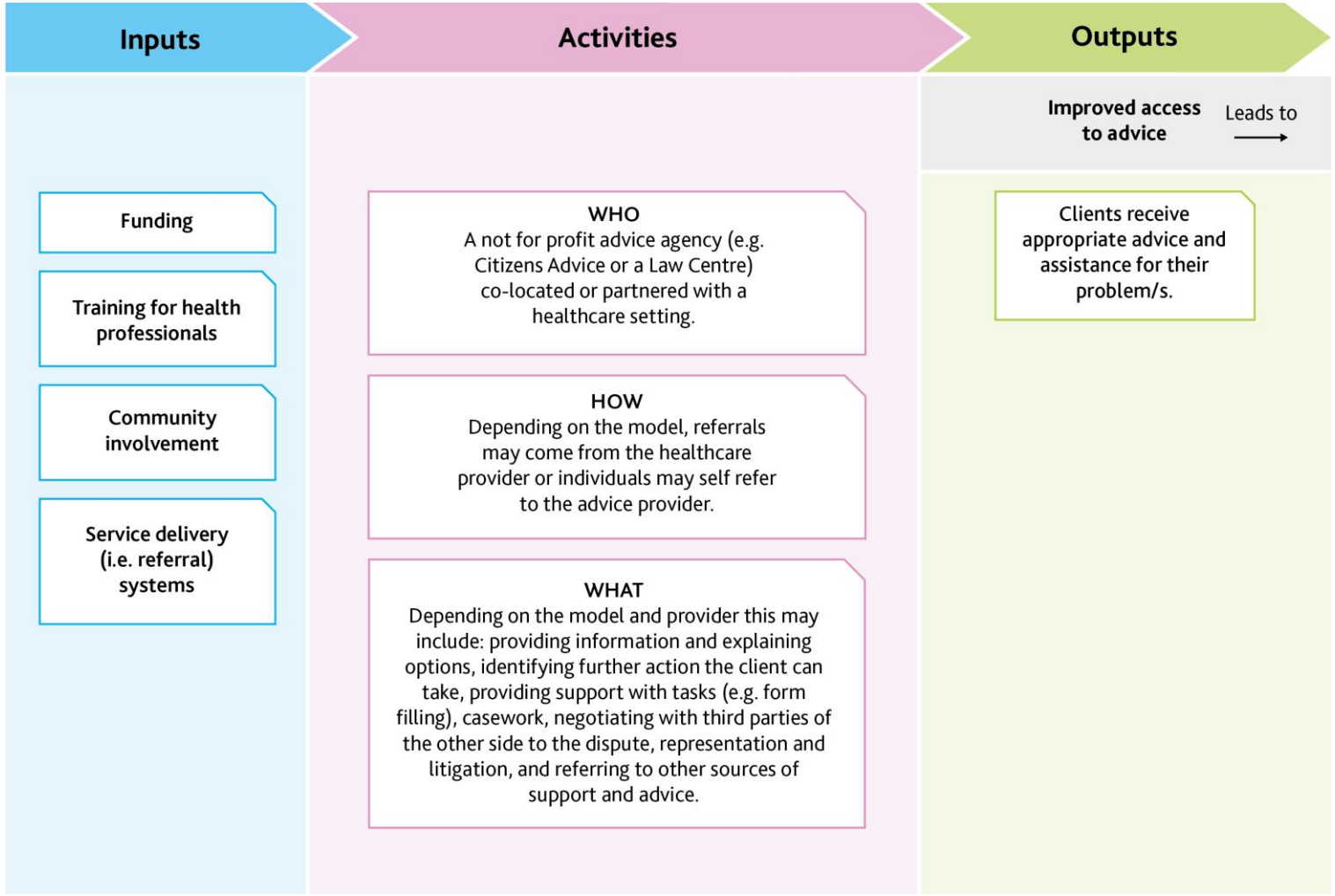
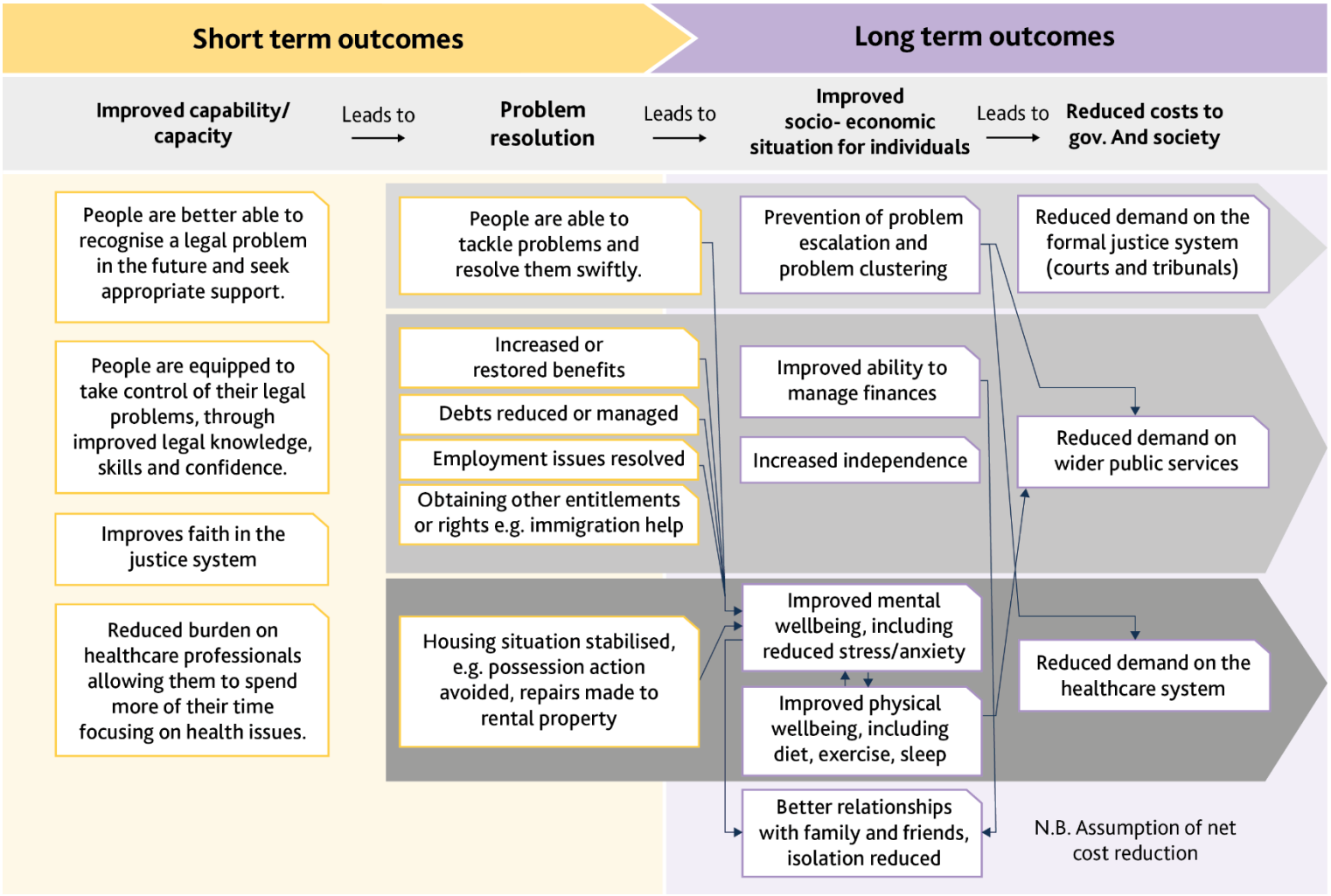
Appendix A: Theory of Change for HJPs

Figure 1: HJP theory of change.

See the full Feasibility Study published alongside this report for a detailed explanation of the ToC including the context and problem statement as well as assumptions, risks and external influences.




Short term outcomes
Long term outcomes
Improved capability/ capacity
Leads to
Problem resolution
Leads to
Improved socio- economic situation for individuals
Leads to
Reduced costs to gov. And society
People are better able to recognise a legal problem in the future and seek appropriate support.
People are equipped to take control of their legal problems, through improved legal knowledge, skills and confidence.
Improves faith in the justice system
Reduced burden on healthcare professionals allowing them to spend more of their time focusing on health issues.
People are able to tackle problems and resolve them swiftly.
Increased or restored benefits
Debts reduced or managed
Employment issues resolved
Obtaining other entitlements or rights e.g. immigration help
Housing situation stabilised, e.g. possession action avoided, repairs made to rental property
Prevention of problem escalation and problem clustering
Improved ability to manage finances
Increased independence
Improved mental wellbeing, including reduced stress/anxiety
Improved physical wellbeing, including diet, exercise, sleep
Better relationships with family and friends, isolation reduced
Reduced demand on the formal justice system (courts and tribunals)
Reduced demand on wider public services
Reduced demand on the healthcare system
N.B. Assumption of net cost reduction

Appendix B: Glossary of technical terms

Table 17: Glossary of technical terms

Term	Definition
Confounding variables.	A confounding variable is a variable that hasn't been accounted for, that can suggest there is correlation when there isn't or introduce bias.
Cost-benefit analysis.	Cost-benefit analysis is a comparison of interventions and their consequences in which both costs and resulting benefits (health outcomes and others) are expressed in monetary terms. This approach allows costs and benefits to be appraised consistently.
Counterfactual group.	The counterfactual group acts a proxy for what would have happened to beneficiaries in the absence of the intervention, in order to estimate the impact of a specific intervention.
Covariates.	Covariates are characteristics of the participants in an experiment (e.g. demographics). If you collect data on covariates before you run an experiment, you can use that data to see how the intervention affects different populations.
Generalised linear mixed models.	A generalised linear mixed model is a statistical model which describe the relationship between variables. Mixed effect models are useful when we have data with more than one source of random variability, for example, if an outcome is measured from the same person more than once, and so within-person and across-personal variability needs to be accounted for.
Lifestyle databases.	Lifestyle databases consist of individuals with phone numbers compiled from a range of different sources, to which it has been possible to match gender and age (e.g., through matching to the electoral roll). Having this demographic sample makes it possible to target people in the harder to reach groups, enabling the research to reach a more representative profile (by age and gender).

Propensity score matching.	Propensity score matching is a quasi-experimental method in which the researcher uses statistical techniques to construct an artificial control group by matching the intervention unit with a control group unit of similar characteristics. For further detail please see Appendix B.
Quasi-experimental design.	Quasi-experimental design attempts to establish cause-and-effect without using random assignment. Quasi-experimental designs encompass a broad range of techniques that are frequently used when it is not feasible or ethical to conduct a randomised control trial.
Random Digit Dialling.	A random digit dialling sample consists of phone numbers that have been randomly generated – this approach can be used to generate both landline and mobile telephone numbers.
Randomised Control Trial.	A randomised control trial is a study in which people are randomly assigned to two (or more) groups to test a specific intervention. One group receives the intervention, the other has an alternative or no intervention at all.
Regression.	A regression is a statistical technique that estimates the relationship between two or more variables of interest.
Sample size.	A sample size is a part of the population chosen for a survey or experiment. The sample size is important for any study which seeks to make inferences about a population based on the sample. In practice, the sample size is commonly determined based on the cost, time or ability to collect data, as well as the need for it to offer sufficient statistical power.
Sensitivity analysis.	Sensitivity analysis is an assessment of the sensitivity of a model to its modelling assumptions. It seeks to learn how sensitive the model outputs are to changes in inputs and how that sensitivity might affect overall findings.
Statistical power.	Statistical power is the likelihood of a statistical test detecting an effect when there actually is one. High power in a study indicates a large chance of detecting a true effect. Low power means there is a small

	chance of detecting a true effect or that the results are likely to be distorted by random and systematic error.
Statistical significance.	Statistical significance helps to quantify whether a result is likely due to chance. A high degree of statistical significance indicates that the relationship is unlikely to be due to chance.
Theory of Change.	A theory of change is a comprehensive description and illustration of how and why a desired change is expected to happen in a particular context.