



**Wales Centre for Public Policy**  
**Canolfan Polisi Cyhoeddus Cymru**

# What Works in Tackling Rural Poverty:

## An Evidence Review of Interventions to Improve Access to Services

**John Powell, Dan Keech and Matt Reed**

Countryside and Community Research Institute

University of Gloucestershire

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# Summary

- Interventions to improve access to services are undertaken largely by central government, rather than the voluntary or community sectors, and fall into three broad categories:
  - ‘one stop shops’ or hubs that centralise a number of services;
  - ‘place-based’ approaches where portals or service centres are located within targeted areas identified as most in need (i.e. closer to those requiring support);
  - taking services to those in need (e.g. through home visits).
- Centralisation of services through one stop shops and resource ‘hubs’ is not new. There are many examples, although an approach that works in one area may not be directly transferable to another context. Working with local stakeholders, forming partnerships, and assessing local needs are critical elements for designing effective interventions.
- Place-based approaches can provide more selective targeting of service delivery and smaller-scale actions focused on specific groups or sectors of society. Evidence suggests community-based delivery can be effective in accessing hard-to-reach groups.
- Health and welfare service delivery in rural areas is dependent to a large extent on the larger format of the national delivery systems for these services, which dictate the flexibility of options for rural delivery.
- Programmes to enhance certain types of service availability (such as child-care) can be targeted at specific localities or sectors of society (e.g. low-income households). Increasing the level of affordable child-care can deliver multiple benefits including job creation, building social capital and networks, releasing people for employment, and improvements in the quality of child care.
- Home-based delivery of services can be effective in reducing social exclusion and increasing people’s access to services. Costs of home-based delivery can be reduced through using local residents on a part-time and/or voluntary basis. The effectiveness of home-based delivery is dependent on high quality training and good relationships with a large number of relevant government agencies.

# Introduction

The Welsh Government has supported a wide range of programmes to address rural poverty and yet recent estimates suggest that almost a quarter of the rural population of Wales is living in poverty. The causes of rural poverty are complex and multi-faceted, but access to services is known to be an important contributory factor.

This report focuses largely on access to health and welfare services, and to affordable child care, exploring the potential for improving service delivery in rural areas of Wales. Access to financial services has not been addressed in the report (other than one example in Australia). Access to financial services and advice (particularly for small businesses) is largely covered in the report on 'Rural economy interventions'. The development of internet banking and internet access to other financial services has reduced the significance of this problem to some degree.

This report explores interventions undertaken in a number of developed countries to improve access to a range of services in rural areas. The evidence provided is based on a literature review and web-based search conducted between December 2016 and February 2017. The report describes a small number of interventions for which evidence of impact was found, it summarises what has worked elsewhere, and discusses the policy implications for application in Wales. The evidence from this report is focussed on access to services but it will also feed into an overall report which examines the implications of the evidence across a number of priority areas for rural development and rural poverty.

## Description of interventions

Access to services is largely managed through government intervention, rather than by the voluntary or community sectors. There have been three identifiable approaches:

- Government service delivery through a 'hub' or 'one stop shop' whereby the customer only needs to go to one location to access a wide range of services, delivered by government employees.
- A 'place-based' approach whereby portals or service centres are located in areas identified as most in need (i.e. closer to those requiring support), and services are delivered by state/central government or through a partnership approach made up of local community organisations (sometimes with local authority involvement) underpinned by government funding.

- Using trained personnel (sometimes local paid part-time, or volunteers) to take services to those in need (e.g. through home visits), typically providing support to old people and health care in the home.

Resource hubs have been developed in an effort to create more effective welfare systems that integrate a range of services, and to make it easier for service users to access (what is presented as) a seamless range of linked services. The place-based approach has developed to make it easier to support the more hard-to-reach groups in a population by providing access to services much closer to the area of identified need. The third approach relies more on identifying those with specific needs in communities and taking the service to the household/individual requiring support. A fourth approach, using internet access, is developing in some areas (particularly health services in remote locations) and is changing the nature of access, with the result that not all services need to be present in a centre or hub in order for a customer to get support. This can be considered more as an extension of the first or second approach.

The majority of interventions identified (summarised in Table 1) are concerned with either access to employment and a state's welfare benefits system, or access to health care. In some countries there are more targeted programmes to address specific issues; for example, access to financial services in remote parts of Australia (the Rural Transaction Centres), and access to child care in rural areas of the USA. Relatively little was found with regard to improving access to training, skills development, and education services, other than in the USA where there have been long running programmes (such as 'Head Start') targeting low income households and based on theories regarding improvement in life-long opportunities arising from early age child support. No interventions were identified with specific goals of enhancing access to recreational and/or social activities in rural areas (except for those linked to mental/physical health improvements). Although this report does not address the large scale early years intervention programmes that have been delivered in the USA (such as Head Start), and more recently in the UK (e.g. Sure Start), it is worth providing a brief overview here. These are large scale national programmes targeting families with young children in deprived areas, with significant resources to establish, operate, and evaluate a range of child and parent-centred support programmes. Although Head Start has been delivered in the USA over a long period of time, and there have been countless evaluations (Isaacs, 2008; Gibbs, et al., 2016), the evidence of impact is still unclear. In the UK, central government initiated the Sure Start programme in 1998, though its involvement was short-lived, and responsibility was soon devolved to local authorities, which had flexibility in the focus and approach taken, and few obligations to continue delivery. When it began, Sure Start was an area-based approach (with variations in Wales, Scotland and Northern Ireland), aimed at improvement of childcare, early education, health and family support, in order to tackle child poverty and social exclusion. By 2003 responsibility was transferred to local

government to operate 'sure start centres', and this was followed by funding cuts and in some places, such as Oxfordshire, closure of all Sure Start centres by 2017 (BBC News, 2016; Guardian Newspaper, 2017). Evaluations undertaken at national and more local levels (NESS, 2008, 2010, Hutchins, et al., 2007) indicate mixed results, partly due to the variable nature of programme delivery across the country, and outcomes remain controversial. Wales has also seen changes in the implementation approach (e.g, Cymorth was delivered through local Children and Young People's Partnerships within each local authority). Currently Flying Start (Welsh Government, 2012) is targeted at families with children under 4 years of age and living in disadvantaged areas of Wales. A total of 37,260 children accessed Flying Start services in Wales (2014-15 figures) which is anticipated to increase. Flying start provides free part-time childcare for 2-3 year olds, a health visiting service, parenting programmes, and support for speech, language and communication development.

**Table 1. Summary overview of interventions influencing access to services**

**Subject: Access to Services**

<b>Intervention</b>	<b>Location</b>	<b>Characteristics</b>	<b>Description of intervention</b>	<b>Evaluation</b>
One stop shops: Heartland Services	New Zealand	Provision of services to remote and low density population. Operation: 2001 - present	Co-location of wide range of government services and information within a single point. Links 36 government departments and 50 community organisations. Uses site-based coordinators.	Process evaluation (conducted 2004) suggests significant cost savings (but limited in quantitative data). Identifies strengths and weaknesses, and some of basic requirements to make it work.
Pilot one stop shop service	N. Ireland	Support to young people around personal and lifestyle issues. Operation: 2009-2011	Piloted the development of dedicated “One Stop Shop” services for young people, offering drop in information and advice services in relation to alcohol and drug misuse, suicide and self-harm, mental health and wellbeing, sexual health, relationship issues, coping with school/employment.	Effectiveness measured via a set of key performance indicators. From a strategic point of view model considered successful in that all aspects of all of the KPIs were achieved. Very high level of satisfaction expressed by users (helpfulness of staff (94%), help with issues or problems (88%), confidentiality of the service (86%) and service location (85%)) is a significant and positive achievement.
New Employment and Welfare Administration (Norwegian abbreviation: NAV)	Norway	To coordinate national insurance and employment services and social services, the NAV reform established a one stop shop – a joint frontline service – in each municipality.  Operation: 2006 - 10	New Employment and Welfare Administration (Norwegian abbreviation: NAV) with a one stop shop called a NAVoffice. The one stop shop organized as a partnership between the merged employment and insurance administrations (a central government responsibility) and the social services administration (a local government responsibility). Mandatory for municipalities to participate; financial social assistance from the municipalities (social benefits) had to be offered through the one stop shops. In addition, a range of other municipal social services ‘could be’ included in a specific local partnership.	NAV reform merged the administrations for national insurance and employment, but the social services administration remained a local government responsibility. In 90% of cases municipalities opted to include non-mandatory municipal tasks in their task portfolios. For instance, most municipalities decided to include treatment for drug abuse and social housing in the one stop shops. In 90% of cases the partnerships chose unitary management, meaning that one person is in charge of both the municipal and the state side of the partnership.



**Subject: Access to Services**

<b>Intervention</b>	<b>Location</b>	<b>Characteristics</b>	<b>Description of intervention</b>	<b>Evaluation</b>
Municipal level job centres	Denmark	Single one stop shop system with 'one entrance' to the employment arena.  Operation 2009: present	In 2009 government decided that municipalities should take over responsibility for the insured unemployed and payment of unemployment benefits. All employment services would be offered in one stop shops – job centres – that would be backed by municipal operational responsibility but subject to central regulation.	Structure as it currently stands is quite simple, with the job centres now run solely by the municipalities with a high level of autonomy. Municipalities are comparatively strong decentralized units.
Midgley Community Room	England, Pennines, Yorkshire	Provision of local services by a community forum. Operated: 2001-10	Comprises a shop and community room. Population of 1,040 has access to services. 40 volunteers run shop and community room.	Shop open 48 hours over 6 days/ averages 80 customers/day. Stronger community built; reduced isolation, social networks strengthened
Rural Transaction Centres	Australia	Access to a range of government information and services, private sector services and products, and office space for community uses	Rural Transaction Centres (RTC) are intended to assist small communities to establish centres to improve access to basic services that would otherwise not be available. Each RTC responds to the needs of specific communities.	Limited evaluation data from 2003 suggests a range of problems in implementing the RTC programme. Slow implementation, limited number of centres established; lack of financial services offered.
Local Community Net, Finland	Finland	Service delivery through internet communications (conferencing, email and web-based communications)	The Local Community Net project was a pilot project which aimed to provide a service to the local area which would encourage the establishment of a community network based on computer conferencing, email and web-based communications. The project had particular objectives to prevent social exclusion, support social innovation, and to improve services and living conditions in the pilot area.	

**Subject: Access to Services**

Intervention	Location	Characteristics	Description of intervention	Evaluation
Village Agent scheme	England	Supporting people living in rural communities to access services, and helping to shape service delivery  Operation: 2008 onwards (although scheme has ended in some areas)	Village Agents work with all ages dealing with a wide variety of issues, although tend to have a focus on elderly and social care issues. Village Agents also: - help to shape services by feeding back information about gaps in service - motivate and support a community to respond to local needs  Potential for integrating into wider work - reducing isolation and exclusion, supporting services.	Evaluation of Gloucestershire Scheme in 2008 revealed 30 agents covering 162 parishes working within clusters of communities that have limited or no access to services locally. Offers low cost means of helping people access services using part-time and trained local people who live in the area and are trusted by local community. Village Agents in Gloucestershire helped local people increase their benefit claim by £6,000 per week, and access more services
Rural Childcare network	S.W. region, England	A group of community based childcare organisations that work together.  Operation: 2007-13 (RDP funding)	Established to provide a range of support services for member playgroups. Services include: - • mentoring support for business planning • web-site to share information and services: applying for grants, payroll, and group purchasing to reduce overhead costs. • access to two shared relief childcare workers to cover for staff off sick	Initial funding came from the South West Action for Rural Development (SWARD). Shared services reduce costs to individual child care providers. No formal evaluation identified.
Child Care Programme. Vermont Community Loan Fund (VCLF)	Vermont, USA	Community-focused alternative lender. Makes loans to child care providers who don't qualify for a loan from a traditional lender.  Operation: 2000 present	Combines loans with financial consulting and business development services. VCLF is a private, non-profit alternative lender. Wide range of programmes including child care	Created or preserved quality care for 3,400 children and their families. Child care programme evaluation shows that VCLF serves companies that support more low-income families: 44.8% of VCLF total enrolment are low-income compared to under 30% state-wide. VCLF enables greater access to quality infant and toddler care: 85.6% of infants in programs run by VCLF borrowers are enrolled in high quality child care

Child Care Business Initiative (CCBI)	Vermont, USA	The CCBI project provides business training and technical assistance to start-up and existing childcare businesses.	A state-wide project of the Vermont Community Action Agencies' Micro Business Development Program. Services delivered by the grant included: the Kauffmann Child Care Course, technical assistance and business counselling services, workshops on specific topics, and referrals to resources such as social services and loan packaging.	Evaluation 2006: Students felt more confident in their skills and as a business owner. Clients who entered the CCBI program in the start-up stage, learned about the steps to start a childcare business, state regulations, and the feasibility of running this type of business. Total number of clients who received CCBI services = 329; 43% (139) were below poverty level
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**Subject: Access to Services**

<b>Intervention</b>	<b>Location</b>	<b>Characteristics</b>	<b>Description of intervention</b>	<b>Evaluation</b>
Neighbourhood and community centres	New South Wales, Australia	Access to services; reducing reluctance to utilise services.  Operation: 1961 – present but funding altered in 1991 & 2010	Neighbourhood centres provide cost effective services through use of volunteers (31% service delivery) and low paid workers. Centres also able to raise funds from range of sources. Centres provide direct services, act as conduit to other services, provide indirect benefits such as building social capital.	Neighbourhood centres have existed in NSW since at least 1961, growing in response to community awareness about self-help, resident issues and welfare rights. In 1991, the core funding was integrated into New South Wales Community Services 'Community Services Grants Program' (CSGP) - more than 300 centres established.
Cape York Partnerships: Family Income Management (FIM)	Australia	One of a number of linked initiatives being undertaken to address the critical needs and issues facing the Indigenous people of Cape York.  Operation: 2008 - 2013	Most of the aboriginal communities on Cape York are very isolated and have no access to mainstream banking facilities. FIM was set up to overcome these barriers and help Indigenous families better manage their incomes to achieve their goals. The objectives of FIM: o Develop the capacity of families and individuals to manage income; o Engage family groups in income management processes, assist participants to identify and discharge responsibilities to each other and to their communities.	FIM operates in 8 communities and has over 700 participants whose living standards have been improved. March 2013 Australian Government evaluation of the reform trial found mixed results associated with income management. Some evidence for improved income management: 78% of income managed people surveyed reported that the scheme had made their lives better. Evaluation found that there had been improvements in areas such as school attendance and reductions in crime. Difficult to draw conclusions as 'many other Indigenous communities in Queensland had also shown improvements'.
Poverty: A Clinical Tool for Primary Care Providers	Ontario, Canada	Poverty tool for primary care providers (also applied in other provinces across Canada).  Operation: 2015 - Present	Directs providers to use key questions to assess a patients' living situation and current benefits; includes links to key government and community resources to support positive interventions.  To optimize patient outcomes, tasks involved in screening patients for poverty and benefits, connecting them to help applying for benefits, and modifying health assessments, are shared across interdisciplinary health teams.	Started in Ontario in 2015 – now adopted by most other provinces across Canada. A 2016 evaluation of an on-line benefits screening tool found that 61 benefits were recommended to patients who were eligible for, but not receiving them. Over 47% of recommended benefits were related to disability support. Physicians see a role for themselves in screening for poverty to improve patient health. Benefit screening requires a follow-up process that directs patients to next steps.

# Effectiveness of interventions

The evidence suggests a mixed level of success in relation to service delivery. Initiatives in Australia (Rural Transaction Centres [RTCs] and Cape York Partnership) identify a range of issues associated with delivery of services in remote rural locations, including lack of adequate planning and the demands made on local volunteers within small communities to deliver significant elements of a scheme (RTCs), and the lack of counterfactual evidence and long-term nature of benefits that make evaluation of such programmes difficult (Cape York Partnership).

One stop shop approaches appear to have been moderately successful, although there is wide variability across initiatives in terms of the mechanics of implementation. A scheme in New Zealand (Heartland Services) is still operating after 16 years and appears to be moderately successful in delivering a wide range of government and community organisation services across more than 30 locations. Schemes and initiatives reliant on government funding are likely to suffer from limited budgets and Heartland is no exception, with evaluation reports suggesting poor infrastructure resources from low budgets which restricts services offered, and makes confidential discussions difficult. One stop shops have also been applied in Norway, Denmark and the UK in relation to linking social benefits and employment service delivery. Programmes have reduced delivery costs and helped integrate services, and in Norway and Denmark the level of responsibility assigned to local authorities (where municipal government is comparatively stronger) has enabled some flexibility and a tailoring to local conditions. However, integration of services and partnership delivery approaches can bring their own unique problems; for instance in terms of inter-agency power dynamics and a tendency for one partner to dominate. Evaluations of the one stop shop programs have noted the importance of creating effective institutional structures in the success of one stop shop and integrated delivery approaches.

A more recent development has been the integrated approach developed in Canada (Poverty: A Clinical Tool for Primary Care Providers) whereby health care providers are now undertaking specific poverty 'assessments', in order to explore underlying causes for health problems. Providers run through a set of questions to assess living situations and current benefits. Where issues are identified, patients are directed to government and community resources (that may operate out of the same building) offering additional support (e.g. assistance with claiming disability benefits). The information can also be shared across multiple team members involved in health care, and social welfare organisations. The approach has spread rapidly from a single province across the whole of Canada in less than two years. The approach is a form of one stop shop but using primary health care providers (e.g. GPs) as the entrance to an integrated support system.

Place-based approaches offer scope for more focused targeting of delivery to meet local needs and conditions. Place-based approaches are not always successful, for example, the Rural Transaction Centres (RTCs) established in Australia suffered from poor implementation and limited service delivery, despite government funding and an identified need for small business support in remote rural areas. Evaluation suggests multiple causes for failure (Parliament of Australia, 2004; Australian National Audit Office, 2003) including the widespread nature of the problem (closure of banking services in many remote rural areas), insufficient funding, poor execution, based on a weak programme theory, and lack of consideration of opportunities offered by new technologies (i.e. internet banking and related services).

On the other hand, place-based approaches that have targeted specific areas or communities requiring support have been more successful, for example, the neighbourhood centres and houses in New South Wales. The key outcomes from neighbourhood centres include direct access to a range of services for local people (e.g. family support and parenting programmes, childcare, youth development, adult education and life skills, support groups for domestic abuse and addiction problems), provision of links to other services; improvements in social capital, and most importantly, a non-stigmatising 'soft' entry point into the service system. Factors influencing success of the centres include the level of community involvement, the location of centres within target communities (which reduces 'stigmatisation' and increases use of the services by 'hard to reach' sectors of society), and the reliance on volunteers for delivery (Perry and Savage, 2012; SA Centre for Economic Studies, 2013). The Cape York Partnerships project also seems to have been successful (although there is limited evaluative information), through its place-based approach using local support workers to work with households on family income management.

The next logical step of taking services to households that need support, assisting old people to access services, is a more expensive option but has worked well for specific kinds of support, such as decreasing social exclusion. One example is the Village Agents scheme, which uses local people in the community as Agents on a part-time basis. The advantage to using local people is that they know the locality and many of the people, thus engendering higher levels of trust, particularly among older residents. Evaluations suggests the approach has resulted in favourable returns on investment, brought income into local economies through assisting residents to claim welfare and pension entitlements, and decreased social exclusion. By helping to keep older people in their homes they have also reduced health and care costs.

Programmes or schemes that target specific gaps in service delivery (such as access to child care) indicate modest levels of success. Vermont has a range of different approaches to improving access to quality affordable childcare using both state government grant funding and not-for-profit loan funding. The Child Care Programme of the Vermont Community Loan Fund is an interesting approach to improving access to child care through supporting low

income households to develop their own child care businesses. An impact assessment (Whitely 2013) noted that

“...VCLF’s loans have contributed to an overall increase of quality child care available to low- and mixed-income families in communities around the state, have increased wages and added jobs”. (Whitely, 2013: 4)

The approach of providing loans (particularly to low income households) for setting up and operating child care businesses both creates jobs and alleviates issues surrounding access to child care. State funding delivered through the Vermont Child Care Business Initiative (University of Vermont, 2006) plays essentially the same role using grants to support child care business development and improvement. Both approaches have increased the level and quality of childcare available in rural areas.

In the UK there is also evidence indicating advantages from creating supportive member based or partnership-type organisations to support child-care delivery. The Rural Childcare Network in the south-west region of England (Rural Childcare Network, 2017) illustrates potential savings from centralising basic support and administrative services through a membership-based organisation. Members get access to business planning support, administration such as payroll, information, relief workers, and a shared handyman, making it cheaper to run a child care business and easier to establish a new business.

An evaluation of the pilot Community Childcare and Early Learning Hubs programme (Dorrans, et al., 2015), run by 4Children (funded by the Department for Education), identified some of the benefits and constraints of partnership approaches to childcare delivery. The aim of the pilot programme was to:

“bring together high-quality day care providers, schools, children’s centres and childminders into Community Hubs...to develop a financially sustainable model for more flexible and responsive childcare and early education in a local area”. (Dorrans et al., 2015: 4)

Although not developed specifically for rural areas, the hubs aimed to increase access to ‘blended’ childcare, improve provision of childcare for two-year old children (targeting a perceived gap in provision) and improving the quality of provision. The evaluation found that linking different partners was difficult, although the hubs did provide for increased interaction between providers leading in some cases to closer relationships between practitioners, sharing of ideas/experiences, and best practice between hub members. The evaluation

recommended hub development should build on existing local networks or partnerships (which encourages early action and new members), and tailoring delivery to the needs and wishes of local providers based on a needs assessment.

## Policy Implications

Wales, and the UK more generally, have fully functioning health and welfare services. Any proposals or changes need to fit within the existing systems, and demonstrate potential to achieve cost efficiencies in a period of reductions in public financing of health and welfare services. Large-scale changes to welfare systems (e.g. Norway, Denmark) are only undertaken by national governments seeking more effective and efficient service delivery across urban as well as rural areas (Lægneid and Rykkja, 2013). They are useful, however, to illustrate some of the benefits and constraints of integrated service delivery.

One stop shop approaches linking health and welfare support services clearly offer the potential for cost savings through co-location in centralised locations. Identifying clients who are not claiming all the benefits to which they are entitled, and provision of support to enable that to happen in the same location clearly results in efficiencies for those delivering services, and those trying to access them. Benefits are likely to include better health care, and increased support to deal with underlying causes of health problems (e.g. fuel poverty, social exclusion, poor diet), as well as indirect local economic benefits with increased spending from those accessing higher levels of entitlements (in much the same way as Village Agents help residents claim more benefits). Such centralisation of service delivery in rural areas also offers savings to system users who only need to travel to a single location, and if that is an existing service centre it is likely to be served by public transport. There is potential to integrate public transport services with location of centralised service delivery, but it requires integrated policy and programme implementation.

The one stop shop approach has been applied in many different countries under different contexts, and with varying degrees of success (Rennie, et al., 2002; INSEAD, 2013; Social Market Research, 2011). Potential constraints include:

- available infrastructure, whether suitable buildings are available to house centralised service hubs
- the cultures of the co-located agencies, and the institutional capacity for different government departments, agencies and organisations to work together
- the need for privacy and confidentiality in working with clients
- former uses of the building (locally negative connotations and stigmatisation issues)



Evaluations of interventions elsewhere have noted the difficulties encountered when agencies are co-located to deliver services in remote locations but operate on the basis of achieving different targets, and face variable levels of resource constraints. The new approach taken in Canada using health providers to explore poverty issues as a part of a medical review (Prosper Canada, 2016; Centre for Effective Practice, 2015), and then directing clients on to (possibly) co-located colleagues, offers scope for accessing previously hard to reach sectors of society and addressing some of the underlying causes of poverty. Adopting such an approach needs to be explored with stakeholders, and through application of pilot studies to ascertain its potential effectiveness in the Welsh context.

Analysis of one stop shop interventions suggests a need for an overarching set of policy and programme goals relevant to all agencies involved; the achievement of which is integrated into departmental goals, and criteria for advancement and promotion. Putting people in an office together may result in some cost savings but does not constitute integrated delivery. There is significant institutional change required at policy level and in the management of front-line staff in order for such approaches to deliver improved services and achieve success. Where effective partnership operation is already occurring and there is willingness to engage in new delivery methods, changes and improvements in service delivery can be achieved relatively quickly (as demonstrated through delivery of the Poverty clinical tool in Canada).

Place-based approaches offer scope for more localised targeting of needs at the community level, and enable delivery of services through smaller-scale and targeted actions. Evaluations of existing programmes suggest the need for community involvement and partnership working to deliver services effectively to the intended target audience. In more remote rural areas, however, small community centres may offer the means to increase local access to varied combinations of health and social services.

Evaluation of home delivery of services, through schemes such as Village Agents, suggests potential for multiple benefits. In order to be cost effective the approach relies heavily on volunteers and/or relatively low-paid local residents, who require some training. Establishing a 'village agent' type of scheme will require implementation of support mechanisms and training schemes to enable local 'agents' to direct clients to relevant support organisations and government agencies.

In the case of more targeted approaches, such as delivery of child care (University of Vermont, 2006; Dorrans et al., 2015), there is scope for more flexibility and tailoring of programme delivery to different contexts. Affordable child care is a service that has been identified as being in short supply in Wales. Targeting support at low income families to help improve the level and quality of child care has multiple benefits (University of Vermont, 2006), including job creation, reduced travel, reduced isolation and social exclusion, and freeing people up to enter into employment. This would potentially contribute to two of the

three main objectives of the 2011 Child Poverty Strategy for Wales, namely to reduce the number of families in workless households, and to improve the skill level of parents and young people in low income families so that they can secure well paid employment (End Child Poverty Network Cymru, 2012). Any intervention would have to integrate with, and complement, the activities of the Flying Start programme currently being delivered in Wales (Welsh Government, 2012). The initiatives in Vermont and south west England suggest a range of options which might be of benefit if applied to rural areas of Wales, but they require some initial government action to create favourable conditions for building capacity for business development, and support for basic infrastructure (e.g. house alterations, equipment).

The benefits from membership of the Rural Childcare Network in south west England established under the 2007-13 Rural Development Programme (Rural Childcare Network, 2017) suggests that modest grant/loan funding to establish member based organisations could be valuable in increasing child care provision and raising quality standards. Improving child care in rural areas requires support for access to training, business management skills, household improvements (potential for links to improvements in energy efficiency), and a monitoring programme to ensure quality. Encouraging development of child care provision in specific service/employment centres with established transport links may also improve access to services.

One issue not addressed in this report is the use of personal health budgets or direct payments to manage long-term conditions (allowing certain groups of patients and NHS staff to purchase services or equipment), which may offer new ways forward to delivering certain health services in rural areas. This is the next step in service delivery, going beyond the third approach of delivering services in the home, to involving the client directly in deciding what is required and when those services are needed. The approach is likely to transform the relationship between care givers and patients, require more detailed planning, and may take time to be implemented across the whole UK (Coulter, et al., 2013). Whether the outcome will result in more efficient and effective use of resources is difficult to tell at this point, as the outcomes depend on levels of funding that will be made available, and how it might be prioritised. There is also concern, however, that the approach is a 'backdoor' means of privatising the National Health Service via an insurance based approach (Samuel, 2015).

# Conclusion

Any of the three broad service delivery approaches (centralised hubs, place-based approaches, home delivery) can be organised and delivered through state/central government, or through a partnership approach made up of local community organisations (sometimes with local authority involvement). The way health and welfare services are delivered in rural areas is dependent, to a large extent, on the format of the national delivery system for these services, which will shape the level of flexibility possible for rural delivery.

As stated earlier, centralisation of services through one-stop-shops and resource 'hubs' is not new. There are many examples, but an approach that works in one area may not be transferable to another context. Working with local stakeholders, forming partnerships, and assessing local needs are critical elements for developing effective interventions. Creating suitable institutional structures to support partnership delivery is an often overlooked but critical aspect of centralised service centres where different organisations are co-located to deliver a range of services. Institutional structures require clear linkages, from policy aims to front-line delivery, capable of harmonising policy goals with personal actions of staff at all levels.

Place-based approaches offer scope for more selective targeting of service delivery and smaller scale actions targeting specific groups or sectors of society. Interventions suggest community-based delivery can be effective in accessing hard-to-reach sectors of society. Evidence from interventions suggests that in many cases exploring poverty issues, through a more personal one-to-one approach provides benefits directly to clients who are not accessing all the benefits to which they are entitled, and indirect benefits to the local economy from larger incomes and spending. Although individual amounts may be small, the effect can be significant over time for both individuals and local economies.

Programmes to enhance certain types of service availability (such as child care) can be targeted at specific localities or sectors of society (e.g. low-income households). Increasing the level of affordable child-care can deliver multiple benefits including job creation, building social capital and networks, making people available for employment, and higher quality child care. This approach requires government support to establish training programmes, provide funding for setting up businesses (possibly in the form of loans), and establishment of monitoring systems for quality assurance.

Home-based delivery of services can also be effective in reducing social exclusion and increasing people's access to services. Costs of home-based delivery can be reduced through using local residents on a part-time and/or voluntary basis. To be effective, training and strong links to relevant government agencies are required.

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# Appendix 1 – Further Information Regarding Access Interventions

## One stop shop approaches

### Heartland Services, New Zealand

The aim was provision of government services linked with community service delivery to remote and low density population areas through One stop shops. Delivery is through co-location of a wide range of government services and information sources within a single location. The 'one stop shops' links 35 government departments and 50 community organisations using site-based coordinators, the intention being to reduce delivery costs through sharing office space and reducing the need to locating staff in remote areas. With the proposed approach a relatively small number of front-line staff could deliver services to a wide geographic area. It also allows for greater inter-agency cooperation. Services delivered include the following (the list is illustrative and not comprehensive of all services offered):

- ACC - New Zealand's accident compensation scheme
- Careers New Zealand - job, training or career path assistance
- Child, Youth and Family - Funding for services for children, young people and families
- Ministry of Justice – Legal advice; Youth justice
- Ministry of Business, Innovation and Employment (MBIE) - Business support; Consumer affairs; Employment law and regulation; Information about health and safety
- Inland Revenue - Business tax advice; Child support; Personal tax advice
- Social services for children, young people and their families.
- StudyLink - Student Allowances, Student Loans, Unemployment Benefit
- Building a business - Community funding
- Work and Income - helps job seekers and pays income support
- Workbridge - a professional employment service for people with disabilities and injuries

(Source: <http://www.heartlandservices.govt.nz/our-services/index.html#acc1>)

Not all government services are represented within each location so the site coordinators play a key role in passing people on to relevant contacts. A total of 30 centres were opened over the period 2001-03. A process evaluation (conducted in 2004) suggested the approach



led to a significant cost savings (although quantitative data was limited). The evaluation identified strengths and weaknesses, including the following:

- Co-location of sites in the premises of existing community-based organisations resulted in higher levels of public awareness about the service. Centres co-located in government offices were less well-known.
- Sites co-located with a government agency were ‘type-cast’ (i.e. people associated the service with the government agency or the former use of the building making it hard to imagine new services being delivered from the site).
- Co-location of sites with a pre-existing government agency reduced take-up of the service.
- The name confused people, who misunderstood or unsure of what the organisation provided.
- Privacy was a problem on some offices with close proximity of desks making it difficult to conduct confidential discussions and phone calls with clients.
- Linking 35 government and 50 community organisations on a limited budget involved compromise in terms of provision of work space and service delivery. Not all sites could offer all services, and in many sites work space was severely limited.
- Performance was measured through simple output data, and these performance indicators were linked in some cases to annual remuneration increases – increasing the scope for biased statistics. There was little incentive to improve poor quality data due to the use of outcome data for agency ‘point scoring’ and to ‘embarrass politicians’.
- Co-location with an existing government agency led to over-emphasis on that agency’s interests (often because they were monitored locally by that agency) and imitation of the style and culture of the agency, sometimes to the detriment of the needs of the local community.

A performance audit in 2010 recorded over 100,000 visits to the 35 Heartland service centres (for the previous year, although the time period is not clear), and 95% of survey respondents indicating high levels of satisfaction, making it easier for them to access services. A case study analysis in 2013 (INSEAD, 2013) noted that the “...initiative saved money for each of the participating agencies by removing or reducing their cost of rural office space and providing a means by which a comparably small number of front line personnel could deliver services to a geographically large area.” The overall aims of the service when it started were to:

- improve access to government services for people in rural areas
- improve interagency collaboration

- support community and other voluntary agencies in rural areas.

The INSEAD (2013) report identified some critical requirements for successful implementation:

- assigning the initiative to a well-resourced lead agency with an existing network of rural offices that can be adapted to co-locate OSS sites, and formally tasking other agencies to participate in the initiative
- appointing a senior executive with strong rural experience and networks, and who is an effective communicator to lead the project. This is especially important in securing the cooperation of cross agency partners and local communities.
- recruiting personnel systematically, based on a considered analysis of their intended role, and providing a standardised induction about how to do the job so that they can work efficiently toward the objectives of the initiative.
- monitoring performance according to outcomes that are meaningful (number of clients whose needs were adequately met) versus outputs (e.g. number of clients served) so that the project achieves real value for money.

The report also noted factors that constrained performance:

- There is a penalty involved in co-locating OSS sites in government premises that continue to perform a function that may deter some members of the community (eg. basing an OSS in a rural court house or social welfare office).
- Co-locating an OSS partner site in premises designed for one particular agency will not suit all other providers. Looking forward it may be advantageous to provide different categories of OSS offices to deliver different clusters of services.
- Co-locating OSS partner sites in the premises of an existing agency that relates to clients in a less than friendly way (e.g. an unemployment benefits office that requires its staff to minimise time spent with clients), creates tensions that will compromise effectiveness

### **Pilot one stop shop service, N. Ireland**

The focus of the pilot programme was to provide dedicated support to young people around personal and lifestyle issues. The centres, located in the communities where there was a

perceived need, provided drop-in information and advice services in relation to alcohol and drug misuse, suicide and self-harm, mental health and wellbeing, sexual health, relationship issues, and coping with school/employment. Four projects were set up to deliver a different range of support:

- North Down and Ards: Forum for Action on Substance Abuse (FASA)
- Enniskillen: Fermanagh Underage Entertainment Life (FUEL)
- Banbridge: REACT Ltd.
- East Antrim: Carrickfergus Community Drug and Alcohol Advisory Group.

From a strategic point of view the model was considered successful in that all aspects of all of the selected performance indicators were achieved. There was also a high level of satisfaction expressed by service users (helpfulness of staff (94%), help with issues or problems (88%), confidentiality of the service (86%), and service location (85%). From an operational perspective, the feedback from the key personnel delivering the pilots suggests that some elements were more successful than others, though little information is available of the differences or the causes.

### **Rural Transaction Centres, Australia**

The Rural Transaction Centres (RTCs) were established in 1999 with £26 million of Federal government support for a 5-year period. The funding was available to undertake initial community consultation and business planning to identify local needs, and support for capital costs of establishing and RTC and subsidising operating costs in the first year so service. Funding went to local authorities or non-profit organisations to establish the RTCs. The aim was to establish 500 centres in rural communities of less than 3,000 people, partly driven by the reduction in financial services in rural communities formally provided by commercial banks.

The aim was to improve access to a range of government information and services for those living in remote rural areas through a community-driven approach. The centres also give access to private sector services and products, and provide office space for community uses. Examples of services offered includes central government services (e.g. tax, employment, benefits), financial services, state and local (e.g. vehicle tax, roads, libraries), post office, business and secretarial, tourism and booking services, insurance, and scope for operation of small private businesses. The overall aim is to support small communities to establish locally run and self-funded centres to improve access to basic services that would otherwise not be available. Each RTC operates individually and varies in the types of support and access provided, responding to the needs of the local communities in the area served.

A Parliamentary Committee Report (2004) noted a number of shortcomings of the project including: the length of time taken to establish an RTC (in many cases > 18 months) resulting from 'difficulties in galvanising local support; a large number of bureaucratic obstacles associated with the scheme; a long approval process; limited range of services offered, and high demands on volunteer community members to initiate and take forward the process.

[See:

[http://www.aph.gov.au/Parliamentary\\_Business/Committees/Joint/Corporations\\_and\\_Financial\\_Services/Completed\\_inquiries/2002-04/banking/report/c10](http://www.aph.gov.au/Parliamentary_Business/Committees/Joint/Corporations_and_Financial_Services/Completed_inquiries/2002-04/banking/report/c10)]

In terms of financial services weaknesses were noted: in particular, the RTCs “...do not always meet or suit the requirements of business customers and face security and privacy issues. For example, most RTCs do not facilitate business transactions including business cash deposits and withdrawals nor form part of the commercial world providing advice and access to finance so necessary for small businesses to develop”. In addition it was noted that the small number of RTCs established did little to combat the loss of large numbers of commercial banking centres, and left small businesses facing problems in both depositing and withdrawing funds.

The Committee also noted the release of a report by the Australian National Audit Office (2003) which stated a key finding: “...was that the Department of Transport and Regional Services did not translate the Government’s program objectives for the RTC program into ‘operational objectives that would have helped to establish an appropriate performance management framework to monitor the efficiency and effectiveness of program delivery’. It found failings in the initial planning process, in particular ‘the absence of any mechanism for feeding information gained from the evaluation of individual projects into an evaluation of the efficiency and effectiveness of the programs.’”

By 2002-03, it was reported that a total of 164 RTCs and 119 RTC Electronic Point of Sale (EPOS) sites had been approved. A total of 80 of the approved RTCs and 101 RTC EPOS were operational supplying a range of services such as banking, Centrelink, Medicare easyclaim, business services and a range of government and private sector services. RTCs became part of the Rural Partnerships programme in 2003, delivered through the Department of Infrastructure and Regional Development. No additional evaluation information has been located although the RTCs still appear to be operational in some areas.

## **New Employment and Welfare Administration (NAV), Norway**

This was a central government initiative to deliver welfare and employment support services. NAV reform merged the administrations for national insurance and employment, but the social services administration remained a local government responsibility. To coordinate national insurance and employment services and social services, the NAV reform

established a one stop shop (the NAV office), intended as a joint frontline service, in each municipality. The NAV office was organized as a partnership between the merged employment and insurance administrations (a central government responsibility) and the social services administration (a local government responsibility). It was mandatory for municipalities to participate in the partnerships, and financial social assistance from the municipalities (social benefits) had to be offered through the one stop shops, along with a range of other municipal social services if desired locally. The majority of municipalities (90%) included non-mandatory municipal tasks (e.g. most municipalities included treatment for drug abuse and social housing in the one stop shops).

The multi-level partnership model delivering the NAV one stop shops was identified as an organizational innovation in the Norwegian political-administrative system; combining ministerial responsibility and sector specialisation with local self-government and territorial specialisation.

### **Municipal level job centres, Denmark**

The Danish government, like Norway, also embarked on a one stop shop approach based on the notion of 'one entrance' to the employment service area. Structural reform in 2007 created two types of one stop shops to provide services related to employment but it did not work well and in 2009 the government handed responsibility for the insured unemployed and payment of unemployment benefits to municipalities. All employment services would be offered through job centres (the 'one stop shop') delivered operationally by municipalities but subject to central government regulation. The structure from the customer's point of view is quite simple, with the job centres run solely by the municipalities, with a high level of autonomy since these are comparatively strong decentralized units.

### **Co-location of medical and CAB services, Gateshead**

A range of studies show a clear link between poor health and stress. Experience is available from GPs and mental health trusts in urban areas where considerable face-to-face practitioner time is expended discussing personal and social challenges and insecurities which result in patient stress and ill-health. Lessons from such urban work may be transferable to rural areas, especially if contact with health practitioners is infrequent and difficult.

An example of co-locating health and social advice services was trialled by NHS Gateshead, which included CAB support within some GP practices. Evaluative research by the University of Northumbria's School of Public Health found that people visiting GPs made use of the CAB welfare advice. Partly, this was because the surgery was regarded as a more

comfortable/neutral space for discussion, which minimised a sense of stigma. The trial helped CAB staff engage with clients in more detailed ways than experienced at conventional CAB offices, and allowed them to understand individual contexts more closely. However, researchers indicate significant challenges involved in turning data about changes in service provision/use into predictions or trends about health outcomes.

## Place-based approaches

### Neighbourhood and community centres, New South Wales, Australia

Neighbourhood and community centres were established in several parts of Australia to address problems of social exclusion, particularly among disadvantaged and low-income households. The initiative is based on research that showed the importance of community 'buy-in' for programmes to be effective and successful. One approach to increase community engagement was the establishment of centres in specific neighbourhoods with the support of the Local Communities Services Association. Neighbourhood centres are not a new concept and have existed in NSW in some form since the early 1960s, steadily growing in response to changes in community awareness about self-help, resident issues and welfare rights. In 1991, the core funding for neighbourhood centres was integrated into the New South Wales Community Services 'Community Services Grants Program' (CSGP) and which provided funds to more than 300 centres throughout NSW, but more recently (in 2010) the CSGP was abandoned and replaced with the new 'Community Builders Community Hub funding'. Reports indicate that some of the newer neighbourhood centres have not been able to access this funding stream, core funding has declined and in some areas neighbourhood centres and houses have been encouraged (starting in 2005) to co-locate with the new community hubs established with government funding to deliver services. Co-location has not always improved delivery and a recent report suggests the community context should be taken into account when making decisions over co-location.

The key outcomes from neighbourhood centres include the following:

- Direct access to a range of services (services include family support and parenting programmes, childcare, youth development, adult education and life skills, support groups for domestic abuse and addiction problems)
- Acting as a conduit to other services
- A non-stigmatising 'soft' entry point into the service system (overcomes reluctance to engage with services; enables engagement with 'hard-to-reach' groups and early intervention and prevention)
- Indirect benefit such as improving social networks and building social capital

Other advantages relate to the ease with which the centres can adjust to changes in the local situation. Neighbourhood centre infrastructure can be quickly mobilised, expanded, adjusted, or reduced to respond to community needs and the Centres provide cost effective services through use of volunteers (31% service delivery) and workers whose pay is considerably lower than comparable government rates; centres are also able to raise funds from range of sources.

A survey of 534 centres across Australia carried out by the Australian Neighbourhood Centres and Houses Association (ANHCA), revealed wide diversity in role, programmes, sources and levels of funding, and focus in different states (Rooney, 2011). Most relied on core government funding though they engaged in a wide range of additional fund raising activities and all relied heavily on volunteers for delivery of services. The centres surveyed by ANHCA had the following characteristics:

- the provision of infrastructure including meeting space, activity space, space for visiting services and as shared space with other services
- centres represent a range of types of facilities and a number of organisations operated more than one facility
- some centres were purpose built and many are re-furbished buildings (mostly suburban houses)
- 78% of buildings were owned by state or local government and only 6% were owned by the organisation itself.
- centres in some regions in Australia have a part-focus on Adult and Community Education (such as Victoria) while others do not
- centres are run by the community for the community and provide a foundation for civic participation; the majority were incorporated associations with volunteer committees or boards
- average association membership (formal) was 86 people and each committee spent around 34 hours per month on committee business
- on average there were 2.8 volunteers for every paid worker and 52% of centres employed only part-time staff
- 58% of centres had annual incomes of less than \$250,000; 20% had a gross income of \$251,000-\$500,000 and 22% had incomes of over \$500,000 p.a.

An impact study of 107 neighbourhood centres in South Australia summarised the role of the centres as:

“Community centres are not-for-profit community organisations operating in local communities using prevention and early-intervention strategies to assist those who are disadvantaged and previously disengaged people through community development, health and well-being, social inclusion and life skills programs.”

“The economic contribution of the network of community centres is significant. These include...enabling people to engage in further learning and work through volunteering, foundation skills courses and breaking down barriers to participation such as through literacy and numeracy and the provision of childcare that enables engagement and participation.”

The study found the following impacts:

- over 2 million visitations to centres per annum (numbers attending the 107 centres each week = 42,800)
- the value of volunteer contribution lies in the range \$32 - \$43 million (based on: 4,500 – 5,600 volunteers engaged for 28,462 hours/week; Full time equivalent volunteers per centre = 7.6 creating a ratio of 3.2 volunteers per paid worker and 1.2 volunteer hours per paid staff hour).
- the value of 66,742 hours of crèche services provided per year, either free or for a very small donation are valued (conservatively) at \$1.3 million.
- literacy and numeracy programmes cost \$4.73 per hour to deliver and generate benefits estimated at \$11.14 - \$19.30 per hour (i.e. a return ratio of 2.4 to 4.1)

### **Cape York Partnerships: Family Income Management (FIM), Australia**

The scheme represents one of a number of linked initiatives being undertaken to address the critical needs of the indigenous people of Cape York and is viewed as ‘*a key enabler for the effective implementation of Welfare Reform*’.

The scheme is targeting isolated aboriginal communities on Cape York that have no access to mainstream banking facilities. FIM was set up to overcome barriers to accessing financial services and to help Indigenous families better manage their income. The objectives of FIM are defined as:

- to develop the capacity of families and individuals to manage income;



- to engage family groups in income management processes, assist participants to identify and discharge responsibilities to each other and to their communities;
- to develop group purchasing arrangements to source and provide access to quality, affordable household goods and small business plant and equipment;

These objectives are achieved through a working intensively with individuals and families to:

- develop a household budget, ensure bills are paid and children are cared for;
- ensure each individual contributes to household bills, food buying accounts, and savings;
- provide education and access to internet banking and telephone banking facilities .

The scheme is resource intensive, utilising family ‘facilitators’ and resource workers who work within each community to target mainly indigenous families who self-select to participate in the programme. Resource workers help pay bills and provide advice on what to buy, negotiate agreements to repay debts, stop ‘book up’ systems (local credit given by stores – often the only credit available in a community) and provide for cashless shopping through a voucher system (using money saved rather than credit).

The resource worker and the family work together to identify household income, debts, and essential household expenses, creating a household account and ‘sub-accounts’ to cover key expenses. The family also identifies other needs and goals, such as desired goods and services and longer-term aspirations, and with help from the resource worker develop a budget to manage household income, expenditure and savings. Once completed the resource worker liaises with welfare services (electronically) or the employer to arrange direct deductions from income support payments or wages to the FIM account. Money is then distributed into the participant’s agreed sub-accounts, such as rent, power, phone, food, education, car, debt repayments or savings. The participant’s bills are paid from their accounts, and the resource worker also helps research the best deals for desired purchases, including car loan products.

The scheme operates in 8 communities and claims to have improved the living standards of over 700 participants. FIM data suggest that project has led to ‘scores’ of purchases of household goods, resulted in fewer phone and power disconnections, reduced bill paying costs, more spending on food, and reduced book up debts at local stores. In addition, there have been suggestions that the programme “contributes to increased motivation for training and work, reduced stress and family conflict, and improved school attendance”, although no evaluation evidence exists to support that statements.

In March 2013 an Australian Government evaluation of the scheme reported mixed results associated with income management, making the following observations:

- There was some evidence that income management assists in reducing behaviours that lead to people being reported to the body in charge of welfare reform.
- 78% of income managed people surveyed reported that the scheme had made their lives better.
- There was some concern about income management aspects of the scheme, 'with common complaints being the inability to use it in some stores and the paternalistic nature of the intervention'.
- Some improvement in areas such as school attendance and reductions in crime,
- progress was lacking in some components of the scheme, such as housing and economic opportunities

The evaluation also noted that it was difficult to make strong conclusions about the effectiveness of the scheme for two reasons: first, the evaluation took place only five years after implementation and the expected outcomes may take much longer to appear; secondly, 'many other Indigenous communities in Queensland had also shown improvements' and there was no strong counterfactual evidence base to enable comparison.

### **Midgley Community Room, Yorkshire, England**

On a much smaller scale the Midgeley community room is run by volunteers with no core external funding. The project focuses on provision of local services by a community forum, comprising a shop and community room. The shop provides services to a small remote community (population of just over 1,000) have access to services and uses a team of 40 volunteers to run the shop and community room. The shop is open 48 hours per week (over 6 days) and averages 80 customers/day. Community leaders report that as a result of the activities they now have a 'stronger community' with reduced isolation, and stronger social networks.

## **'Taking the service to the user' approaches**

### **Village Agent scheme, England**

The overall aim of the scheme is to support people living in rural communities to access services, along with helping to shape service delivery by feeding back information from the 'bottom-up'. Schemes developed from the 'LinkAge' project run by the Department for Work

and Pensions and have been operating since 2006 (although the scheme has ended in some areas). Village Agents work with all sectors of communities addressing a wide variety of issues, but the overall focus tends to be elderly and social care issues; in particular, helping people to stay in their homes through ensuring they have access to support services, and through reducing isolation and exclusion. Due to the fact they operate within communities themselves the Village Agents are able to shape service delivery by feeding back information about gaps in service (e.g. transport provision), quality of service, and extent of the population in need. They also operate to motivate and support communities to respond to local needs by working together to address issues.

In Gloucestershire the focus was on older people (>50 years). Agents received training and were paid to work 10 hours per week in 'clusters' of communities, each with a population of between 330 and 1,125 people aged over 50 years. An evaluation of the Gloucestershire Scheme in 2008 revealed 30 agents covering 162 parishes. Individual agents work within clusters of communities that have limited or no access to services locally. The evaluation concluded that the scheme provides low cost means of helping people access services, using part-time and trained local people who live in the area and are trusted by the local community. Specific achievements cited in the evaluation report include:

- Made a total of 31,244 contacts, 151 referrals to home improvement agencies, and 309 referrals to the DWP during the 2007-08 year.
- Village Agents in Gloucestershire helped local people increase their benefit claims by £6,005 per week (a total of £312,780 in extra benefits into the county per year – “almost equivalent to the annual cost of running the Village Agents service”)
- Older people were more likely to contact statutory organisations as a result of contact with Agents
- Older people have a better awareness of preventative measures
- Older people feel more secure, more cared for and have a better quality of life
- Social networks are supported and promoted
- Initiatives and information can be directly targeted to the intended recipients
- Putting older people in touch with different statutory and voluntary agencies has resulted in people receiving more service, which helps them remain independent in their own homes

As a result of the effectiveness of the scheme, Village Agents in Gloucestershire are now a mainstream council service with an allocated budget provided jointly from Social Care and PCT budgets. Schemes in other parts of the country have also been successful (e.g. Cumbria).

## Pooling personal health budgets in rural Scotland

Increasingly, the NHS is encouraging people to take control of the type of care they wish to receive, through the use of personal health budgets. By allocating a budget to individuals, patients can decide the type, frequency and location of their medical care, rather than having this allocated to them via a local practice or hospital. Some rural areas find it hard to recruit or retain rural GPs thus threatening the operational and financial viability of some GP practices. In other cases, rural isolation leaves communities vulnerable to unexpected events: in 2014 the residents of Braemar, Aberdeenshire, decided to pool their personal care allowances to develop a local clinical practitioner scheme after being totally cut off by floodwaters. A very similar scheme was set up in the village of Carradale on the east coast of the Mull of Kintyre peninsula, where residents pooled allowances to avoid the need to journey to Cambletown to seek medical care. This is an example of rural communities pro-actively seeking and organising tailor-made solutions to local care needs, rather than being a top-down initiative.

## Specific service approaches: child care

### Child Care Programme, Vermont Community Loan Fund (VCLF), Vermont, USA

The VCLF is a community-focused (private, non-profit) alternative lender providing financial support to a wide range of economic development activities in rural areas. Since 2000 it has also had a Child Care Programme working towards the alleviation of a shortage of high quality affordable child care across the state (i.e. working towards enabling better access to affordable child care) through financing “the improvement of home and centre-based facilities”. The programme makes loans to child care providers who don’t qualify for a loan from a traditional lender and combines loans with financial consulting and business development services to enhance the likelihood of business success.

An impact statement in 2008 noted the following:

“The Vermont Community Loan Fund (VCLF) is a Community Development Financial Institution that provides loans, technical assistance and support for the development of affordable housing, community facilities, local businesses, childcare programs and other projects that benefit low- and moderate-income Vermonters. VCLF was formed in 1987 to address the lack of affordable housing in central Vermont. In 1991, VCLF began lending to non-profits and in 1995, it began to lend to small businesses. In 2000, VCLF launched its childcare lending program, an agritourism loan fund and a down payment program for mobile home ownership. In 2003, VCLF began providing direct technical assistance services to childcare providers.”

“Since its founding in 1987, VCLF has provided over \$45 million through 539 loans, creating or retaining 1,059 jobs, 2,294 affordable housing units, and 1,379 childcare slots in Vermont.

“Child Care Lending: The need for childcare in Vermont currently outpaces its availability by nearly 50 percent. Now in its seventh year of childcare lending, VCLF recognizes the unique challenges in financing the start-up or improvement of childcare programs. VCLF provides financing and technical assistance to both home- and center-based childcare providers. Loans are used by providers to achieve professional standards, meet state regulatory and ADA-accessibility requirements, increase staffing or capacity for service, and purchase necessary equipment.”

[Source: Trillium Asset Management Corporation, 2008]

An evaluation conducted in 2012 noted that since the year 2000 VCLF had made loans to 99 child care providers, loaned \$7 million and leveraged an additional \$3 million “to improve access to quality child care with a focus on low-income families and communities”. The report indicated the loan fund had enable the creation or preservation of quality care for 3,400 children and their families, and provided affordable care for low-income families. Over the period the funding had also increased the net number of jobs in the new and supported centres by 35% (85 new positions and a net gain of 58 jobs). Reported achievements include the following:

- Serves more low-income families: 44.8% of VCLF Child Care Programme enrolment are from low-income families compared to under 30% state-wide

- VCLF creates greater access to quality infant and toddler care: 85.6% of infants in programs run by VCLF borrowers are enrolled in high quality child care, compared with 39% of infants enrolled in high quality care state-wide.
- Higher wages for those working in businesses operated by those who had taken loans with VCLF (\$12.28/hour compared to state average of \$10.63/hour for a child care worker in 2011)
- A much higher proportion of child care businesses operated by those who had taken loans with VCLF were enrolled in the STARS programme (a quality rating system) compared to other child care businesses across the state

An impact statement covering the period July 2012 – June 2013 noted the following childcare impacts:

- Loaned: \$475,100
- Child care slots created or retained: 201
- Jobs created or retained: 37
- Additional project dollars leveraged: \$239,875
- Total lending July 1, 2012 - June 30, 2013: \$5,413,258
- Under Project SUCCESS, which provides training for child care providers, in groups or one-on-one, focusing on the business skills and strategies critical to running a child care center:
  - Provided 1,875 hours of Technical Assistance (TA)
  - Provided one-on-one TA to 127 child care providers serving 960 children and their families
  - Provided 14 group trainings statewide, serving 130 providers

[Source: Vermont Community Loan Fund Social Impact Report 2013  
<http://legislature.vermont.gov/assets/Documents/2014/>]

### **Child Care Business Initiative (CCBI), Vermont, USA**

The CCBI project is a state funded scheme which provides business training and technical assistance to start-up and existing childcare businesses to make them more financially sustainable and resilient, and to try and increase the availability of quality childcare. The project is delivered across the state (urban and rural areas) through the Vermont Community Action Agencies' Micro-business Development Program. The CCBI activity is underpinned by a grant which delivers the following: the Kauffmann Child Care Course; technical

assistance and business counselling services; workshops on specific topics; and, referrals to resources such as social services and loan packaging. An evaluation undertaken in 2006 reported the following:

- Overall, 64% of all clients completed the Kauffmann course, with 79% of low-income participants completing.
- Students felt more confident in their skills and as a business owner. Clients, who entered the CCBI program in the start-up stage, learned about the steps to start a childcare business, state regulations, and the feasibility of running this type of business. Students, who came to CCBI already in business, improved their business management skills.
- A total of 329 clients received CCBI services, of which 43% (n=139) were below poverty level (including TANF recipients, dislocated workers, and unemployed individuals)
- Gross annual revenue (self-reported) from childcare businesses of all clients averaged \$22,900 per annum (n=92).

### **Rural Childcare network, S.W. region, England**

A group of community based childcare organisations that work together mixing web-based and practical support. Operating during 2007-13 based on RDP funding support. The Rural Childcare Network was established to provide a range of support services for member playgroups. The services include:

- Internet-based Management Information System
- Shared “Relief Childcare Worker”
- Shared payroll service, and help with accounts and financial management
- Shared handyman service, and group purchasing

### **Community-based First Responders scheme in the Scottish Highlands**

This initiative was a part of the Remote Services Futures (RSF) in the Scottish Highlands. In 2010, the RSF project included a partnership between NHS Highlands, the John Hutton Institute and four Highland and Island communities. Details of the cost of health service delivery was provided to local people, who then – through a managed community consultation exercise – prioritised how that level of funding could be re-directed towards local health priorities decided upon by local people. In one community, a key concern was the long time it took for an ambulance to attend emergencies. As a result, a group of 10 local volunteers were trained as ‘first responders’, namely people on hand with enhanced first aid skills. These people could then step in in emergencies while ambulances were alerted. The

scheme was not fully evaluated over time but anecdotal feedback from the John Hutton Institute has reflected that by 2014 the first responder network was down to 4 individuals. The fall in numbers was linked firstly, to a lack of training follow-up, which made the first responders feel they carried too much responsibility without the on-going and regular refresher training; and secondly, because the local NHS Trust was perceived to be using the first responders as a routine extension of the ambulance service.

### **Local Community Net, Finland**

Service delivery through internet communications (conferencing, email and web-based communications). The Local Community Net project was a pilot project which aimed to provide a service to the local area which would encourage the establishment of a community network based on computer conferencing, email and web-based communications. The project had particular social objectives to prevent social exclusion, support social innovation, and to improve services and living conditions in the pilot area.



## Author Details

**John Powell** is a Senior Research Fellow at the Countryside and Community Research Institute (CCRI), University of Gloucestershire.

**Dan Keech** is a Research Fellow at the Countryside and Community Research Institute (CCRI), University of Gloucestershire.

**Matt Reed** is a Senior Research Fellow at the Countryside and Community Research Institute (CCRI), University of Gloucestershire

For further information please contact:

**Emyr Williams**

Wales Centre for Public Policy

Tel: 029 2087 5345

Email: [info@wcpp.org.uk](mailto:info@wcpp.org.uk)

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