Just what the doctor ordered

Welfare benefits advice and healthcare

A report by Neil Bateman for Age Concern England
About Age Concern

Age Concern England (ACE) is a national voluntary organisation aiming to improve the opportunities and quality of life of people over 50. We work through campaigning, public policy development, research, information provision, publishing, training, grant-making and international and European work. ACE is part of Age Concern, the UK’s largest federation of organisations working with and for older people. There are 370 local Age Concerns in England and independent national Age Concerns in Scotland, Wales and Northern Ireland. Age Concern provides vital services and information locally throughout the country. Every day we are in touch with thousands of older people, enabling them to make more of life.

The Policy Unit develops the charity’s public policy on ageing and older people, and influences Government and other policy makers through research, responding to consultations, working in partnership, and holding policy events.

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About Neil Bateman

I am an author, trainer and consultant who specialises in welfare rights/social security law and policy. I provide the following services to local authorities, voluntary bodies and others:

■ Second tier advice to advisers.
■ Casework and advocacy in complex cases.
■ Expert witness reports.
■ Training on social security law.
■ Expertise in benefit take-up strategies.
■ Reviews and audits of advice services.
■ Development of advice strategies.

I was assisted in this assignment by Geoff Fimister. Geoff is a writer, researcher and consultant, specialising in anti-poverty, disability, social security and advice services policy and related issues. For 25 years, Geoff managed the welfare rights service at Newcastle City Council and has also managed campaign staff at Child Poverty Action Group. He has also done some international work on these issues. He is currently working with the Royal National Institute of Blind People. Geoff has particular expertise in how social welfare law advice can play a role in tackling poverty and social exclusion. Geoff particularly focused on fieldwork and interviews with advice agencies and acted as a peer reviewer.

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Acknowledgements

We would like to thank the following people for their help with this project:

- Shawn Mach and his colleagues at Rightsnet and Kelly Smith of Child Poverty Action Group for help in publicising the project to advisers.

- Colleagues at Citizens Advice, in particular Marolyn Burgess, for providing helpful data and background details as well as suggesting Citizens Advice Bureaux for interviews.

- Joan Mackintosh, Public Health Research Group, Faculty of Medical Sciences, University of Newcastle.

- The Royal National Institute of Blind People for facilitating Geoff Fimister’s involvement in the project.

- Everyone who took time to complete survey forms and to participate in interviews and fieldwork visits, especially David Paterson from Southwark Council’s Welfare Rights Service and Maria Vaccarello from Age Concern Liverpool.

- Sally West and Catherine Bennett from Age Concern England.
Foreword

The links between poverty and ill health are well established. Poverty and low income are associated with shorter life expectancy, poorer health and other indicators of disadvantage. Despite this, policymakers do not always look at these issues together. Within Government, tackling ill health has tended to be the responsibility of the Department of Health while addressing poverty – for example by encouraging older people to claim pension credit – has remained the responsibility of the Department for Work and Pensions (DWP). However, there is a growing recognition of the need to approach problems holistically which is now reflected in the Government’s new Public Service Agreement on reducing poverty and promoting greater independence and well-being in later life replacing the previous poverty target which focused on take-up pension credit.

Making links between different areas of policy and service delivery is essential. Despite major efforts by the DWP and the Pension Service to encourage older people to make contact and claim their entitlements, up to 1.7 million older people have failed to apply for the much publicised pension credit. Yet most of these will be in contact with other public services – we know for example that people aged 65 and over visit their GP on average around seven times a year. Recognising this, many welfare benefits services, particular those run by Citizens Advice, have made links with local GPs and other health services. The advantages to individuals are clear: the possibility of higher incomes and an improved standard of living. We called our recent report on the impact of information and advice “Transforming lives” to reflect the difference that benefit advice can make. Furthermore, it can improve public health: reducing poverty can increase mental well-being and may improve physical health.

We commissioned this research to find out more about the impact of benefits advice in healthcare settings, to get a picture of current provision and to identify factors that lead to a successful service. We are grateful to Neil Bateman and Geoff Fimister for their hard work on this project and to the service providers who found time to respond to questionnaires or take part in interviews. We hope this research will benefit those providing advice services who may want to extend their reach to disadvantaged older (and younger) people, health service staff looking for new ways to improve the lives of their patients, managers in central and local government and Primary Care Trusts and others who have the ability to fund and promote services that improve the quality of life for local people.

Gordon Lishman
Director General, Age Concern England
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Overview

There is a growing body of evidence that suggests welfare benefits advice linked to healthcare services can improve the well-being, mental health and the quality of life of service users. However more robust evaluation is needed in particular to explore the impact on physical health.

Current provision

Our survey carried out during 2007–08 provided information about welfare rights provision based on 2006. Although we are confident that this provides a good picture of provision not all providers will have responded so this is likely to be an underestimate of provision. Some of the key points based on the survey are:

We received information showing 889 General Practices with some form of linked welfare benefits advice provision of which 523 are linked to Citizens Advice. This amounts to 10.5% of the 8,433 general practices in England – although there may be more that did not respond to the survey. Distribution of services across England is very variable and appears to be reducing. Citizens Advice reports a dramatic 33% decline in GP-linked services from 2005.

In addition to services linked to GP surgeries we received information about nearly 200 other services in hospitals, mental health and other health-care settings.

Funding

We estimate that services reported in the survey received total funding of around £5.8 million which provided the equivalent of 167 full-time post (55 of whom are local authority employed welfare rights advisers).

Funding came from a variety of sources including Big Lottery, local authorities, Primary Care and NHS Trusts, and Neighbourhood Renewal Funds. The Macmillan Cancer Care Fund is a significant funder.

Benefits gained

Where services recorded such data, 28,216 people were helped (a significant under-estimate because data were only available for about a third of services).

Overall we estimate the service users gained between £43 and £58 million over a year. The benefit gains were equivalent to around £260,000 additional benefit per full time adviser, an extra £1,549 per service user and a return of around £10 benefit gained per pound spent on the services.

The lack of data kept by some services points to the need for all welfare rights advice services to keep reliable and verified statistics on the additional benefit they have gained which can help demonstrate their value to funders and others. However, money gained is not the only result of advice services and there is a danger that funding is skewed towards projects which
can show higher benefit gains because they target particular groups or advisers ‘cherry pick’ customers.

The National Audit Office commented about the need for reliable, standardised benefit statistical methods by the advice sector and this may be an area for development by a body such as the National Association of Welfare Rights Advisers.

Overview of factors that lead to success and failure

Secure funding and good links with healthcare professionals and GP practice managers consistently emerged as the most significant factors for successful services. Services also needed to have consistent and reliable advisers and interviewees expressed the need to provide flexibility. Successful projects had responded to premises problems by having modest requirements.

The main reason why services fail appears to be the ending of fixed term funding rather than any evidence that the services had not delivered or met funders’ expectations.

Factors which inhibited success include unstable and/or inadequate funding and poor links with health professionals. Services with ongoing funding had the challenge of how to manage the demand for the service.

Working with health professionals

Projects which had done well had invested substantial time in building relationships, including informal links with health professionals and bodies. Good links produced a regular supply of work, and helped projects reach people who were not in touch with advice services.

Many services had invested time in providing training to health professionals – some had sessions which were accredited for Continuing Professional Development purposes which had helped overcome resistance to spending time training.

Advisers often felt that Primary Care Trusts were uninterested in their work and the preventative role of benefits advice was not generally acknowledged. However where the PCT was fully engaged this leads to welfare services being more sustainable and well-integrated.

The impact of services

The interviews found consistent messages about the value of services to users in terms of improved quality of life and a reduction in stress and money worries.

Advice services felt links with health care enabled them to provide a more rounded service to individuals while those with stable funding noted that links with health services had contributed to the stability. Those who worked in health services felt that links with advice services added value and could also reduce demand for health services.
Outline of the project and research methods

Recent years have seen increased interest in the links between poverty and ill-health and the role that a lack of income can play in this. Yet significant numbers of people fail to claim the benefits they are entitled to – between £3.1 and £4.6 billion of income-related benefits are underclaimed by older people each year. And there is evidence that experiencing a social welfare legal problem can affect both physical and mental health with 16% of civil justice problems leading to physical ill-health and 27% leading to stress-related illness.

The value of information for patients is also recognised as an important element of clinical care – for example, the concept of Information Prescriptions is highlighted in the Department of Health’s White Paper ‘Our health, our care, our say,’ published in January 2006.

In response, many local areas have seen the development of independent welfare benefits advice projects linked to health care services, mostly GPs’ practices.

A typical welfare rights advice service located in a healthcare setting would be an outreach session from the adviser’s main office base with pre-booked appointments, made either by the health professionals or the public and with follow-up work (such as advocacy and appeal representation) being done back at base.

Many local evaluations have been carried out of such projects, but a significant weakness is the lack of formal research. Little nationwide work has been undertaken, other than a report in 2005 from Citizens Advice showcasing best practice and the range of CAB advice provision in health settings and the 2004 final Evaluation Report for Citizens Advice on the Wales-wide placement of CAB advisers in all Welsh GPs’ practices (which is discussed further on in this report). The National Audit Office has published work on the scope for improved benefit take-up by older people via healthcare settings.

The purposes of this research project are to:

■ Bring together evidence of effective advice/take-up initiatives in health care settings.

■ Examine the nature, extent, funding and sustainability of such projects.

■ Consider how these have been monitored.

■ Show evidence of the wider impact of these projects.

■ Identify the gaps that exist in the provision of benefits advice in healthcare settings.

■ Explore the role of health professionals in alerting older people to claim benefits.

■ Consider how Age Concern locally and nationally could make the greatest impact through partnership work in such areas.
Research methods

The research was carried out during 2007 and early 2008 and used the following research methods:

- A review of the published literature on the impact of benefits advice.

- A mapping exercise of healthcare-based welfare rights advice, based on data obtained from organisations representing the advice sector and individual advice bodies providing such services.

- Distribution of the questionnaire via bodies representing advice services, via the Rightsnet website and on www.neilbateman.co.uk

- The questionnaire sought to identify inputs, outputs and outcomes for these services and the sources and timeframe for funding. The questionnaire also asked about the factors which hindered or helped the development of services.

- In depth, follow-up telephone interviews with five projects to explore the impact of the services, the challenges and success they had and the reasons why. Projects interviewed were in very different geographical locations (rural, urban, and old industrial areas) and included advice services based in GP practices, a hospital-based project, an advice service for cancer sufferers and their families and a local authority welfare rights service which reached patients by a mailshot to older people via GP records.

- Interviews were also held with 12 healthcare professionals and other stakeholders in these projects. We found it difficult to get busy health professionals to give up time to be interviewed.

- Fieldwork visits and interviews with advisers, stakeholders and service users at two advice projects (Liverpool and the London Borough of Southwark) to showcase best practice.

It was decided to confine the research to England in order to keep it manageable and because there are different funding streams and policy priorities in the devolved administrations.

This has been a fascinating assignment which we believe will be of great value to the advice sector, government, local authorities and NHS bodies.
What is the impact of welfare benefits advice?

There is a growing body of evidence about the wider impact of welfare benefits advice on service users. This chapter summarises some key research findings.

The messages from research show that increasing the take-up of benefits (by people of all ages) has a bigger impact than just on the recipients’ disposable income. The impact can be summarised under several dimensions:

- lifestyles and feeling valued and included
- health and well-being
- economic

The impact of increased benefit income on lifestyles

It may be stating the obvious that increasing the income of those on very low incomes will feed through to an improvement in older peoples’ standard of living and lifestyle and research confirms that this is so.

Research for the National Audit Office carried out by the Universities of Hull and York showed that older people who had been helped to claim benefits, spent the extra money in five main areas:

- Greater weekly spending on essentials, particularly food, clothing and basic utilities (e.g. fuel).
- Enhanced mobility.
- Making use of a wider range of goods and services (for example, casual handymen, cleaners, decorators and more frequent use of hairdressers).
- Lump sum expenditure that had previously been beyond their means – for example, a mobility scooter, carpet or fridge.
- Personal forms of expenditure which had not previously been possible (for example, presents for family members or attending family or community events).

The research also highlighted that there were intangible gains – for example, a greater sense of independence and dignity.
In a survey of 650 older people using Age Concern information and advice services across England the three most common ways of spending extra money gained was:

- practical help at home (cleaner, gardener, etc) – 56%
- extra heating – 46%
- food – 40%

A survey in Sandwell, West Midlands of 71 older people whose benefits had been increased by the local authority welfare rights team, showed that:

- 20% of those surveyed now spent more on food
- 26% worried less about their heating bills
- 11% felt able to buy presents for family and friends

Similar findings emerged from evaluations of Age Concern’s HABIT project aimed at advising older people via GPs’ practices in Liverpool. Focus groups found that individuals used the additional benefits to finance domestic help when they were not eligible for help from social care services and that people ‘no longer felt obligated to friends and family for their informal help, as they could now pay their way’.

Work by Noble et al examining the impact of Disability Living Allowance expenditure found that a significant amount was spent on broadly care-related services and products and this had the effect of adding 25% to the local authority’s community care budget. It is reasonable to assume that because of the similar eligibility criteria, very similar findings would be found with a study of Attendance Allowance.

Both the National Audit Office and Sandwell research also examined how the additional money made older people feel about themselves. Participants whose income had been increased demonstrated that they felt greater levels of:

- independence
- dignity
- participation and
- identity

In the Sandwell study, 26% of respondents worried less about making ends meet, 20% felt happier than before, and 14% felt they had more self-respect.
Abbott et al studied 345 people whose benefits had been increased after advice and found that over half stated that they were better able to pay bills, nearly half stated that they used transport more and over a third stated that they could now eat more and/or better food. A study in Wales of the impact of welfare rights advice on older people found that 70% of participants spent more on fuel, 56% more on food and 45% on ‘independence’.

The impact of increased benefit income on health and well-being

Measuring the impact on health has been the subject of numerous research studies. Many of the studies are classified as ‘grey literature’ – for example, internal reports which may not meet rigorous scientific standards, but there are also a number of empirical studies which show small, positive effects on health.

One problem, with measuring the impact of welfare benefits take-up on health is that by the time a person with health problems is seen by an adviser linked to a healthcare service, the damage to health may already have occurred: ‘...the health benefits of increased welfare benefits may be temporary or offset by ongoing, irreversible health deterioration’. Indeed, in one study, 10% of participants died before the evaluation could be completed.

A further difficulty is that there appear to have been no studies which compare the effect of increased benefit income on people with similar conditions and no account has been taken of the variable effect of illness on different individuals.

Yet another problem is the fact that not everyone whose benefit is increased is on a low income – for example, they may qualify for Attendance Allowance which is not means tested. It is a reasonable hypothesis that the impact of additional income will be greater on people who have a low income and the additional amount of benefit gained can anyway be very variable. None of the studies have taken these aspects into account.

‘There are good theoretical reasons why income supplementation should improve health, but currently little evidence of adequate robustness and quality [our emphasis] to indicate that the impact goes beyond increasing income’. However, evidence from a number of studies does show that increased benefit income following advice in a healthcare context, does lead to a significant improvement in functioning on measures such as vitality, role functioning, mental health, general health, pain tolerance and emotions.

One study indicated that there had been ‘an improvement in psychological well-being’ while another that welfare rights advice delivered to the over 60s in a primary health care setting ‘had a positive effect on quality of life and resulted in increased social participation’.

Yet another study showed that increased income from welfare rights advice was associated with a reduction in physical pain and mental health-related issues such as anxiety and a slight reduction in GP consultations.
In Wales, where all GPs’ practices have a linked adviser, a study of a sample of these GPs indicated that 62.5% felt that patients who had been advised had an improvement in their general health\(^2\). In the evaluation of HABIT, 40% of those surveyed and whose incomes had been increased, said that they felt healthier\(^2\).

While the evidence about impact on physical health may be inconclusive, there is evidence of an impact on aspects of mental health and well-being. This is an area which requires further research.

**The local economic impact**

There is evidence that improved benefit take-up has a positive effect on the local economy.

For example, the research by the Universities of Hull and York which was cited earlier\(^2\), showed that older people are most likely to spend the additional benefit money on local services and goods. The authors also commented that: ‘In just one of our fieldwork sites (Cumbria), it appears that around £34 million per annum may be lost to the local economy [from unclaimed benefits]. This equates to approximately 800 jobs, a significant contribution to the rebuilding of a local economy hit by the impact of Foot and Mouth Disease’ (the fieldwork was undertaken during early 2002).

A study by the Fraser of Allender Institute stated that for this reason, welfare rights advice was the most cost-effective form of job creation and that a welfare rights service in Glasgow which generated £10 million in additional benefits created an additional 258 jobs (mostly long-term)\(^2\). Another study concluded that for each pound of extra benefits, there was a multiplier effect on the local economy with spending being multiplied by 1.7 before that money left that economy\(^2\).

**Conclusion**

Looking at the wider impact of benefit take-up, there is strong evidence to suggest that benefit take-up has a significant impact on the living standards of poorer older people and there are wider impacts on health, well-being, self-esteem and the local economy. The impact on health is, however, complex and requires further work and funding bodies should consider this as a priority area for further investment.
Findings about advice provision in healthcare settings

We undertook a survey and mapping exercise during 2007-08 to identify the scale of welfare benefits advice being delivered in healthcare settings which include older people during 2006. Because of different funding arrangements, the exercise was limited to England. Publicity about the survey was generated via the National Association of Welfare Rights Advisers, Advice UK, Rightsnet, Age Concern and Citizens Advice.

The aim of the exercise was to establish the distribution and scale of advice provision in healthcare settings. We always knew that it would be impossible to obtain a complete picture and for various reasons it proved to be difficult to obtain detailed information about a number of advice sessions. However, we are confident that we have gathered a good picture about the scale and distribution of such services as well as some useful data about their impact and the return on funding.

An additional aim of this part of the project was to identify critical factors for the success of such projects and to identify the scale of short-term funding.

Survey results and feedback from follow-up interviews

We are confident that we have identified the substantial majority of health-care based welfare benefit advice services. According to our survey, in 2006 there were 889 General Practices with some form of linked welfare benefits advice provision (of which 523 are CAB-linked). This amounts to 10.5% of the 8,433 General Practices in England. Even allowing for under-reporting, this means that the vast majority of GPs’ practices in England have no linked welfare benefits provision. The vast majority of services were provided via short-term funding and we had anecdotal evidence that many services which used to exist, no longer do so after the end of the funding period. For example, Citizens Advice reported a dramatic 33% decline in GP-linked services from 200529 and several projects we were told existed, no longer did so when we enquired. Financial pressures on Primary Care Trusts appear to be the major factor why such services do not receive ongoing funding after the end of any fixed term funding.

Distribution of services is very variable. For example, based on the responses we received Cornwall has no services, but neighbouring, more prosperous Devon has 21 (but none in North Devon). Hampshire has five, which is five more than neighbouring Surrey. The London Borough of Tower Hamlets appears to have none while neighbouring Newham with a similar socio-economic profile has 35. The huge variability of distribution suggests that there is no over-arching national strategy to develop advice provision in health-care settings and provision is often the result of local initiatives and enthusiasm – something borne out by our interviews and fieldwork.

In addition to those located in GPs’ practices, we were told about services in 74 hospitals, 93 mental health and 27 other health-care settings.
Our exercise found 6,179 hours of advice provision linked to health services, equating to 167 full-time adviser posts (55 of whom are local authority-employed welfare rights advisers). In addition, services have additional posts dedicated to managerial and administrative support. Where services recorded such data, 28,216 people were helped (a significant under-estimate because data were only available for about a third of services). However, as we were unable to gather data on these points from all the advice services (including all the CABs), these figures significantly understate the scale of provision.

The survey showed that over £4.3 million was spent on funding services, though again this is a significant under-estimate because funding figures were not available for all services. Assuming an estimated gross annual cost of £35,000 (including overheads) per adviser, this suggests that about £5.8 million is being spent annually. There are a variety of funding sources, including Big Lottery, local authorities, Primary Care and NHS Trusts, and Neighbourhood Renewal Funds. Extending provision to even half of all GPs’ practices would therefore involve substantial additional spending and at a level which charitable sources could not meet.

The Macmillan Cancer Care Fund is a significant funder of both voluntary and local authority health-based welfare rights services, providing funding for welfare rights advice to cancer patients and their families via 60 local authority, CAB or other independent advice services. Macmillan’s total spend on welfare rights advice in England during 2007 was estimated to be £4.5m funding 94 full-time equivalent advisers. Because of the distribution of this funding, we may well not have captured much of it in our survey because we were unable to survey each Citizens Advice Bureau and some services did not respond to the survey.

In terms of outputs and outcomes, the survey showed that the healthcare based advice services obtained £43.71 million in additional benefits during 2006. This again understates the success of these projects, because a significant minority of services do not keep figures for the additional benefits gained and verified. This was the equivalent of £260,523 additional benefit per full time adviser, an extra £1,549 per service user and a return of £10.13 per pound spent on the service. Multiplying the estimated £5.8 million being spent on advice services by this figure would suggest that over £58 million in additional benefits were gained during 2006 across England as a result of advice in healthcare settings. This will be an under-estimate for the reasons cited earlier.

The reported amount of additional benefit gained per full time equivalent adviser was very variable, ranging from £71,000 to £1.2 million. There was a clustering of additional benefit gains of about £500,000 per adviser and this may be more typical. The variation may reflect different levels of skill, different service user profiles (for example, lone parents or unemployed people in their fifties who generally have smaller levels of benefit entitlement than disabled people) and the fact that some services also provide advice about other areas (such as housing, debt and employment rights) where benefit gains will be less as a proportion of adviser time.

The survey highlights the need for all welfare rights advice services to keep reliable and verified statistics on the additional benefit they have gained. A surprising number in the survey did not keep such statistics. There are a number of methodological problems with benefit gain data and it does require additional administrative time to follow up service users to establish the outcome of their claims (in any event, follow up is good advice work practice).
Benefit gains data are also vital to demonstrate the value of services to funders, enable performance to be monitored and illustrate how benefit administration services are failing to meet the needs of their customers. However, there is a danger that funding is skewed towards projects which can show higher benefit gains because they target particular groups or advisers ‘cherry pick’ customers who have higher potential benefit gains, when equally important work, from a social inclusion perspective, can be undertaken with groups with smaller benefit gains.

In 2002, the National Audit Office commented about the need for reliable and standardised benefit gain measurement and statistical methods in the advice sector and we would endorse this recommendation. This may be an area for development by a body such as the National Association of Welfare Rights Advisers.

The survey (and follow-up interviews) showed very variable approaches to monitoring of services by funders. Many had light touch arrangements but the most frequent approach was one based on regular (usually three-monthly) reports to funders on activities and outputs. One service we examined had had to tender for funding, whereas others operated with a variety of contracts, business plans with targets (for in-house services) and sometimes looser service level-type agreements.

The survey highlighted the most common reasons why healthcare-based advice services fail to succeed. The main reason for failure appeared to be the ending of fixed-term funding rather than any evidence that the services had not delivered or met funders’ expectations.

In terms of success, secure funding, and good links with healthcare professionals and GP practice managers consistently emerged as the most significant factors.

Factors which inhibited success included the end of funding and poor links with health professionals who would be key to ensuring a good supply of appropriate referrals. Paradoxically, services which had succeeding in obtaining ongoing funding, found that a new challenge emerged – how to manage the demand for the service.
The role of health professionals

Strong links with health professionals are crucial. Projects which had done well had invested substantial time in building relationships, even to the extent of investing time and effort in informal contact at social events and making a point of dropping-in and chatting to health professionals. From this, services felt better able to build an understanding of health professionals’ advice service needs and to clarify how an advice service can help.

Many services had also invested time in formal training of the health professionals linked to their service. This ensured that situations where an advice service could help were clarified, as well as tackling common myths about benefit entitlement. Some GPs were resistant to spending time in training events, so for example, Liverpool’s HABIT project addressed this by having the sessions accredited for Continuing Professional Development purposes and had engaged the PCT in this process.

Feedback from fieldwork and interviews also showed that it is essential to have consistent and reliable advisers, who always turned up for advice sessions at the right times and days. Flexibility also emerged as a strong theme with interviewees stressing that one needed to be able to fit in referrals at short notice, and to tailor a service to the needs of particular locations.

An example of a failed initiative by the DWP was given to us where the advisers were frequently changed, did not always turn up and where the terms of reference for the service were vague. This adviser was reported as spending much of their time reading the magazines in the waiting room, due to this failure to establish a reliable service.

One project we interviewed had not provided feedback to the health professionals about the success rate of benefit claims. The professionals found this puzzling and while it did not deter them from helping, it was perceived as a barrier. It is reasonable to assume that feedback on the performance of an advice project would motivate health professionals to cooperate further.

Advisers felt that having good links produced not only a regular supply of work, but the referrals were more likely to involve people who would not otherwise approach advice services and whose health and recovery was being inhibited by benefit issues. For example, HABIT in Liverpool stated that 93% of their advice service users from primary care services, had never used a mainstream advice agency before.

Southwark Council’s Benefits and Health Project reported that the success of the service combined with strong relationships had resulted in local GPs’ practices actively advertising the benefits advice service as part of a drive to get new patients to register.

Evidence from our interviews and fieldwork suggest that personal links and relationships built up over time with health professionals were a far more effective process that relying on leaflets and posters displayed in waiting rooms.

Of course, building links takes time and needs to be included in the overall costs and time estimates of running an advice service in a health setting.
One strong message from our interviews and fieldwork was that too often advisers had felt that Primary Care Trusts were uninterested in their work, unclear which PCT officials to relate to and that the wider public health and preventative role of benefits advice was not generally acknowledged. Frequent organisational change has not helped and has made communication more difficult. This points to a need for national level work to engage PCTs strategically as well as for advice service managers to invest more time locally in building effective links with them. Southwark’s service had largely overcome these problems because of a long history of joint service delivery by the local authority and PCT resulting in an organisational merger a few years ago.

One advice service (Blackpool CAB) had helped their local PCT to gain Beacon Status as a result of its primary health care advice service. The PCT had been closely involved from the start as a result of being lobbied by GPs to fund an advice service for their practices.

As stated earlier, health-based advice services can secure funding and be effective in spite of the PCT, but to become sustainable and well-integrated, the PCT corporately needs to be engaged in and championing the service.

We had anticipated that suitable premises would be a major problem for advice services and that the lack of space in GPs’ practices would be a barrier. Successful projects had responded to this by having modest requirements for workspace. As long as the space allocated was confidential, included a desk, chairs and phone, the job could be done. Other helpful (but less essential) facilities, included Internet and email access, photocopying and direct access to patient records.

Where there were insurmountable premises problems, some advisers found alternative approaches, such as the health professionals at those premises making referrals to advisers at another health location or by approaching patients using a mailshot sent out by the practice.
Feedback from follow-up telephone interviews

We carried out follow-up telephone interviews with seven advice services (in addition to the two fieldwork sites we visited) to test out emerging hypotheses and to explore themes in more detail. As part of this process we also interviewed key external stakeholders – such as the Primary Care Trust, linked health professionals or local authority service commissioners.

These interviews provided qualitative evidence about the history and impact of the services and also to identify lessons from their experience.

We have summarised key messages from our interviews under the following headings:

1. Why projects were set up.
2. What has worked well.
3. What has not worked well.
4. Impact of the project on patients.
5. Impact on advice services.
6. Impact on health services.

1. Why projects were set up

The lack of any national or wider strategy to encourage the development of welfare rights advice linked to healthcare, meant that services had often developed opportunistically as a result of a specific trigger – this was either a local champion (usually from within the advice sector) who promoted the idea, lobbied funders and obtained support or because of lobbying by interest groups. This helps explain the very variable distribution of advice services discussed earlier.

‘The PCT had feedback from GPs that patients were asking for help with benefit problems’ (advice manager).

‘[At the time of the community care reforms] we invited the voluntary sector to put in bids to help people stay in their homes...we were open to ideas at the time’ (local authority commissioner).

‘Origins lay in ways of looking at depression’ (advice manager).

‘[Funder] approached us showing evidence of non take-up of benefits. The proposal was in the right place at the right time for all concerned’ (consultant nurse).

‘It was my manager’s idea’ (advice worker).

‘It was a local Age Concern initiative taken forward by the PCT and local authority’ (advice worker).
‘It came from the demand from patients for benefits advice. Social workers have training on benefits, but we’re not experts’ (hospital social worker).

2. What has worked well

Where projects had been felt to be a success, several common themes emerged – reaching people not otherwise reached by advice services, having a real impact on people’s lives and the quality of links between health professionals and advisers. Secure funding, where it had been obtained, was clearly something which projects thought worked well, enabling them to build better quality services.

‘We get clients who have never sought advice before, which generates lots of new claims’ (advice manager).

‘The whole concept has been a huge success and has helped us obtain recurrent funding’ (advice manager).

‘Being on the wards in close contact with health and social care staff…reaching people who might not have gone to seek help…ease of access’. (local authority commissioner).

‘Face to face contact with customers. As the letter comes from the GP it inspires confidence’ (advice worker).

‘It’s not difficult to do [the mailshot] and there’s lots of positive feedback from patients’ (practice manager).

‘Establishment of good relations…dealing with the benefit issues gives us a ‘way in’ to other issues’ (consultant nurse).

‘Personalities have helped a lot…referral systems are good and funding has been generous and flexible’ (Macmillan advice manager).

‘The continuity of contact between the advice workers and the ward staff’ (hospital social worker).

‘Helping GPs and enabling them to focus on the healthcare needs of their patients’ (advice manager).

‘Multi-agency approach…awareness sessions [for health professionals]…the quality of the advisers…reaching people who don’t normally use advice services’ (advice manager).

‘The link with primary healthcare teams – the shared approach…ongoing contact with clients’ (PCT manager).
3. What has not worked well

The paradox of stability and success leading to demand management issues was mentioned earlier and was a common theme in the interviews. Some projects had to learn lessons from methods of delivery which had not worked well in the health setting. One project had not succeeded because it had not been based on evidence of need, links with health care professionals were very weak and there was a lack of focus about what services to provide. Some GP practices were not enthusiastic.

‘The 75+ medicals did not work, so we changed; some practices did them, others didn’t…some practices had to be chased’ (PCT manager).

‘One practice wanted a financial incentive before referring patients so we withdrew’ (advice manager).

‘Lack of feedback from the welfare rights advisers’ (practice manager).

‘Caseload is very difficult to manage…we’re too successful’ (advice manager).

‘It can be very hard to get information [from DWP] when the patient has a head injury and officials plead data protection’ (hospital social worker).

‘Meltdown caused by the PCT’s restructuring has caused problems of continuity of personnel’ (PCT manager).

‘Sometimes we have to convince GPs that benefit take-up is relevant to health’ (adviser).

‘Hard to say what has worked well…we’ve had very limited take-up of our service and are not sure why. The area is saturated with advice services, we did no needs analysis and have just relied on publicity’ (adviser, unsuccessful service).

‘Problems with sudden hospital discharges…there’s no time to provide a service and we just signpost’ (advice manager).

‘Demand outstrips supply which creates waiting times so you are more likely to get Do Not Attends’ (advice manager).

4. Impact of the project on patients

Consistent messages emerged here and the quotes speak for themselves.

‘Raised incomes…relieve a lot of anxiety and makes their experience much better for them and their families’ (consultant nurse).

‘Feedback is very positive…we are seen as providing help at a difficult time’ (Macmillan advice manager).

‘They often have considerable financial problems at a very stressful time. The project addresses this’ (Macmillan service manager).
‘Very good impact and uptake better than expected’ (adviser).

‘We get lots of feedback from clients. The service has a big impact on their quality of life’ (advice manager).

‘[Service users] say the project improves their quality of life: diet, transport, leisure, affordability of prescriptions, getting out of hospital quicker’ (advice manager).

‘The project has an impact on what they can afford to do or buy – it increases their quality of life’ (PCT manager).

‘The impact is greatest for those with mental health problems. By tackling stressful situations caused by money problems, there is a greater impact from treatment and better compliance with medication’ (advice manager).

‘The extra income has a big impact on their quality of life, including contributing to healthy eating. It’s part of the holistic approach to care in the community’ (hospital social worker).

5. Impact on advice services

Interviewees felt that having a health-based advice service had helped make their service more rounded. Many services commented about the problems caused by not having ongoing financial stability and those that did have such stability commented how having a healthcare arm, helped that stability. In some settings, emotional pressures on advisers can be acute and they need appropriate support and supervision for example:

‘It has improved awareness of the welfare rights service generally’ (advice manager).

‘It’s given us more stable funding’ (advice manager).

‘Inspires the volunteer advisers’ (advice manager).

‘It’s a positive extension of our work’ (advice manager).

‘We are proud of what it has achieved and the awards have contributed to this. But the continual stress of looking for finance is very hard for them’ (PCT manager).

‘Overall, very positive’ (advice manager).

‘Some very nasty cancers are involved and some patients are young with children. When someone dies, boxes of tissues can be needed’ (adviser).
6. Impact on health services

There was a strong perception that the services had added value to health services and were helping to reduce demand.

‘It's difficult to prove quantifiably or in a way which can be costed, if you increase the quality of life there will be less demand on health services’ (PCT manager).

‘There are no downsides – it’s win, win, win for them. It gets people out of hospital quicker and keeps them in the community longer’ (advice manager).

‘The project enhances health services’ (LA commissioning manager).

‘GPs get fewer requests for form-filling’ (advice manager).

‘I can leave it in the capable hands of the people with the knowledge’ (hospital social worker).

‘The project has a major impact in providing an excellent service to people with cancer and their carers’ (Macmillan manager).

‘Creates some positive good news for my staff…alleviates workloads for doctors and nurses’ (consultant nurse).
Case studies

We visited two health-based benefits advice projects, the Health Advice Benefits Initiative Team (HABIT) run by Age Concern Liverpool and the Benefits and Health Project run by the London Borough of Southwark. The aim of the fieldwork was to get an inside view and also the perspectives of service users and then to present the two projects as case studies in best practice.

### London Borough of Southwark Benefits and Health Project

#### Description

A local authority welfare rights service which includes a team of eight welfare rights advisers whose full-time work is dedicated to advising and helping patients of 39 GP practices across the borough with their benefits issues. All practices (except one with very unsuitable premises) have advice sessions. Fifteen have weekly sessions and 24 others fortnightly sessions, for up to five patients and with cases then being taken on for ongoing casework, including benefit appeals.

In 2006, the service helped 2,004 people to gain an extra £1.7m in benefits. While 21% of service users are aged over 60, a significant proportion is people in their late fifties whose health is failing, often after a lifetime in low paid or insecure work.

The team is part of Southwark’s Health and Social Care Directorate – a joint service which includes both the local authority’s social care and the local Primary Care Trust’s health care services. The welfare rights service’s manager is a council employee and his manager is employed by the PCT. The aim is to integrate health and social care services across the borough.

The service has stable, ongoing funding from the local authority and PCT.

#### Interesting features

We found that this health-based welfare rights service was highly valued by patients, social care and health professionals and GPs. GPs use the service as an active way to market their practices to prospective patients, to help with appointment keeping and to target benefits advice where this will particularly impact on people’s health.

The service has placed a high priority on being flexible while also always consistently delivering a service through each practice’s nominated adviser. Great care is taken to build and sustain trust and to maintain an informal rapport with practice staff.

The close organisational integration of health and social care services in Southwark has greatly helped the service to have financial stability, become a mainstream service for GPs’ practices and to resolve problems quickly. It has also made the service more secure financially compared to other areas of advice provision.
Service user feedback

All the service users we interviewed had previously had longstanding benefit problems which were linked to their poor health and had also not been able to resolve these through traditional advice provision. Comments about the service included: ‘A really excellent service’, ‘Marvellous’, ‘[adviser] was a brilliant lady’.

Contact

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Age Concern Liverpool - Health Advice Benefits Initiative Team (HABIT)

Description
Age Concern Liverpool set up HABIT in 2000. HABIT is a preventative service which aims to help people remain safe, warm and independent in their own homes and to reduce the risk of falls, admission and re-admission to hospital.

It currently employs four full time advisers and it operates by targeting all patients aged over 75 who are registered with GPs in Liverpool. The project works by mailing patients on a rolling basis, so that eventually all those aged over 75 are contacted. The letter in the mailshot is sent jointly by HABIT and the GP and has proved to be very effective in reaching people and in getting them to respond to the offer of advice. There are also some outreach services.

Originally, it had been hoped to link the service with the standard 75 plus health checks, but these proved not to be comprehensive enough. A large number of home visits is undertaken and advice is provided not just about benefits but also about a range of care and support services as well as other issues affecting older people.

Funding for the service comes from Liverpool City Council with some past funding from the Neighbourhood Renewal Fund. Age Concern will have to tender for the work under future funding arrangements.

During 2006, 490 people were actively helped to obtain entitlements and 2,720 were made aware of benefits they were entitled to, gaining a total extra £944,258 in additional benefits (over half of which was Attendance Allowance).

Interesting features
The project has a multi-agency steering group and the rolling mailshot approach is a very cost effective way to reach large numbers of older people who would otherwise not seek advice, including those on low incomes who live in more affluent areas. This method also makes it easier to manage the incoming work and keeps workloads realistic and waiting times for appointments to no more than five weeks. Feedback has consistently shown that 91% - 93% of people who respond have not been in touch with an advice agency, so the service reaches those who do not normally seek advice.

There was NHS involvement from the outset and a variety of sources of funds were used to pump-prime the project so that it has been able to secure more stable funding. The project was originally linked to a Health Action Zone.

Raising awareness among health professionals of what the service can and can’t do has been crucial in building support and the service has also been flexible – for example, in Liverpool 8 the lower age range has been reduced to 60 because of higher early mortality rates and by also providing outreach advice sessions at a joint health and social care centre in the North End of the city.
The project has been formally evaluated several times by different researchers with very positive evidence of its impact on the lives of service users and the partner health services.

Service user feedback

Evaluations have shown consistently positive messages from people who had been advised; overall the importance of being perceived as ‘on their side’ emerges, as do the tangible gains for service users from the pro-active mailshot-based approach. ‘They listen and take notice and do something about it’. ‘…over the moon, I feel so much more independent’. ‘We would not have enquired about benefits – we would have struggled on’.

Contact

Maria Vaccarello. 0151 330 5584
Messages for Age Concern and other advice providers

This research has important messages for anyone who wishes to develop an advice service which is linked to a healthcare setting and this includes not just advisers but funders and service commissioners. The messages include:

Secure and sustainable funding is vital otherwise valuable time is spent managing insecure or short-term funding and constantly having to engage in fundraising activity. Services can also develop, succeed and then fail from a lack of sustainable funding.

Funding doesn’t solve everything. Managing demand while maintaining quality of service is a challenge faced by longer-standing services.

You can develop a service without the NHS/PCT, but you need to actively engage them to make it sustainable. This is essential to ensuring long term success and for ironing out problems. It was also clear that many PCT managers do not understand the role of advice work, the nature of the advice business and sometimes have an over-simplistic view of such services and also fail to understand the importance of independent sources of advice. The advice sector needs to work at engaging the NHS and improving understanding among managers.

Relationships, reliability and trust with NHS colleagues are crucial. This was a strong theme and can make or break a service. Very effective services had invested time in nurturing relationships on both a formal and informal level and had found that this had opened up other opportunities and had enabled trust to be built up. Services had worked hard to adapt to NHS service needs and to be viewed as reliable. Feedback on successes is also important – hence the need for standardised, good quality statistics.

Good quality and credible output and outcome statistics are crucial as evidence about what works, to persuade funders and motivate advisers.

Paid advisers are essential. The work is at the more complex end of the advice spectrum, and continuity of adviser is felt to be essential. Very few services use only volunteer advisers for this work and it was also clear that services had invested in training and support so that advisers were viewed as professional equals to healthcare professionals.

During interviews and fieldwork we asked respondents to list their top messages for anyone setting up an advice service in a healthcare setting. These are some of things they said:

‘Do it – it’s been great really’.

‘Don’t under-estimate the volume of casework, be realistic about what you can do with the money and take time to set up systems’.

‘Engage all stakeholders from the outset’.
‘Have clear quarterly milestones, concise reporting and good data collection’.

‘Try to establish sustainability from the outset’.

‘Careful persistence and getting in touch with all the right people in the GP practice’.

‘Make it as easy as possible for health people to refer’.

‘Research your area and the need for the service, find out who is doing what and build strong links’.

‘Communicate with health professionals – parachuting in doesn’t work’.

‘Admin support is vital’.

‘Develop trust with practices, pick suitable practices with sympathetic GPs, be flexible, find a champion to drive things forward, have high quality staff’.

‘Make sure you have staff who can work in a healthcare setting – there are emotional pressures. We have lost staff who can’t handle this’.

‘Make sure that health professionals understand the advantages of having such a service in their settings, that the service is provided at a time convenient for patients and at a time convenient for the hospital – that it doesn’t disrupt procedures’.

‘Ensure that your steering group is enthusiastic and multi-disciplinary’.

‘Ensure that your service delivery is reliable, committed and enthusiastic with older people’s health at the forefront’.

‘Get Health involved at an early stage; get them to accept ownership; keep re-evaluating and adapting to changing circumstances’.
Conclusion

This study has emphasised the importance of linking advice services to health care services and given an overall picture of the current provision and insights into the factors that lead to success or failure. Many healthcare providers see the value of such services to their clients but this could be increased if there was more evidence about the direct impact of increasing benefit income on health outcomes and we believe research is needed in this area.

Central to success has been the issue of funding and this study is not alone in showing the pressures than many advice services face. In Scotland and Wales the devolved administrations have funded and promoted healthcare service-based welfare benefits and other advice services within the independent sector. There is an urgent need for a national strategy to look at delivery and funding of independent advice provision.
References

1 Income related benefits estimates of take-up in 2005-06. DWP.


4 Information Prescriptions are given by health and social care professionals and are intended to help people with long-term health or social care needs to be guided to relevant sources of information and support (including benefits advice), to help them manage their condition and live healthier, more independent lives. Expectations are that the NHS will be able to provide these from 2008. See www.informationprescription.info.


10 Age Concern (2008) Transforming lives – tackling poverty and promoting independence and dignity through information and advice.


29 Why benefits should be part of the cure The Observer Cash supplement. 4/11/07.

30 Source: Personal communications with author.

31 For example, single, poorer people with disabilities who tend to have multiple benefit entitlement.
