Reducing poverty: welfare rights and health inequalities:

a HAZ project.

An evaluation of primary care based specialist welfare rights advice provision in Lambeth, Southwark and Lewisham.

A stitch in time-

Accessing and funding welfare rights through Health Service Primary Care

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February 2002

Acknowledgements

There are numerous people who have contributed to the successful implementation of this project, and the authors would like to thank everyone who has been associated with its planning and execution. We would particularly like to thank Ian Sandford and the six Primary Care Group representatives for work on the steering group, facilitating the implementation of data collection within practices, and for their subsequent comments on findings. We are grateful to the practice managers, practitioners, providers and patients who participated in the study. Our thanks also go to the community based organisations that provided access to those people who the work intends to support. Lastly we would like to acknowledge the contribution made by David Woodhead, Lisa Webley and Sarah Rogers to the early stages of this project.

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2 Summary

Although the provision of welfare advice in surgeries is not uncommon, little is known about the nature of such provision or best practice. This study addresses these issues through a study of health-funded advice provided in three London Boroughs: Lambeth, Southwark and Lewisham. The study collects data from four stakeholder groups: practice managers, primary health care practitioners, welfare rights advisers and users of the service. It does so through a range of quantitative and qualitative methods. A set of findings and recommendations are then provided.

2.1 Need for the service

There is a significant literature demonstrating the link between poverty and poor health. Generally, primary care is ill-placed to tackle poverty in its entirety. However, the provision of welfare rights advice within GP surgeries has the capacity to contribute to this. It can do this directly through increasing welfare benefits take up and tackling other problems (e.g. unfair dismissal) with financial remedies. It can also ameliorate or remedy other problems associated with poor health, notably homelessness, housing disrepair and community care help. Solving such problems should lead to improvements in physical and mental health.

This study reveals further evidence relevant to the need for in-surgery advice. Practitioners estimated that 1/7 (15%) of their consultations involve welfare rights issues. Half of the practitioners felt the welfare rights issue to be urgent and 71% reported that there had been an element of mental health to their most recent case where welfare rights was an issue (e.g. anxiety or emotional turmoil). These figures suggest that the need for welfare benefits advice is prevalent, pressing and impacts on clients’ mental health. In more than one third of cases the welfare rights issues naturally arose from the consultation and medical reports were (or will be) needed in half of the cases. Thus there is already a nexus between primary care and welfare rights work which is either putting extra pressure on practitioners or leaving welfare benefits needs unresolved

2.2 Benefits of the Service

Overall this move is seen as positive from all perspectives. All stakeholders were strongly positive about the GP-based service. The majority of practices would like to expand welfare advice in various formats. Advisers recognised strong quality and access benefits for in-surgery provision. Patients were very positive about access and quality.

Patients find the actual GP consultations around their medical needs to be short and pressurised. Conversely, the GP surgery is seen as a relaxing, comfortable environment, and somewhere to solve anxieties. From the patients' perspective, confidence and trust already exist in the surgery, making an ideal place for welfare rights to be addressed. This reduces access barriers for patients/clients. The lowering of access barriers was demonstrated from our surveys of practice managers and practitioners. Practices with specialist welfare advisers were more likely to find welfare provision to be adequate; that practice staff could access services for patients; that patients can access advice themselves (reducing the burden on

GPs and surgery staff); and, that the process of obtaining advice runs smoothly. Practitioners were significantly more likely to raise a welfare issue with their patient if they had in-house specialist advice provision. Patients were significantly more likely to ask for information or guidance from those practitioners with access to specialist welfare advice.

In terms of quality, for patients the provider skills of the advice worker were strongly valued. Their discussions suggested that the pre-existing clinical relationship facilitates understanding of the patient's illness. In addition to advice giving, form filling and advocacy at appeal were important tasks performed by the adviser.

For practitioners, those *with* specialist welfare rights provision were more likely to be more satisfied with the quality of provision for their patients. Those with specialist in-house provision were also significantly more likely to agree that welfare rights provision improves the health and well-being of their patients.

Advisers were conscious of a number of "health-welfare synergies" which emerged from forming working relationships with health professionals. This benefited the work of both practitioners and welfare rights providers and the patients. Multi-professional approaches to welfare rights in primary care work well in terms of raising issues and referring to specialist advisers.

86% of respondents felt there were patients less able to access the advice they needed (identified as people with language difficulties, ethnic minorities, those with mental health problems, and the elderly). There was little evidence of targeting of groups with high needs.

Surgery-based provision seemed particularly helpful for older patients. They also have particular needs. The centralised arrangements of traditional advice services are unsuitable (e.g. queues that require clients to stand for long periods). Customer service and good attitude from advice staff are crucial aspects of services for older people. Older women have particular advice needs, as they may be unaccustomed to dealing with financial matters. Older people find that the complexities, stresses and stigma combine to discourage them from gaining advice or applying for benefits. Comprehending the system of advice provision, and the materials provided, is difficult.

2.3 Barriers to service and difficulties with current provision

The principal difficulty with the service is that there is not enough of it:

- Geographical coverage is incomplete (there is a postcode lottery); and,
- Levels of demand are high. Appointment waiting times can be up to 6 weeks

For surgeries, lack of space and funding were the principal reasons for not having in-house specialist provision. A lack of need for/prioritising of this type of service was identified in half of those without specialist provision.

A large number of welfare benefits problems are not raised by clients. Staff need to be aware of basic welfare rights issues, but training/information for staff to update on benefit eligibility and changes in payments was provided in only 8% of surgeries.

Home visits and interpreting services were only available to patients in half of those surgeries with advisers. Confidentiality and accuracy of information were weakened with the use of lay interpreters.

Asylum seekers are a group which is particularly hard to reach . Not all have a GP, and these will be denied a surgery-based advisor. They are also particularly likely to have no idea where to turn for advice.

Adviser time is roughly evenly divided between client contact and administration of cases/doing case work. Advisers suggested that there is inadequate time to do casework as a result. This is in contrast with one PCG representative’s view suggesting that two thirds of adviser time should be spent on direct client contact and only one third on case/work administration. It is possible that funders are modeling their concept of provision on the medical context, rather than the realities of legal advice work. Assistance and follow up are essential parts of the legal work and are key determinants of its quality and effectiveness.

Advice services within surgeries were concentrated on welfare benefits advice, and the extent to which other areas of advice could be given was patchy although housing, family and employment were the most common additional issues.

Facilities within surgeries were described as good or adequate, although the provision of appropriate confidential space was sometimes problematic. A lack of availability of interpreting services was reported.

Monitoring and quality control varied greatly, as did levels of training. Joint funding (health/social services) had been achieved in only 2 PCGs. Contracting decisions and budgets had been inherited from health authorities and contracts did not generally specify proportions of casework/administration, case continuity or targeted work. Monitoring data was not returned consistently. Sharing management and managed resources between services could enhance efficiency and provision.

2.4 Recommendations

These are divided into training, management, funding and provision, and development issues.

- Funding of welfare rights through health service primary health care provides two key benefits from the consumer perspective. One is that it considerably increases the likelihood of patients seeking advice with their welfare rights problems. The other is that it enables advisers to provide higher standards of service because of the synergies between welfare rights advisers and health professionals.

- For the health care professionals, it enables their surgeries to provide a better service which is likely to improve mental and physical health but also reduces pressure for non health advice within medical health consultations.

- The evidence is that all stake holders with experience of in service provision are strongly supportive of in-house welfare rights provision. Those who do not have in-house provision put a strong case for having in-house provision.

- The constraints to provision and expansion are complex. At times they are economic, relate to geographic considerations, limited by management, historical and occasionally but not to be overlooked, attitudinal.

- Provision is currently patchy and needs to be extended to uniform levels across the borough.

- Service should be extended across the health authority.

- Attention should be given to all levels of extension, including creation, size of provision, allocation of time and resources.
- Management structures to ensure quality provision should be included

- The pressure on services may leave the most needy least met. Consideration should be given to targeting hard to reach groups either via existing services or the creation of additional services.

- Creativity may be needed in order to enhance promotion and targeting which are likely to produce clear benefits.

- Inadequate provision may backfire and create backlog, access barriers and frustration.

- Coordinated monitoring with common data sets will streamline provision, allow different funders to have their information needs met and minimise the burden on providers who may be stretched by the immediacy of client need. Such co-ordination should be at regional and national level, merging the requirements of other funders under the aegis of the Community Legal Service Partnerships.

- Training should be part of provision. This includes training of health care providers to detect and refer adequately as well as legal service provider training.

- There should be coordination and provision of training for welfare rights advisers.

- Complaint systems, supervision, and quality management should be developed in a form which could integrate with the general practice environment.

- Low level information and signposting provision should be made available to surgeries and users in addition.

- Provision must be in a confidential separate room and not in a public waiting room area.

- An office with a telephone, desk and basic storage facilities are minimal requirements.

- General Practitioner support is vital.

- Reception staff support and training on facilitation is vital. They often are the "gatekeepers" of access and can have positive or negative effects on both the clients and the providers who may be viewed essentially as "guests" in their environment. Blocking and deflecting access could be a serious impediment . Integration, on the other hand streamlines provision, with facilities and provisions such as joint appointment list keeping, facility sharing such as fax and telephone and office supplies.

- Home visits form a key element in provision, especially for housebound and disabled clients. This has specific funding and resource implications.

- Subject area limitations could impede provision. Flexibility in approach to the needs of clients will ensure a more effective service in meeting unmet need.

- Although provision is couched under the heading of welfare rights, we do not think the service should be confined to advice on welfare benefits problems exclusively. Other advice needs have implications for mental and physical health and often overlap.

- Welfare rights case work needs follow up, engagement with external agencies and institutions and sometimes representation in order to complete cases effectively and to maximize outcomes for patients. Funding systems and work practice need to allow proper time beyond client contact hours to maximise benefit. This model may be in contrast to a health care or therapeutic model of the balance between patient interaction and outcome. This needs to be acknowledged and provided for.

- The Health Authority should carefully consider the coordination and joint management of all welfare rights contracts delivered under the Health Authority's funding (even if devolved) in order to maximise efficient use of management and casework staff (including e.g. sickness cover), equality of monitoring, training and assessment of quality.

3 Introduction and overview

This Health Action Zone study was undertaken to review the provision of welfare rights advice through Lambeth Southwark and Lewisham Health Authority (LSL) from a range of perspectives. Key local stakeholders in the funding, provision and receipt of specialist advice were identified: funders (Primary Care Groups [PCGs]), providers (statutory, voluntary and Legal Services Commission contracted legal advice providers), health practitioners (primary care staff) and the target population (patients).

The Project Advisory Group consisted of all PCGs representatives (Gill Baker, Sharon Jones, Kirsten Campbell, Gill Ross, Jane Miller, Sue Arnold and Lucy Day), academic research staff from the 2 institutions undertaking the research (see list of authors), and the HAZ representative from LSL (Ian Sandford). David Woodhead was first chair of the Group, and the chair was subsequently rotated between PCGs. Ian Sandford acted as secretary for project meetings. The research questions were formulated, implementation planned, and data disseminated and discussed by the group at each stage of the study.

The study took place over a period of 15 months (beginning in September 2001). During the implementation of this project, a health authority funding round took place and several decisions regarding funding and provision were taken within PCGs. Therefore, all data reflect arrangements at the time of collection. The formative and consultative nature of the review enabled funding decisions to be informed by emerging data.

3.1 Setting for the present welfare rights advice project

This study was conducted in surgeries among the 6 Primary Care Groups (PCGs) that comprise an inner London Health Authority with a high level of deprivation, scoring 44.22 on the Jarman rating. Male life expectancy is 2 years lower than the average for England and Wales, and the birth rate higher (16.5 live births per 000, compared to 12.2 for England and Wales). There is a comparatively high rate of termination, higher proportion of babies with low birth weights, the still birth rate is twice as high, and rates of teenage pregnancy are 70% higher, than that of England and Wales. Also, rates of perinatal mortality, and deaths from respiratory disease, cerebrovascular disease and accidents are higher than for England and Wales (Lambeth Southwark & Lewisham Health Authority 2001).

There are 158 GP surgeries serving a population of approximately 750,000 residents. The health authority is divided into 3 boroughs, each of which is divided into North and South. Each of these 6 divisions have their own Primary Care Group (PCG) and PCG representative. PCGS have initiated and funded welfare rights contracts to provide specialist advisers within a number of surgeries.

- This report will describe the service from the perspective of contracted providers and consider what information exists on other services are available in the areas (chapter 4). A Survey of practice managers (chapter 5) is complemented with practitioner case audits (chap 6). Finally, the funders’ viewpoints (PCGs) (chapter 7) and a consumer audit (chapter 8) are presented.

Ethical approval for the research was granted by the Royal Free Hospital & Medical School Local Research Ethics Committee (ref no 231-2K).

Figure 1. Health inequalities and welfare rights: project overview

4 Welfare rights and health inequalities: a review

The effects of low income and poverty are recognised to be key determinants of an individual's health. This link has been found to be consistent across studies, and universal access to healthcare does not reduce inequalities (Marmot et al. 1997). Several studies have found that poverty is a factor leading to significantly poorer health. Thus, multivariate analysis of the relationship between income and self-perceived health among British men found that low individual and household income were related to poor health, after adjusting for employment status, education and social class (Rahkonen et al. 2000). In Britain, 50% of the health disadvantage of lone mothers is accounted for by the mediating factors of poverty and joblessness (Whitehead et al. 2000). The higher morbidity and mortality among Black Americans in comparison to their White counterparts has been explained as primarily a result of socio-economic conditions not health risk behaviours. In considering interventions to address this inequality, there is no evidence that there are differences between ethnic groups in their ability to transform socio-economic resources into good health (Hayward et al. 2000).

Socio-economic predictors of increased GP consultation rates have been identified as living in public housing, being from an ethnic minority, and coming from a single parent family (Balajaran et al. 1992). Elevated rates of consultation have also been identified among the permanently sick and the unemployed (Carr-Hill et al. 1996). Among young mothers, relative deprivation has been associated with greater morbidity and increased GP consultations for stress related conditions such as depression, headache and anxiety (Baker & Taylor 2001). Interestingly, elevated patient deprivation scores have been associated with both higher scores of psychological distress and shorter GP consultation time (Stirling et al. 2001)Stirling AM, Wilson P, et al. 2001 ID: 23}{Stirling AM, Wilson P, et al. 2001 ID: 23} therefore reducing the likelihood of detection and discussion for those with greatest welfare needs.

It has been suggested that interventions aiming to reduce health inequalities may be difficult to undertake, and that despite the research evidence linking poverty to poor health outcomes, there have been few practical interventions (Syme 1998). The means by which poverty and health inequalities are to be reduced must be clarified, in particular identifying whether we aim to reduce absolute or relative poverty. Relative poverty has been identified as a stronger indicator of health inequality then absolute poverty (Wilkinson 1997), and this is attributed to the psychosocial circumstances of those in positions of greater deprivation relative to others, and the resultant stresses and behaviours. The influence of socioeconomic deprivation is initially apparent in primary care, and it is in general practice that we may be most able to provide solutions to UK health inequalities (Beale 2001).Beale N 2001 ID: 22) {Beale N 2001 ID: 22} Similarl, increasing welfare benefits take-up is a strategy likely to have an immediate impact on absolute and relative poverty. However, the formulation of an adequate response may be the greatest current challenge to British General Practice (Smeeth & Heath 2001).

An audit of consultations with 7000 patients over a two-year period found that 2.3% of presenting problems were connected with the patients' social circumstances. Among chronic patients, one third were found to have unclaimed welfare rights entitlement, leading to the conclusion that surgery staff are well placed to detect need (particularly as two thirds of the population see their GP once a year) but not to meet it (Jarman

1985). Contact with social or medical care providers does not necessarily mean that welfare rights eligibility will be detected. A study of mental health service users found that 51% were not receiving the welfare benefit to which they were entitled, irrespective of whether they had accessed advice previously, or had ongoing contact with care services (Pacitti & Dimmick 1996). Income maximisation is an effective tool for GPs to promote health, and there appears to be an assumption on the part of patients that GPs will automatically inform them of their entitlement (Ennals 1990). This assumption has also been found among clients of mental health services (Pacitti & Dimmick 1996). However, it is unrealistic to expect clinical staff to maintain accurate knowledge as the eligibility criteria, range and value of welfare benefits are constantly changing. Although the time spent with patients in consultation is increasing, the pressures due to increased roles (e.g. health promotion) create extra stress for general practitioners, and may only be relieved through the reconfiguration of practice services (Mechanic 2001). One solution is the specialist provision of welfare rights in primary care settings.

There are currently few evaluations of specialist welfare advice in primary care, and these have used mainly descriptive and single group methodologies. An evaluation of a Citizens' Advice Bureau in a primary care setting found that among those whose income had increased as a result of the service, there were improvements in psychological (but not physical) health (Abbott & Hobby 2000). Although the goal of such income maximisation interventions is to address broad health inequalities, it is argued that in the shorter term we are likely to find improvements in psychological rather than physical health. An aim of the provision of welfare rights in primary care settings is to increase access, and retrospective data on such a service found that 58% of users had not previously accessed any advice service (Coppel et al. 2001). A prospective study of

CAB sessions demonstrated the effectiveness of the service on several outcomes. The sessions generated a large number of welfare benefit payments, those who used the service had rarely accessed such services elsewhere, and were the most in need (i.e. the disabled, those on low incomes, single parents and people living in public housing) (Paris & Player 1993).

Primary care based interventions to reduce poverty and health inequalities will depend on practices recognising the importance and potential impact of specialist welfare rights providers within practices, and viewing them as part of the multidisciplinary primary care team. The general practice perspective of how they currently meet welfare rights needs, how they view the importance of the provision of welfare rights advice, and how and where they would like to see such specialist provision developed, is not yet known. Although the provision of specialist welfare rights information in primary care settings is seen to be an appropriate and effective intervention for reducing health inequalities, provision is patchy and not necessarily encouraged by clinical staff. The GP perspective on the biopsychosocial model of care (which includes patients' welfare in the remit of primary care), has been investigated in a study which measured how appropriate GPs found a range of potential presenting issues (Dowrick et al. 1996). Social problems were found to be seven times more likely to be seen as inappropriate than medical problems, and issues involving housing or welfare rights were seen as highly inappropriate to present, or for a GP to manage. Predictors of psychosocial problem disclosure to primary care clinicians have been identified as greater familiarity and prior enquiry, therefore making the general practice setting an appropriate place for some patients to address welfare rights issues (Robinson & Roter 1999).

5 Contracted providers of specialist advice

This chapter summarises data from interviews with four organisations providing welfare rights through GP Surgeries in Lambeth Southwark Lewisham, undertaken in early 2001:

- Lewisham Association of People with Disabilities (LAPD) (GP service now closed)
- Lewisham Citizens Advice Bureau Service
- Southwark Consumer and Money Advice Centre
- Lambeth Money Advice Project

The principal aims of the interviews were to explore the way that the services were managed; the types and levels of service provided; how issues of quality control were managed; and to examine how advice services were structured within GP settings.

The interviews revealed, in particular, differences in the management of services and the work types and levels of service provided within each organisation.

Some quality control issues may need addressing, particularly if the service is to move towards being quality marked as part of the Community Legal Service.

5.1 Overview

Each service was structured on fairly similar lines in terms of provision within the surgeries. Advice workers were allocated to particular surgeries and attended either weekly or fortnightly in those surgeries usually for one morning or afternoon session per week. Conversely, one large surgery was attended full time by one adviser. In general, the services were provided by appointment, such appointments being managed by the GP surgery receptionists. Clients would usually be either referred by GPs or other workers within the surgery or self refer in the light of publicity and awareness of the service generally within the locality. Some advisers suggested there were high levels of self-referral. Although there was some variability in the rate of non-attendance by clients with appointments (usually referred to in the statistics as “DNAs” (do not attends)), the services generally appeared to be running at or close to capacity. As well as appointments, advice workers generally reported that they were willing to, and frequently had to, see clients as emergencies outside of the ordinary appointment scheme.

Adviser time was generally split fifty percent between interviews and fifty percent for casework and administration. As clients were generally seen on the basis of half hour appointments, this would suggest that the time available for casework on cases in the surgeries was quite limited. Specific figures were not available. Some caseworkers and managers reported caseworkers having to take large amounts of work home with them to ensure that clients’ cases were properly progressed. It is difficult to see how, within current resourcing patterns, and apparently increasing levels of demand for the service, this problem can be addressed. There are merits in considering a move towards a lower ratio of interview to casework time if resources can be found.

Evidence provided from advice workers and managers as well as primary care group liaison suggested that geographical coverage is incomplete and has arisen on an historical and/or ad hoc basis. It has been suggested that services could move towards a cluster basis whereby GP surgeries would refer clients with welfare rights problems to another surgery which housed a welfare rights adviser. High levels of demand in existing surgeries would suggest that this may be problematic. Similarly, there is some sensitivity amongst GPs to sending clients to other surgeries. There are also access problems for clients in being asked to travel to a new, unknown, surgery. Part of the access benefit of the service is that clients access it within very familiar surroundings. There are also considerable benefits for clients, welfare rights advisers and health practitioners in the human contact which takes place in surgery based services. These “health welfare synergies” are discussed further below.

‘Do not attend’ rates appear to present a problem in a minority of surgeries. Agencies generally dealt with this by trying to keep waiting lists for appointments down (though in some surgeries waiting times were up to six weeks) or employing reserve lists whereby the surgeries would offer clients appointments the day before the adviser was due when vacancies became apparent. This apparently worked well in some areas although advisers in surgeries appeared to prefer booking in clients over slightly longer periods.

5.2 Variations in service

This project was not able to make any direct assessment of the quality of work provided by each individual agency. Evidence received, albeit generally self serving, suggested that advice work was of a satisfactory or high quality. The principal interest, however, lay in processes for dealing with casework and in the types of service that were provided. There were significant variations in the work categories that each service expected to cover. Sometimes, it was also noted that there were differences in the expectation of the Health Authority/Health Action Zone funders and the service providers.

All agencies seemed to concentrate mostly on welfare benefits type provision. One service (LAPD) concentrated solely on welfare benefits and related advice for disabled clients. Two other services (Lambeth Money Advice Health Project and the Southwark Money Advice Project) were funded, in their view, to concentrate on welfare benefits advice although Lambeth also did some debt related work. Southwark referred debt work to debt workers separately funded by the local authority. They similarly referred clients with consumer problems to consumer advisers separately funded. Nevertheless, advisers under the Welfare Benefits and Health Project tended to see clients with a range of problems and consider those problems initially to see if there was a welfare benefits component to them. Thus, in particular, housing problems would be reviewed to see if there was a housing benefit or council tax benefit element to the problem. Similarly, one of the advisers dealt with some social service issues unrelated to welfare benefits advice. Largely, the expectations of the providers, their training and approach was geared towards giving welfare benefits advice.

This could be contrasted with Lewisham CAB where the advisers saw themselves as providing generalist advice on almost any type of problem with which the client presented (other than legal problems where the client would clearly need to be referred to a solicitor). One of the reasons for this difference was the conception of this service within the broader CAB framework. Another reason was that the Lambeth and Southwark services, being funded within local authority frameworks, were constrained in the types of case that they could continue with. There were particular problems, for instance, with conflicts of interest arising where the client was being advised in relation to debt and that debt would, or would be likely to, relate to court proceedings which were being taken by the local authority. Similarly, advising clients in relation to housing debt was quite likely to involve the adviser in advising in relation to a case being brought by the local authority. Not only was this in itself a potential conflict, but such cases can often lead to disrepair cases being brought by clients against the council as a counter claim against the local authority. It is important for the HAZ funders to be aware of these potential conflicts in deciding who to contract with and what for. Different patterns of referral would lead to varying levels and types of casework The CAB service was also supported by a much wider information service (then NACAB information system) on CD-roms which meant that the advisers could easily transfer the information into computers at the surgeries or carry the information with them. There was some suggestion in comments made by PCG liaison people that a more generalist service led the CAB service to be not as good at welfare benefits type issues. Conversely, there is a potential for clients with problems which stray outside of the welfare benefits field to be dealt with by the GP service advisers without the need for referral (and the potential then for the client to give up on their problem). This can lead to important outcomes as one interviewee exampled:

> **“***one fairly notable one where the woman did come and see me about debt and wound up getting a three thousand pound settlement from her employers with no idea that she had an employment problem when she came in and saw me.”*

Even the CAB service, however, tended to refer certain types of problems where they had an internal service to refer to (particularly debt advice was referred in-house).

As well as the work categories on which advisers would typically advise and take casework, there were some variations in the level of work that would be performed for clients. In particular, the CAB service appeared less inclined to take cases to tribunals. They would prepare submissions for clients but indicated they would only attend tribunals where there was a particular need for the client to be represented (e.g. learning difficulties or other concerns with the clients’ ability to represent themselves). This was not a limitation that the other providers indicated they worked under.

There were also differences in their ability to do home visits. All advisers indicated that they would try and do home visits where appropriate. The CAB service was under some limitation on the basis that there had been a policy issued which required advisers to do home visits in pairs (i.e. advisers were not allowed to visit on their own). Advisers indicated that on occasion they would ignore this guidance where they felt that their safety was not in jeopardy. Other agencies were reluctant to do home visits because of the extra time that they took. Policies on when home visits would take place were unclear. Sometimes this was decided by the GP or surgery, on other occasions the adviser formed a view on whether it was necessary.

Another particular area where the type of work done for clients differed was in the handling of medical reports. Some advisers in some agencies would prepare draft medical reports based on their interviews with the clients for doctors to review and adopt. Other advisers were much more reluctant to involve themselves in this process, seeing medical reports as the responsibility of the doctor. There were obvious advantages to the GPs (reported by advisers) to the practice of advisers doing draft reports for them. Welfare advisers had a closer knowledge of the factors that would influence benefit decisions. They also had more time to spend with clients to collect information about disability related problems which could then go into the report. One adviser reported some problems in producing evidence in this way in the eyes of third parties, however, and there is an obvious issue about doctors being sure that the evidence they give is correct.

5.3 Facilities

Generally, advisers reported that facilities were either good or adequate for their surgeries. The following were considered important facilities:

- A room which was confidential and did not present security risks to the adviser (i.e. was not too isolated from others in the surgeries and/or did not have the possibility of the client making it difficult for the adviser to leave the room, etc.). There were some examples of surgeries finding it difficult to provide a room which was suitably confidential although most advisers indicated that they had managed to sort out these problems with surgeries currently participating in the project. It seemed that some surgeries had been removed from the project on the basis of their inability to provide confidential and appropriate accommodation.

- An important point in relation to access and facilities is that the room available for welfare rights advisers should be on the ground floor. This was usually, but not always, the case.

- Some advisers reported difficulties in not having telephones in their rooms or not being able to dial out on telephones to certain numbers (e.g. mobiles of clients and benefits agency numbers in Northern Ireland). Some of them felt that surgeries resented them using basic facilities such as faxes and photocopiers.

- Access to computer terminals was variable.

- A related resourcing issue was access to interpreters. Advisers reported sometimes long waiting lists for translators. They generally relied on clients bringing relatives or friends who could translate for them although this could present problems for the client, particularly when they were discussing sensitive medical issues.

- Access to reference material was very basic in surgeries. Some agencies reported limited office-based reference materials.

5.4 Management

There appeared to be significant variability in the level of management resource applied to particular services. Most advisers were working in a self-sufficient way within agencies (i.e. away from their own offices) for large portions of the week. Advisers reported experienced teams within which they could discuss issues that arose on cases. Lewisham and Southwark both had managers responsible for overseeing the service. Lambeth did not have a funded manager although a member of staff from another department was attempting to carry out a managerial role on a “pro bono” basis. Lambeth has had particular problems as the service appears to have been transferred between three departments with the final host department initially understanding that the service was solely funded by the Health Authority and not realising that they were supposed to be providing managerial support. The Lambeth interviewees reported no resourcing for training and other types of managerial support.

The services did provide, or were supposed to be providing, detailed statistical breakdowns on a quarterly basis of clients, attendance rates, case profiles and outcomes. This meant that an important part of resourcing the service is administration and managerial activity. It also suggests that there may be the potential for co-ordination and sharing of these responsibilities between the services, perhaps even bringing some aspects of this work together. This would obviously present problems in terms of overcoming organisational boundaries and so on but there appear to be some significant duplication of management roles within the organisations which, if properly resourced and sensitively handled, might be better dealt with in a more unified way. Similarly, some advisers suggested that the individual providers were too small to provide adequate or sensible sickness cover but collectively the services could (say) fund a caseworker to provide sickness cover.

Some aspects of quality control within the organisations were impressive. Several of the agencies involved conducted surveys of host organisations (e.g. practice managers and clients). The surveys, although self-serving to an extent, provided some impressive data on levels of satisfaction and support for the service within the surgeries and the various client groups. However, there were two areas where quality control issues were not handled at a level approaching best practice.

The first of these was with regard to the supervision of the quality of casework by individual caseworkers. As discussed above, caseworkers were largely working independently within GP surgeries and on their own cases. Whilst advisers reported that they would typically discuss problem cases with other workers or managers, the agencies did not have clear approaches to file review which involved managers and/or supervisors selecting files at random and then reviewing the quality of work conducted on them (this is a key feature of the quality mark approach adopted by the Legal Services Commission and recognised as good practice). Under the agencies' current approach, it appeared there was the potential for advisers to control the types of cases that were reviewed if any were reviewed at all.

The second area where there appeared to be a general lack of procedures or clarity of approach was in the handling of complaints. This could be particularly important given the potential for complaints to affect two organisations (agencies and surgeries). Some organisations did not appear to have any written complaints policies. Others had clear complaints policies but there was not a clear protocol for linking their complaints handling with the complaints handling of GP surgeries. It may be that this is being dealt with suitably on an informal basis. However, a developmental point which could be raised with the agencies is the agreement of a suitable complaints protocol with their host agencies which ensures that the host and the advice agency both have suitable feedback and involvement in the complaints process.

Another area which may need some clarification is welfare rights advisers having access to medical records. Advisers only indicated that they did this where they had the client's consent. It was not clear to the researchers what process was gone through to gain this consent and how that consent was recorded.

The relationship between advisers and funders (particularly via the primary care groups) was apparently managed through regular meetings and reports (usually quarterly). Some adviser/managers reported that quarterly meetings for some services had fallen into abeyance. Such meetings split management and administration between a number of agencies and services. It is an area of management duplication which could be made more effective and less resource intensive if managerial control could be unified in some way.

Levels of training varied between the agencies. Consideration should be given to encouraging joint training.

Links between the service and the surgeries appeared generally cordial and sometimes very strong. However, there was an impression created by the advisers that relationships with some surgeries could be improved and, in particular, it was difficult for advisers always to have strong links with all GPs within particular surgeries. This is an inevitable effect of advisers working within doctors' surgeries on an area which is important, but peripheral, to the main concern of the doctors and where doctor involvement might require more time than can be committed. Some agencies tackled this through holding training sessions in GP surgeries and simply trying to build up relationships on a day to day basis with any interested medical staff in the agency. For instance, one adviser reported that a "problem" surgery had been converted to the advice service by a locum doctor who had enthusiastically backed the service within the surgery. From advisers' points of view, it may be sensible for surgeries to consider how they might increase the profile of the adviser within the surgery without increasing significantly the time burden of other members of staff. For instance, some surgeries had hoped to invite advisers to their surgery meetings. This is a very sensible idea, but requires the surgery to be able to time their meetings to a day when the adviser is able to attend (given their commitments in other surgeries).

5.5 Targeting Special Groups

There was generally very little evidence of services targeting particular client groups or problem types. There were, however, some contrary indications. One agency, for instance, had begun to target the over seventy-fives by mailing out information to them through the GP surgery about the possibility of having welfare benefits reviews. Similarly the welfare benefits needs of particular types of patients were also emphasised informally within the surgery (e.g. expectant mothers) in the hope that health staff would encourage those clients to approach the welfare rights adviser on a more routine basis. Areas of particular need which were identified by the advisers we interviewed were:

- Expectant mothers and single parents.

- Asylum seekers (although a problem was reported in trying to address asylum seekers through GP surgeries where such surgeries might be reluctant to register asylum seekers as patients).

- The terminally ill and carers who were a key group who might need, and could receive welfare benefits help.

- Patients with mental health problems.

- Over seventy-fives.

5.6 Overview of the service: health welfare synergies

Advisers were highly committed to, and enjoyed, their role within GP surgeries. They saw a number of benefits to providing a service within this context. In particular, there were a number of “health welfare synergies” which developed as a result of having the service situated in a GP surgery. These included the following.

- Advisers and medical staff were able to discuss the interrelationship between the clients disabilities and their needs as welfare benefits recipients. Welfare advisers gained a greater understanding of doctors’ perspectives on these problems and were able to informally educate the doctors about how the welfare benefits system structured its response to medical issues.

- Welfare benefits advisers were better able (because of the time they could spend with clients) to identify symptoms and problems which were relevant to their welfare benefits problems which doctors could then consider in a way which would not be possible through doctors' normal appointments (being very short and aimed at diagnosis/treatment).

- These benefits extended beyond the clients' immediate welfare benefits problems and sometimes led to the client receiving further health services (e.g. identifying problems which doctors were not aware of which required medical treatment and/or counselling).

- Surgeries presented major benefits in terms of access. The fact that the surgeries were appointment based (rather than the more typical queue based systems employed in voluntary organisations and advice agencies generally) meant that clients could be sure of getting a contact. Another access benefit for clients is that the advice takes place within an environment with which they are familiar and they are recommended to the adviser by someone they trust. Several advisers reported that the context of the advice meant that it was much easier for advisers to build up trust and rapport with clients which was important when they were collecting information with regard to, for instance, sensitive disability problems.

Conversely doctors sometimes have unrealistic expectations of the advisers expecting them to deal with all problems other than health problems.

5.7 Legal Services Commission mapping data

5.7.1 Rationale and procedure

This section considers other providers of advice that are known to be providing welfare rights services in the three boroughs making up the HAZ area. Each of the three boroughs has signed up to borough-wide Community Legal Services Partnerships. One of the tasks of these partnerships is to map the supply of advice services in their locale. After discussion with the partnership coordinators, the research agreed not to conduct its own mapping exercise but to rely on the Partnerships' mapping exercises and thus avoid supplier 'burn out' from repeat questionnaires. The current situation is that mapping exercises have been concluded in Southwark and Lewisham. The CLSP in Lambeth has not, however, been able to complete its mapping exercise, so it is not possible to report data on Lambeth.

5.7.2 Findings

Southwark CLSP sought to map information, advice and representation services amongst 485 providers in the borough (Southwark Community Partnership, 2001). 161 responded to their survey, of which 60% were not for profit (NFP) agencies (including advice centres, law centres and community organisations) and 31% were solicitors. The remaining 9% were principally in-house local authority services. The principal funders of these services were the Legal Services Commission, the London Borough of

Southwark and various charities. In Lewisham, 74 providers were mapped from potential list of 139. 58% of these were NFP/voluntary agencies and 29% solicitors.[1]

Although these numbers appear high, ‘providers’ can include basic information and general sources of advice. The most important part of the mapping exercise for our purposes is the identification of specialist advice providers as these are providers operating at levels similar to the in-house GP services funded by the health authority. Even this data is of limited use as it provides no indication of the volume of advice provided by each specialist provider. Similarly there is a tendency for such supply mapping to overestimate levels of provision, e.g. because providers self-identify as ‘specialists’. Data in Southwark is particularly likely to overestimate provision. Nevertheless data on specialist providers is included for indicative purposes:

Table 1 Specialist providers in Lewisham and Southwark

Work category	Number of specialist help providers	
	Lewisham	Southwark
Housing	6	37
Welfare Benefits	8	29
Debt/Money Advice	2	16
Employment	6	17
Consumer	0	14
Education	0	2
Health and Mental Health	3	11
Community Care	0	5
Immigration	6	31

Specialist providers are predominantly solicitors operating under Legal Services Commission contracts (legal aid). Other specialist providers include specialist advice centres, law centres and community organisations. The Lewisham data suggests that

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[1] Unpublished information provided by Legal Services Commission

Catford, Lewisham, Deptford and New Cross have significantly more providers than other parts of the borough, notably Downham, Grove Park, Brockley, Honor Oak and Blackheath, where there is little or no provision.

The Southwark exercise also provides data on apparent needs for advice. Advice needs are reported as being high in housing, welfare benefits, debt, consumer, mental health and immigration, and above average in employment, education and community care. Needs profiles are likely to be similar in Lewisham and Lambeth. It is worth noting that the Southwark CLSP Strategic Plan describes a, “current crisis in housing benefit administration”. This is a common problem in London, and elsewhere and has led to high need for housing advice and welfare benefits advice in particular. The plan also notes especially low levels of provision in consumer advice and community care. This is consistent with general patterns of advice provision. Consumer advice is not well funded by the Legal Services Commission and community care is an emerging specialism and hence not a prevalent area of advice.

Mapping information of specialist providers is still at an early stage of development. The information excerpted here was provided in confidence and as a courtesy by the Legal Services Commission as a part of its work on developing the Community Legal Service. At present it is not clear how reliable this information is, or its utility. As far as this research is concerned, the mapping information shows potential provider services in both boroughs covered by existing “mapping exercises”. In Lambeth, the number of specialist providers is low and particular wards within the borough are poorly served. In Southwark the figures are less serious, but this may be because of inadequacies in the data, rather than high levels of supply of such services. In any event, there remain barriers to accessing non-GP based advice, which it is hard for the non-GP based suppliers to counteract. Those who have had the opportunity of using the GP based advice services have noted its clear advantages to them (as seen in chapter 8 - consumers). Both health care and welfare rights providers have also noted access benefits as well as the extra synergies of added value to their services as a result of this method of provision (see chapters 5 practice manager and earlier this chapter).

5.8 Conclusion

Advisers were highly motivated and strongly supportive of the service provided in surgeries. They recognised significant access benefits as well as improvements in the quality of service provided to clients as a result of synergies between health and welfare rights professionals. They were also able to relieve some of the strain for surgeries faced with welfare rights queries that medical staff were unable to resolve.

Services were generally on a one morning a week basis with a further half a day being available for casework. This was felt to be inadequate time to handle casework. Waiting lists for welfare rights advice suggested that services were running at or beyond capacity.

There were a number of inequalities in the service provided. Some geographical areas were not covered. Some services provided advice in work categories other than welfare benefits, whilst others did not. Similarly levels of management differed as did resources for training. The services may benefit from greater consistency, more coordinated management and common training. Some quality management issues may also need to be addressed, in particular, complaints procedures and standards of supervision/file review.

6 Survey of Practice Managers

Under current arrangements, practice managers have a role in broad strategy development and implementation, and for identifying the cost implications of in-house providers (Dornan & Pringle 1991). They reflect both the vision of the surgery, and the views of GPs as employers. This survey aimed to assess the current level of provision, and satisfaction with, welfare rights information in GP surgeries, and to establish if and how specialist provision could be expanded in primary care.

6.1 Procedure

All practice managers in GP surgeries across the 6 PCGs were identified (n=140), and each received a postal questionnaire in December 2000. Those practices that had not responded after 2 weeks were given reminders to return their questionnaire.

The questionnaire addressed current practice in terms of surgery size, whether specialist advice is provided, and if referrals are made to local providers and how far these are from the surgery. Satisfaction with existing welfare rights advice provision in-house and locally, and general effectiveness of provision were measured using a 10-point Likert attitudinal scale (1=strongly disagree, 10=strongly agree). Those without a current in-house provider were asked to identify why not (reasons categorised as major or minor reasons, or not a factor). All respondents were asked to identify how they would like to see future welfare rights provision develop (less, at current level or more for each service option). Data were analysed using non-parametric tests with significance level set at 0.05, using SPSS V9.0.

5.2 Results

Of the 140 surgery practice managers to whom questionnaires were sent, 79 returned completed questionnaires, a response rate of 56.4%. The mean practice size was 6322 patients (median=6000, minimum=1400, maximum=17000). Welfare rights providers were available in 53.2% of surgeries (n=42), providing between 30 minutes and 30 hours of client contact time per week (median 3 hours). In terms of sign-posting patients to other providers, 91.1% of surgeries (n=72) informed patients of other organisations and 81.8% (n=63) made referrals on patients' behalf to other organisations.

The nearest welfare rights facility to the surgery was identified as within walking distance by 26.7% (n=20) (mean walking distance 10 minutes), and bus ride away by 45.3% (n=34). The nearest facility could not be identified by 28.9% (n=22).

Attitudinal responses to the availability, accessibility and adequacy of welfare rights information are presented in table 2.

(1=strongly disagree, 10=strongly agree)

* $p<0.05$

** $p<0.01$

† Trend

Table 2. Availability, accessibility and adequacy of welfare rights provision.

	P=	NO WE HAVE NO SERVICE mean	YES WE HAVE A SERVICE mean
We have adequate welfare and advice services available within our practice	0.001 **	2.67	5.98
We have adequate services available locally	0.065 symbol 61 \f "Monotype Sorts" \s 12†	2.47	2.43
We are able adequately to access services for patients	0.017 **	4.24	5.54
We lack information on appropriate services	0.018 **	6.8	5.15
Patients can access advice service without difficulty	0.008 **	3.97	5.53
Advice services are over-stretched	0.991	2.59	3.22
The process of obtaining advice runs smoothly	0.001 **	3.71	5.75

Those practices *with* specialist welfare rights provision were more likely to *agree* with the statements “we have adequate welfare and advice services available within our practice (p<0.001), “we are able adequately to access services for patients” (p<0.02), “patients can access advice service without difficulty” (p<0.01) and “the process of obtaining advice runs smoothly” (p<0.001). They were *less* likely to agree with the statement “we lack information on appropriate services” (p<0.02).

Among those who did not have specialist in-house provision, the reasons for not having such a service are presented in table 3.

Table 3. Reasons for not currently having in-house provision.

	Major reason	Minor reason	Combined reason major+minor	Not a factor
Lack of space	42.4% (n=14)	8.1% (n=3)	51.5% (n=17)	48.5% (n=16)
Not funded by PCG	71.0% (n=22)	12.9% (n=4)	83.9% (n=26)	16.1% (n=5)
Lack of need from this practice	7.7% (n=2)	26.9% (n=7)	34.6% (n=9)	65.4% (n=17)
There are adequate alternatives	16.7% (n=4)	29.2% (n=7)	45.8% (n=11)	54.2% (n=13)
This practice has other priorities	12.0% (n=3)	36.0% (n=9)	48.0% (n=12)	52.0% (n=13)
Patients rarely demand such a service	19.2% (n=5)	30.8% (n=8)	50% (n=13)	50% (n=13)
This practice has never considered providing this type of service	24.0% (n=6)	20.0% (n=5)	44.0% (n=11)	56.0% (n=14)

The lack of funding by Primary Care Groups was cited as the most common reason for not currently having in house provision, the second most cited reason being lack of space.

In terms of future provision, the formats which surgeries would prefer to see are described in table 4.

Table 4. Preferred formats for future provision of advice.

	More	**As is**	**Less**	**Combined "as is" + "less"**
Within practice specific service	80.0% (n=52)	20.0% (n=13)	0.0% (n=0)	20% (n=13)
System of referrals to other specialist agencies	75.8% (n=50)	22.7% (n=15)	1.5% (n=1)	24.2% (n=16)
Additional funding for welfare provision	84.1% (n=58)	15.9% (n=11)	0% (n=0)	15.9% (n=11)
Availability of patient information leaflets	68.5% (n=50)	28.8% (n=21)	2.7% (n=2)	31.5% (n=23)
Internet provision	67.2% (n=39)	29.3% (n=17)	3.4% (n=2)	32.7% (n=19)
Outreach service	81.7% (n=49)	16.7% (n=10)	1.7% (n=1)	18.4% (n=11)
Targeted provision for excluded/vulnerable groups	82.1% (n=55)	17.9% (n=12)	0% (n=0)	17.9% (n=12)
Training for surgery staff	71.8% (n=51)	23.9% (n=17)	4.2% (n=3)	28.1% (n=20)

All formats that were suggested in the questionnaire were supported by at least 67% of practice managers.

Printed welfare rights information was provided in waiting areas by 66.7% of surgeries (n=52), and among those who provided printed material, 66% (n=33) provided this in languages other than English. Among those with welfare rights providers, 48.6% (n=17) offered interpreters, and 51.3% (n=20) offered home visits for welfare rights advice.

Training/information for staff to update on benefit eligibility and changes in payments was provided in 8% of surgeries (n=6).

Practice size was not found to be related to any of the variables.

Current provision was not associated with what they would wish in terms of future provision in all formats. Neither was it related to whether they provided printed information in waiting areas, whether or not they knew where the nearest provider is, or whether they offered information and training to staff.

Those surgeries who had printed information available were more likely to agree with the statements “we have adequate welfare and advice services available within our practice” ($p<0.05$) and “we are able adequately to access services for patients” ($p<0.04$).

Those practices who knew the distance to the nearest welfare rights provider were more likely to agree with the statements “we have adequate welfare and advice services available within our practice” ($p<0.05$), “patients can access advice services without difficulty” ($p<0.05$), and that “the process of obtaining advice runs smoothly” ($p<0.01$).

Whether they had in-house provision was not related to whether or not they referred to outside agencies.

6.2 Discussion

6.2.1 Service capacity

The client time available for specialist advice is generally low (median 3 hours per week). As surgeries report the service to be operating at capacity, it seems likely that the decision was resource and not needs led. However, despite the low number of available hours, the service has a significant impact on the perceived quality of welfare rights information provision. Despite the high level of satisfaction reported from the provider perspective, it may be that such a low availability of advisers may create frustration and dissatisfaction among potential service users.

Among those who do not currently offer specialist in-house welfare rights provision, the lack of funding by their PCG was the most common reason. While this can be remedied through allocation of funding, the second most common reason (lack of space) cannot. It is unclear how this could be overcome, even if both PCGs and surgeries are keen for a service to be provided. It may be that those who are less interested in having such provision identify lack of space as the issue. A solution to the problem would be the provision of a service to a single surgery within a cluster of local surgeries, providing access to all local patients. When the categories of “major reason” and “minor reason” are combined, all other reasons for not having provision are of approximately equal importance. This includes 4 reasons which represent a lack of prioritising/interest in the service, “There are adequate alternatives” “This practice has other priorities”, “Patients rarely demand such a service”, “This practice has never considered providing this type of service”. The data suggests that these practises are unlikely to be involved in such a service, whether or not it is facilitated through the provision of finance or space. These four reasons demonstrate a lack of awareness of the need for such a service, and of the fact that any patient population may have unmet need in terms of benefits advice and income maximisation. This data represents a challenge for purchasers, in terms of raising awareness of need for specialist welfare rights provision in primary care. However, it has been identified in this study that further provision is required by most practices, regardless of whether they have current provision or not. Therefore, it may be that funding and space are the only true factors that inhibit provision.

6.2.2 Referrals to other providers

The majority of surgeries (81.8%) refer patients to other organisations, regardless of whether or not they have specialist in-house provision themselves. This may be due to the low number of available client hours in primary care provision. Although the signposting of other specialist providers should be encouraged, it does not guarantee that the patient will make contact, make an appointment, or that their claim will be pursued to resolution.

6.2.3 Proximity of providers

The nearest alternative provider was identified as a bus ride away by 45.3% of surgeries, and as mean of 10 minute walk away by 26.7% of surgeries. Both of these reduce access for patients with mobility difficulties, therefore reducing the availability of specialised advice for those who may be in greatest need, i.e. older people and those with disabilities. However, a major difficulty in ensuring patients have welfare needs met is that 29% of surgeries did not know the location of their nearest welfare facility. This information is important for both those who do offer inhouse provision (as they have limited hours of service) and those who have no choice but to direct patients to local providers.

6.2.4 Service development

Despite the apparent lack of awareness of need for such a service, the vast majority of practices wish to see further development of welfare provision in all forms. Among the proposed models of provision, further provision of information leaflets and internet access were the least desired formats, although they still rated at 68.5% and 67.2% respectively wishing for more of this type of delivery. The provision of printed information (regarding eligibility, the range of payments available and rates of payment, and contact details for advice providers) should be encouraged in waiting areas of surgeries, and is a low cost and easily delivered format that can direct patients to specialist advice. However, only 33.3% of respondents did not have such information available in their surgeries, and only 33% of all surgeries had such information available in languages other than English. Only 21.5% of surgeries (48.6% of those surgeries with specialist provision) had an advice service that offered interpreters. The availability of interpreters needs to be increased in order to ensure equity of provision, and to address those who are identified as having greater need (i.e. people from ethnic minorities).

The provision of specialist welfare benefits advice significantly improves the service available to patients. Generally, those surgeries with welfare provision find access and provision to be easier, and more adequate and efficient. Although a lack of interest in welfare provision was identified as a reason for not currently having such a service, no association was found between whether they currently had the service and whether they would wish increased future provision in all formats. Therefore, both those who do currently have the service and those who do not, would like to see more welfare rights provision, even if they felt that it was not a pressing need. This association suggests that provision stimulates demand (among those with a current service) and that even those who see problems in provision are willing to overcome them. It may also be that provision exposes high levels of hitherto unmet need.

The lack of association between whether they have current provision and the variables of availability of printed information, knowing the distance to the nearest provider, or the availability of training for staff demonstrates that there is no difference in willingness to address provision between those who currently do and do not have current provision. However, it may be that those who do not currently have specialist provision have a greater need to know the location of welfare rights providers. Despite reservations among those who do not have provision, it appears that having a welfare rights provider is not an indicator of attitude towards future provision.

Home visits for welfare rights advice were offered by half of those with a welfare service (25% of all respondents). This figure is very low. The intervention aims to address welfare rights in a health context, and so access issues are crucial (particularly among older people, disabled people and those who simply are unable to get to the surgery). We would hope that one of the goals of welfare rights in primary care settings is that we can detect need and offer provision for those who may not be picked up by, or be able to attend, other services. However, health and safety concerns mean that home visits can often be conducted only with a second member of staff in attendance during the session, posing a significant resource problem.

The amount of ongoing training and information provided to surgery staff is very low, being available only to 8% of surgeries. However, we need to consider what may be most useful. Welfare rights advice services are specialist, and covers an area of knowledge that is constantly changing. To expect practitioners to be constantly up to date is unrealistic, and probably not desirable in terms of potential time spent in updating individual knowledge. It may be most useful to ensure a broad and very basic knowledge, and to focus on the importance of ensuring that checks are encouraged and referrals made during consultations. Practitioners need to be able to detect need, have the skills to address need in consultations, and to know where to send people rather than solve problems. In other words, the care pathway would not differ from other types of referrals for specialist care made from general practice.

Those who provided printed information within the surgery were more likely to feel that they had an adequate service, and that access is better compared to those without. And we also know that the provision of printed information was not dependent on in-house welfare rights service provision. Therefore, all practices should endeavour to provide low level information to raise awareness of basic benefit range and target recipients, either as a signposting intervention to inhouse provision or to inform patients of other providers.

We have noted that there is no association between having in-house provision and knowing where the nearest provider is. Those who knew the location of their nearest provider found that obtaining advice runs smoothly, is more adequate, and that patients can access services without difficulty. We should recommend that all surgeries (and their patients) are made aware of the nearest available provider, with some info about the service, (e.g. contact/referral details to be on practitioner’s desk to be given to patients).

The response rate is modest, and reflects the problems of undertaking cross–sectional survey based research in primary care settings (Myerson 1993). In terms of general practice, the response rate is within the range of published data from primary care settings (Dowrick et al. 1996, Hannay et al. 1992). The data was collected in an area with high levels of deprivation, and so may not be generalisable to other areas with less extreme levels of poverty. However, there is no apparent reason to doubt the generalisability of the impact of specialist provision on quality of advice for patients.

6.2.5 Summary

- 79 practice managers across LSL participated in a postal survey.
- Welfare rights providers were available in 53.2% of participating surgeries (n=42), providing a median of 3 contact hours per week.
- The vast majority of surgeries (91.1%, n=72) inform patients of other local providers.
- Almost 30% (n=22) of surgeries did not know the distance to their local provider.
- Those surgeries *with* specialist in-house welfare rights advisers were *significantly more likely* to feel that
    - the provision of advice was adequate,
    - it was easier for staff to access welfare rights advice for patients
    - it was easier for patients to access welfare right advice
    - the process of advice provision ran smoothly

  and also were *less likely* to *lack information* on appropriate services.
- Lack of funding and lack of space were the most common reasons for not having provision.

- A lack of need for, and prioritising of, this type of service was reported among half of those without specialist provision.
- Despite a lack of prioritising, the vast majority of surgeries also stated they would like to see future provision expanded in various formats.
- Printed information was available in 67% (n=52) of surgeries. Of these, only 2/3 (n=33) had information available in languages other than English.
- Only half of welfare providers offered home visits or interpreters.
- Training and information on welfare rights for practice staff was provided in only 8% (n=6) of surgeries
- Capacity for client time is low and should be increased to avoid patient and practitioner frustration

A number of practices need to be made aware of the need for, and value of, welfare rights advice in primary care.
All practice staff should have basic information regarding proximity of, and contact details for, local providers. Interpreting and home visits must be made available.

7 Practitioners’ case audit: welfare rights and primary care consultations

7.1 Procedure

Those surgeries with a practice manager were identified (n=140, and each was sent a set of questionnaires and reply-paid envelopes to be distributed to all practitioners with direct patient contact (excluding specialist welfare rights providers). Reminders to return completed questionnaires were sent after 2 weeks.

The questionnaire asked the respondent to identify the most recent patient that the practitioner had seen in which the consultation had an element of welfare rights (whether it was directly addressed/discussed or not). Each respondent was asked to identify the number of days since the consultation, the demographics of the patient, the nature of the presenting issue, whether mental health issues were present, the nature and urgency of the welfare rights issue, and how the issue was raised and dealt with. In addition, questions were asked regarding the estimated percentage of total consultations which involve welfare rights issues, whether any particular groups of patients are less able to access advice, whether specialist provision is available in their surgery, and satisfaction with, and quality of, provision for patients (using a 4 point scale).

Attitudes towards welfare rights provision in primary care settings were measured on 15 key statements (using a Likert scale of 1=strongly disagree to 10= strongly agree). Data were analysed using non-parametric tests, with significance set at the 0.05 level, using SPSS v10.

7.2 Results

7.3 Response rate

The response rate was calculated as the proportion of practices that returned data from the 140 surgeries contacted. Surgery identification was missing from 6 questionnaires, in a total 153 completed questionnaires returned from 66 practices. Therefore, the response rate from practices was 47%.

7.3.1 Case descriptions

Case analysis is carried out on 153 case histories. The mean number of days since the most recent welfare rights case was 10.41 (median=6, SD=16.98). The presenting issue was described as follows (with the corresponding number described for each):

BENEFITS
All work test 1
Asked for benefit help 1
Asylum refusal 1
Attendance allowance 1
Benefit appeal 1
BP and prescription charges 1
Prescription exemption 2
Request re:DLA (Disability Living Allowance 2)
DLA & HB (Housing benefit) 1
Housing 3
Housing benefit not being paid 1
Income 1
Food shortage 1
None 4 (i.e. need was purely welfare rights driven)
Unable to work 1
Pension 1

MENTAL HEALTH
Agitated depression 1
Alcohol dependency + ulcer 1
Anal fissure, depression 1
Anxiety through housing 1
Bereavement 1
Blood pressure, depression 1
Burns, lice, homelessness, abused 1
Debt + depression 1
Depression & pain 1
Depression & panic attacks 1
Depression 19
Depression counselling 1
Depression headaches insomnia 1
Depression/bereavement 1
Dizzy weak depression 1
Domestic violence 2
Domestic violence, anaemia, termination, poverty, childcare 1
Drug addiction 1
Drug addiction + history of psychosis 1
Epilepsy headaches anxiety 1
Eviction threat, depressed suicidal 1
Financial and housing worries exacerbating schizophrenia 1
Manic depression 1
Memory loss 1
Mental health 5
Mental health and self harm risk 1
Panic attacks agoraphobia chest infection 1
Stress & anxiety 1
Stress 3
Stress agoraphobia 1
Stress and pain 1
Stress through eviction threat 1

GENERAL MEDICAL
Angina, COPD, Hypothyroidism 1
Ante-natal care 7
Appendicitis 1
Arthritis 1
Asthma 4
Back pain 2
Blood pressure check 1
Cancer 1
Child's developmental delay 1
Child’s asthma 1
Chronic fatigue, lupus 1
COAD 2
CVA 1
Deafness and dumb 1
Diabetes 3
Disability 2
Elderly anaemic arthritic 1
Elderly health check 3
Epilepsy 1
Epilepsy and employment 1
Fracture 1
Frail elderly diabetic 1
Headaches 1
Heart problems 1
Insomnia 1
Leg ulcer elderly diabetic 1
Lower back pain 1
Major surgery of partner 1
Medical asylum need 2
Mobility 1
MS 1
Needed glucometer 1
Needed special diet, no £ 7
New patient screening 2
Over 75 health check 2
Pain 3
Parkinson’s 1
Post natal check 3
Postoperative pain control 1
Repeat prescription 1
Routine BP & diabetes check 1
Routine health check 1
Strokes, heart valve replacement 1
Weight gain 1

The welfare rights issues were categorised as follows:

General benefit advice
Advice 14
Benefit form help 2
Benefit loss 3
Needed to renew claim
Unemployment, maternity benefits and housing needs

Asylum seekers
Asylum seeker, no income and new baby 2
Immigration & deportation threat 2
Needed to appeal decision
Refugee application
Refugee housing

Specific benefits
Attendance allowance claim 6
Bus pass eligibility
Council tax issue
Delay in HB causing hardship 5
Disability incapacity allowance 4
DLA 10
Employment & sick pay
Med 3 cert for work 2
Unable to work and has no money 2
Industrial tribunal, insurance, DLA
Sickness benefits
Orange badge
Prescription costs 2

Carers 3

Poverty
Low income/poverty 18
Debt 3
Family & money
Need income for dietary requirements

Miscellaneous
Grant for clothes
Jobseeker with child in custody
Home care
Legal advice
Looking at rehab course and benefit implications
Meeting costs of care needed
Mobility and care
Need for homecare

Unemployment + marital problems
Protection and care of children
Rent arrears poor housing employer sick pay

Maternity
Free milk and sure start for women
Help with baby
Maternity benefit 3

Housing
Housing 13
Neighbour problems
Rehousing due to racial harrassment
Rent arrears 2
Rent arrears and housing benefit

The patient's demographic and related variables are detailed below in table 5

Table 5 Case audit demographic and descriptive variables.

Age	Mean = 46.21 years, median = 41, sd18.31 (missing n=27)	
Ethnic origin		
White UK	43.8%	(n=67)
Afro-Carrib	20.9%	(n=32)
African	11.8%	(n=18)
Irish	3.9%	(n=6)
Other	13.7%	(n=21)
Missing	5.9%	(n=9)
Gender		
Male	34.0%	(n=52)
Female	64.1%	(n=98)
Missing	2.0%	(n=3)
Fluent English?		
No	15.7%	(n=24)
Yes	83.7%	(n=128)
Missing	0.7%	(n=1)
Disabled?		
No	69.3%	(n=106)
Yes	18.3%	(n=28)
Missing	12.4%	(n=19)

Issues relevant to the patient's personal circumstances are described below in table 6 (*multiple responses permitted).*

Table 6 Case audit patient description

	Yes %	
Mental health	41.8%	(n=64)
Ethnic Minority	38.6%	(n=59)
Unemployment	32.7%	(n=50)
Poverty	28.3%	(n=43)
Disability	19%	(n=29)
Elderly	16.3%	(n=25)
Homeless	14.4%	(n=22)
Refugee	12.4%	(n=19)
Drug/alcohol use	9.2%	(n=14)

The frequency of combinations of these variables are shown in table 7.

Table 7 Frequency of variables of need within cases

No of variables reported from table above	%	
0	5.2%	(n=8)
1	33.3%	(n=51)
2	24.8%	(n=38)
3	20.9%	(n=32)
4	9.8%	(n=15)
5	4.6%	(n=7)
6	0.7%	(n=1)
7	0.7%	(n=1)

Additional issues relevant to the welfare rights problems are described below in table 8 *(Multiple responses permitted).*

Table 8 Description of welfare needs.

	Yes %
Housing	47.1% (n=72)
Family	28.1% (n=43)
Employment	19% (n=29)
Debt	11.8% (n=18)
Harassment	9.8% (n=15)
Immigration	9.2% (n=14)
Injury	5.9% (n=9)
Discrimination	4.6% (n=7)
Crime	4.6% (n=7)
Occupational Health	2.6% (n=4)
Consumer	0

The frequency of combinations of these variables are shown below.

Table 9 Frequency of welfare issues within cases.

	Yes %
0	27.5% (n=42)
1	32.0% (n=49)
2	25.5% (n=39)
3	7.2% (n=11)
4	3.9% (n=6)
5	2.0% (n=3)
6	1.3% (n=2)
7	0.7% (n=1)

During the consultation, 65.8% (n=96) of patients requested information or guidance. Whether the patient asked for further information or guidance did not differ significantly according to gender, ethnicity, age, number of reported circumstances (as described in tables 6 and 8 above), fluency of English or disability. Medical reports were needed (or will be needed) in 51% (n=78) of cases.

Practitioners identified the way in which they dealt with the welfare rights issue, as shown in table 10 below.

Table 10 How practitioners deal with welfare rights issues in consultations.

	% yes	
“Deflective” responses ▼		
I did not specifically discuss the issue	3.3%	(n=5)
I advised the patient to seek help	22.5%	(n=34)
I gave them details for further information	21.2%	(n=32)
I made a specific referral to another agency	18.5%	(n=28)
I made a referral to our practice welfare service	27.2%	(n=41)
I completed report requested	6.6%	(n=10)
“Facilitative” responses ▲		
Missing	(n=3)	

With respect to the most recent case, 70.6% (n=108) agreed that there had been a mental health element to the consultation (e.g. anxiety or emotional turmoil).

Close on half of the problems were seen as relatively urgent. When asked to describe the urgency of the welfare issue, 13.2% (n=20) felt that it was “*urgent: needed* *immediate attention”,* 36.2% (n=55) felt it was “*urgent: needed prompt attention”,* 43.4% (n=66) felt it “needed attention (routine)”, and 7.2% (n=11) “not urgent (time open)”.

Practitioners did bring up welfare rights issues, but in the minority of instances. Patients tended to raise the issues almost half of the time, or welfare rights naturally arose from the consultation for just over a third. The detailed data is set out in table 11 below.

Table 11 How welfare rights issues are raised in consultations.

They asked, didn’t know where else to go	26.1% (n=40)
They asked	9.8% (n=15)
Had been recommended to speak to me	7.2% (n=11)
COMBINED 3 ABOVE *“they asked”*	*43.1% (N=66)*
I brought it up	19.0% (n=29)
Naturally arose from consultation	37.9% (n=58)

7.1.1 Attitudes towards, and experience of, welfare rights in primary care

WELFARE RIGHTS AND PRIMARY CARE

Practitioners reported that approximately 15.4% of their consultations involve welfare rights issues (median 10%, missing n=1). The way in which the welfare issue arose for the specified case did not interact significantly with the proportion of consultations practitioners' believed had welfare rights issues. However, 85.9% (n=128) felt that there were groups of patients less able to get the advice they need. These were described in the following way:

Those with language difficulties 31
Ethnic minorities 16
Asylum seekers/refugees 3

Those with depression/poor mental
health 24 Unassertive people 4
Alcohol and drug users 3
People with poor education/low IQ
13

Elderly people 25

People in poverty 4
Single parents 3
Homeless people 3

People who are ill 3
Disabled people 2
Young people 1

The two groups most commonly identified were those whose English was not first language, and the elderly.

Specialist welfare rights provision was available in the surgeries of 55.1% (n=81) of respondents, and in all of these a named person for access to welfare rights information was available. Those *with* specialist welfare rights advice were more likely to find referring patients to welfare rights advice to be easy (84% easy, 16% difficult) compared to those *without* specialist support (easy 19.7% difficult 80.3%, χ^2 =63.0 $p<0.001$).

Those *with* specialist welfare provision were also more satisfied with the quality of welfare rights provision for their patients (provision is good=86.1%, provision is bad=13.9%) compared to those practitioners *without* specialist provision (good=21.6%, bad=78.4%, $p<0.001$ χ^2 =52.35).

The scores on 15 attitudinal statements were compared according to whether the respondent currently had specialist provision. Comparative scores are shown below in table 12.

Table 12. Comparative attitudinal scores between surgeries with regard to specialist provision.

	Do you have a welfare rights facility in your building?		p
1=Strongly disagree, 10-strongly agree.	Yes (mean score)	No (mean score)	
Enough money is spent on welfare benefits advice provision	4.05	3.48	0.212
Such provision should come out of practice budgets	2.30	3.22	0.092 †
Such provision should be funded by PCGs	5.41	4.49	0.127
Welfare rights provision is beyond the scope of health care	4.84	4.97	0.742
Welfare providers should be available on site	7.99	6.41	0.001**
Home visits for welfare advice should be available	7.22	7.11	0.753
It is often easy to miss welfare rights problems	7.27	7.53	0.520
Welfare providers enhance my ability to practice effectively	7.91	7.21	0.060 †
Welfare providers should be located locally but not within practice	4.53	6.11	0.001**
Access to welfare information should be increased	8.05	7.84	0.788
There is adequate feedback from welfare services to PHCTs	4.90	3.25	0.001**
Service based welfare generates more work for GPs	5.72	5.65	0.904
I am able to recognise welfare rights issues when they arise	6.13	6.17	0.746
PHCTs have adequate knowledge of welfare rights	3.90	4.07	0.693
Provision of welfare rights improves the heath and wellbeing of patients.	8.66	8.00	0.051*

Those *with* specialist provision were significantly *less likely* to agree that “provision should come out of practice budgets” and “welfare providers should be located locally but not within practice”. They were significantly *more likely* to agree that “welfare providers should be available on site", "welfare providers enhance my ability to practice effectively", "there is adequate feedback from welfare services to PHCTs" and "provision of welfare rights improves the heath and wellbeing of patients".

7.2 Analysis

Whether or not the patient requested information/guidance was significantly different in those surgeries without a welfare rights service. Although there was no difference if the surgery *did* have specialist provision, among those practices *without* a welfare rights service 77.8% (n=49) of patients requested information or guidance from the practitioner and 22.2% (n=14) did not ($p<0.01$).

The number of days since the last relevant case differed significantly between practitioner roles. Doctors (mean 7.57 days, median 4.5 days) were more likely to see a case with welfare rights issues than both nurses (16.77 days, median 7.5 days, $p<0.01$) and others including mental health professionals (mean 14.14 days median 5 days, $p<0.077$). Doctors were also significantly more likely to than nurses to detect a mental health element to the consultation (doctors =77.9%, nurses=54.8%, $p<0.01$** $\chi^2=8.95$).

The presence of welfare rights provision in the surgery heightens awareness of welfare rights issues, but may also reflect practitioners with a more insightful approach to welfare rights problems in their patients. Practitioners were significantly more likely to report "I brought it (welfare rights issue) up" if there was a specialist adviser in the practice, 71.4% compared to 28.6% of those without, $p=0.054$, $\chi^2=3.727$).

There was no difference between professions on the proportion (%) of cases they believed to have welfare rights elements. There were no significant differences between professions as to whether patients asked them for information or guidance. Whether or not the practitioner had specialist provision did not affect the proportion of total consultations they believed to have welfare rights issues.

7.3

7.4 Discussion

In comparison to UK statistics for all consultations per unrestricted principal, our sample were similar by gender (40% male and 35% male respectively) and age (45-64 being the largest agegroup in UK consultations, and mean age for our study 46 years) (Office of Health Economics 2000).

7.4.1 Magnitude of welfare rights and mental health issues in primary care consultations

The estimation of 15% of consultations to have welfare rights issues is high, and constitutes a considerable amount of clinical time when placed in the context of 269 million consultations in UK general practice per year (Office of Health Economics 2000). That 15% of cases involve welfare rights issues is also interesting in terms of GP training. Around 15% of GP consultations are found to involve patients presenting skin problems, and GPs are given specialist dermatology training during their training in order to be able to address these needs. Currently, welfare needs are not allocated a similar amount of attention during training.

An extremely high number of cases were seen to have had an element of poor mental health (70.6%). There are several feasible explanations for this. It may be that the data reflects cases with prior mental health problems, or that the welfare rights issues are so pressing (and indeed they appear to be so in practitioners' descriptions of the cases' urgency) that they induce anxiety and stress. It may be that the provision of good quality welfare advice services can directly reduce the prevalence of mental health in patient populations. It may also be that this data reflects the current general mental health services provision, in that these needs are not being met effectively across health and social services, thus leaving them to be detected and dealt with in primary care.

The speed and quality of public service provision interfaces (e.g. home office/immigration, authorities and housing benefit, benefits agency) may impact here on stress and anxiety in patients, highlighting the impact of other public service organisations on primary care.

7.4.2 Urgency

As 40% of issues were seen by the practitioners to be urgent (and the surgery may be the first point of presentation), this means referral and appointment systems need to be efficient and speedy. Due to the potential for a mental health impact from unmet urgent need, practitioners should know to whom referrals for specialist information should be made. Only 7% of the work was described as “time open”, therefore placing pressure on practitioners. In addition to meeting these urgent needs for patients, we need to ensure that practitioners know how and where these issues can be dealt with.

Currently it may take some time for an appointment to see a welfare rights provider, as they are only available for 3.5 hours per week. Therefore, patients may continue to make appointments to see clinical staff as first point of presentation for urgent needs. Sufficient appointment time with welfare rights providers should be prioritised, and sufficient local knowledge of alternative providers should be gathered to facilitate swift referral.

It is also important to note that a service that concentrates on responding to urgent situations may become overwhelmed and good practice may dictate an element of preventive practice into welfare rights referral. This would suggest that if problems were picked up early they may be dealt with in a way which is paced and less reactive. This may, in turn, allow for optimisation of outcome and reduction of stress associated with welfare rights problems. Given that many of the problems seem to be urgent, a system of routine checking and early referral may be worth consideration for an optimal development of services.

7.4.3 Consultation and detection of need

Practitioners should be recognised for their skills as many welfare rights issues arise “naturally” from consultations. Clients requesting information and raising issues regarding welfare during consultations is also encouraging, though ideally they would know of an existing in-house service and self-refer.

Although a model is being proposed whereby all welfare care needs can be initially presented to welfare rights providers within surgeries, the amount of information passed between WR adviser and GP is important, as issues such as heating, nutrition, and anxiety all impact on clinical care. Brief notes in medical records may be an important means of facilitating relevant information sharing.

While it is encouraging that so many practitioners bring up the issues themselves, we need to ensure that they can do so in the knowledge that they can refer to a good quality fast service. Adequate resources must be made available to ensure that needs identified by clinical staff in consultation can be met by specialist advisers.

It was very rare that the welfare rights issue was not discussed. Again, how the issue is addressed depends on knowing where a service is and that the patient can access the service and be dealt with swiftly. Advising the patient to seek help is only beneficial if the systems and specialist knowledge are in place. The views from the perspective of surgery patients may reveal a different perspective, describe additional need, and may provide insight into barriers and facilitators which hinder/help patients to articulate welfare rights problems and seek appropriate help.

7.4.4 Current practice

It is unsurprising that referrals are easier when there is an in-house service, but the data also tells us that under current procedures it is very hard to refer to outside providers for those without specialist services (and probably for those with, who also refer out occasionally).

As with the data from practice managers, it seems that those without service are less convinced of its value and whether it should be available, and those who have them value specialist advisers and are keen to continue with the service. However, the attitudinal data does show us that although there are some significant differences between those with and without specialist provision, these differences are not large and responses are all in the same direction on the Likert scale. This suggests that there is broad belief in, and support for, this type of provision among practitioners. The challenge for the future is to optimise this provision and enhance its effectivity in terms of targeting and pacing.

The positive impact of in-house advice provision is demonstrated in the data showing that practitioners were more likely to raise the welfare rights issues if they had an in-house service. Provision may sensitise staff, and it may be that they are more willing to raise issues when an appropriate service is available.

Of all the participating practitioners, GPs were most likely to see a case involving welfare rights. As the estimated proportion of cases with welfare rights issues did not differ significantly between professionals suggests that the detection rate is a function of the number of patients seen, the professional relationships, perhaps the skills in taking case histories and the ease with which patients can discuss these issues. Future planning should enhance skills of other health professionals.

Patients were more likely to ask for guidance from their GP if there was not a welfare rights facility in the building. This may be due to patients' willingness to self-refer and raise issues with specialist providers when available, and that such services are acceptable to patients while reducing the workload of GPs. This may also reflect a bias in the reported data towards patients who are willing to bring their welfare rights issues to the attention of the GP, and more proactive efforts may reveal a higher level of need. Indeed those who do not have skills to raise their problems appropriately, access help pathways and generate solutions may be a group with urgent unmet need. This may miss some problems. Having service available earmarks for the patient the fact that the GP sess this as important, and gives permission to discuss these issues.

7.4.5 Facilitation of welfare advice in surgeries

It may be that several levels of service provision are appropriate. In addition to (direct) surgery based provision, welfare advice may be usefully provided locally for a group of nearby practices (assuming that the service is adequately promoted). In addition, basic low level (indirect) advice regarding the level and eligibility of benefits may be usefully

provided by practitioners who are equipped with simple but clear advice, including most importantly knowledge of local specialist providers, and times/contact details.
Around half of consultations that involve a welfare rights issue went on to require a practitioner to provide a medical report. This figure is comparable to the proportion of welfare benefits cases (under legal aid contracts) which involved illness, disability or injury (Moorhead, Sherr et al. 2000). Currently this task cannot be reallocated from doctors to welfare rights advisers due legislative requirements. This variable regarding the patient's requirement for a medical report may create a bias in the cases described, as there may be a recall bias towards those with medical reports. The data also suggests a greater incidence of welfare rights issues than reported, as those that require medical reports are more likely to be "detected".

Welfare rights issues constitute a significant proportion of primary care consultation, with a large amount of poverty-related need being presented in the health context. The magnitude of potential primary care consultation time involved is suggested in the total of 269 million GP consultations during 1998 (Office of Health Economics 2000). Practitioner time has been well spent in detecting the need, but reconfiguration of services could ensure swift referral on to a specialist welfare rights adviser. However, although the provision of welfare rights advice may not reduce the need for clinical appointments in the short term, we hope it is anticipated that in the longer term the impact on physical and mental health may be great.

7.4.6 Limitations

The calculated response rate appears to be low, and as a cross-sectional survey it would be severely limited in its generalisability. However, as a series of case studies there is no methodological reason to doubt the representative nature of the data, particularly as the data collection instrument asked for recall of the most recent case. This, however, may call into question the possibility of recall bias, as those cases with greater need may be described, and those with less obvious need overlooked. The comparison data between those surgeries with and without specialist in-house provision demonstrates that not only practitioners currently working with welfare providers were motivated to respond to the study.

7.5 Summary

- 153 practitioners returned a questionnaire describing their most recent case where welfare rights was an issue.
- 70.6% agreed that there had been an element of mental health to the case (e.g. anxiety, emotional turmoil).
- 49% of the practitioners felt the welfare rights issue to be urgent.
- In 38% of cases the welfare rights issues naturally arose from the consultation.
- Housing, family and employment were the most common additional issues.
- Medical reports were (or will be) needed in 51% of cases.
- Practitioners were significantly more likely to raise a welfare issue with their patient if they had in-house specialist advice provision.
- Patients were significantly less likely to ask for information or guidance from those practitioners with access to specialist welfare advice.
- Practitioners estimated that 1/7 (15%) of their consultations involve welfare rights issues.

- 86% of respondents felt that there are groups of patients less able to access the advice they need (identified as people with language difficulties, ethnic minorities, those with mental health problems, the elderly and those with significant illness).
- Those *with* specialist welfare rights provision were significantly more likely to find referring easy and to be more satisfied with the quality of provision for their patients.
- Those with specialist in-house provision were significantly more likely to agree that welfare rights provision improves the health and wellbeing of their patients.
- The urgency of welfare issues means that practitioners should be aware of how and where to refer patients.
- Preventive approaches (e.g. benefit checks may avoid the reactive approach to meeting urgent need.
- Practitioners are skilled in detecting need and should be provided with training to maintain and develop this skill.

8

9 Primary Care Groups

9.1 Aims and procedure

This element of the study aimed to understand and compare the configuration of contracting, funding and provision arrangements within and between the 6 PCGs. The representation of comparison data across PCGs allows good practice to be highlighted and difficulties with current arrangements to be expressed. Therefore, the data offers opportunities to develop and harmonise procedures, and also to appraise outcomes in the light of costs and configuration.

A matrix of issues pertinent to each of the three categories of enquiry was drawn up. This matrix was used to form a semi-structured interview schedule, which was administered from October-December of 2000. Telephone interviews with 5 PCGs were undertaken (as two PCGs have joint contracting and funding arrangements).

Data are presented in table 12 (comparison of funding arrangements between PCGs), table 13 (comparison of contracting arrangements between PCGs) and table 14 (comparison of provision arrangements).

Telephone interviews with the 6 PCG representatives were undertaken at the outset of the research. These aimed to clarify the various patterns of funding, contracting and provision across the 6 PCGs. Comparative data are presented on each of these in tables 13, 14 and 15 respectively.

Table 13 Comparison of funding arrangements between PCGs

FUNDING	PCG A	PCG B	PCG C	PCG D	PCG E + F
How many of your surgeries provide specialist welfare rights advice?	8	3	8	11 surgeries, 5 officers.	17
Is this enough?	Would like to see in more surgeries.	Service is very busy, not enough providers.	Not enough, actively securing funding for more.	Need more for this excellent service.	If funding is made available, would like to see more surgeries with provision.
Where does the money come from?	PCG	PCG	Joint funded by health (40%) and social services (60%).	Joint health (40%) and social services (60%).	PCG
How much?	£95,072	£130,000.	£75,000 across 2 PCGs.	£70,200 provided between 2 PCGs.	£100,050
What is the aim of the funding?	Release GP time, bring enormous health benefits, advocacy.	To address relationship between physical and psychological health, and income, reduce stress, improve health and nutrition, reduce GP workload.	Income maximisation for health improvements, reducing GP consultations.	Improved healthcare, buying food and clothes, reducing health inequalities.	To address correlation between health and income, absorb queries to GPs, expected effect on depression, stress, and physical symptoms. Very popular with practices.

Who sets the budget?	PCG contract manager.	Historically set by health authority.	Inherited from health authority.	-	Put out to tender.
Are there any similar local projects that you are aware of?	No	Working with CHC, and Age Concern on benefit maximisation.	No.	No.	No.

Table 14 Comparison of contracting arrangements between PCGs.

CONTRACTING	PCG A	PCG B	PCG C	PCG D	PCG E + F
How was your provider chosen, what criteria were used?	Historical health authority decision.	Inherited decision.	Historical decision.	D/K	Put out to tender.
What monitoring, evaluation or quality assurance systems are in place?	Excellent quality service but lack of quarterly monitoring.	Lack of presentation of expected monitoring data.	Good monitoring, good quality data and yearly report.	Quarterly meetings on uptake, and client profile. Very detailed monitoring provided, incl. how heard about service, and income generated.	Comprehensive and useful monitoring data quarterly. Identity of patients, issues raised, income generated, DNA's.
How is this accumulated information used?	N/A.	N/A	Service use within surgeries, income maximisation, activity levels and reallocation between surgeries to meet need.	PCGs meet with surgeries and look at development plans, also review service with providers.	Surgeries invited to meetings, service development planned using data.

What type of service is funded?	Benefits, legal issues, housing, debt. Broad range.	Welfare rights, although some debt work is included and would like to increase this. Workers do a broader range of work than contracted.	Deal with a broad range as issues are seen to occur across headings- therefore injury and housing are included.	Welfare rights including housing.	Generalist advice: HB, council tax, discrimination, legal proceedings, unemployment.
What is the specified proportion of casework and contact time?	Not specified.	50/50 split between contact and admin time, but needs to be changed to 66/33 contact: admin. (*****cross refer to comment in case worker chapter)	Not specified.	No specification. Problem with home visits is that they take up 3 appointment slots. Problem with increasing referrals from District Nurses is increasing use of service by housebound patients.	Split between admin and contact, 30 minute appointments.
How is casework continuity handled?	Home visits available, but continuity unknown.	No arrangements.	Workers can be contacted outside of surgery days.	Service available 4 days per week. Base office number available.	Office based number given, cases pursued to resolution.
Is there any targeted service for disadvantaged groups?	No.	No.	No.	Development work underway with carers, single mothers and the over 75's.	Future carer strategy being developed.

Is the service being fully utilised?	Yes definitely.	Yes, such a small service leaves unmet need although workers are excellent.	Yes- further worker to be recruited.	Very much so.	Very stretched, trying to reallocate between more and less busy practices.

Table 15 Comparison of provision arrangements between PCGs.

PROVISION	PCG A	PCG B	PCG C	PCG D	PCG E + F
How do you feel the service is going?	Service is very popular, although some management issues could be usefully addressed.	Workers are excellent. Service is over-stretched. Need more strategic provider support.	Going well and very much appreciated in surgeries.	Very pleased and popular with gps.	Excellent positive feedback.
What would you like to see done differently?	Like to see extended into more languages, maybe on a cluster basis, tightened management with more data/feedback.	Would like to see mixed economy of providers- i.e. Also voluntary sector as they pick up a different set of users.	Increase provision and therefore access. Access is currently dictated by geographical location.	Develop interpreting services and work with asylum seekers. Like to provide “joined up” thinking between health and social priorities.	-
Are there any barriers to effective provision?	Management and recruitment.	-	-	Harmonisation of provider and relevant parties.	Poor salary may not retain the excellent staff.

What can be done to mitigate these?	More monitoring and evaluation needed.	Cultural and strategy change and more working together needed.	-	Make sure all parties are on board including practice managers, allocate well between surgeries to avoid access by postcode, more money must be made available. Receptionists should be enhanced as signposters.	Problem is that service is postcode led, access is not equitable. Service must be awarded on basis of quality not cost.

9.2 Discussion

The service is currently well valued among all PCGS, and they report that surgeries are equally as satisfied with the service. However, the service appears to be running at full capacity, a source of dissatisfaction among both purchasers, surgeries (and most likely) for prospective service users. The primary aim of reducing health inequalities was described by all PCGs, but in addition respondents stated the aim of reducing GP consultation time spent on welfare rights issues. This secondary aim can only be met by wider and greater provision of advisers in surgeries.

The future development of advice services may provide an opportunity to reconsider the contracting process. Most representatives described both budgets and providers to be “inherited” decisions from previous health authorities. The new Primary Care Teams will provide an opportunity to reconsider contracting and to consider expansion, joint funding (currently only achieved in 2 PCGs) and to specify monitoring requirements. Joint funded service will enable expansion, and targeted service development can be enhanced through the application of accurate monitoring data (which is currently lacking).

The new contracts should also pay attention to the specific remit of the advice service. Currently several different types advice are being funded (including both strictly health and welfare payment focused and broader debt, legal and employment advice). It was acknowledged by a PCG representative that the type of service being delivered may in fact be wider than that specified in the contract. The identification of specific advice problems as “inappropriate” may hamper thorough and complete advice provision. The pursuit of joint funding may enable health budgets to contribute to more useful advice services with broader remits, reflecting the complexities of case advice needed.

The contracts also need to pay attention to how resources are allocated in terms of case continuity and access, for example representation at appeals and home visits. These aspects of the service are necessary (and should have criteria stated for such services) but also carry resource implications. Contracts should pay attention to how the needs of specific groups (e.g. the elderly and those without fluent English) will be met, and development work should be encouraged. Issues of equitable access and opportunity were not only described in terms of stratification and disadvantage, but also as a result of patient postcode. The current patchy provision of the service means that access is dictated according to postcode, and this must be remedied by ether full expansion or the suggested provision of satellite advice services.

In conclusion it appears that there are number of core issues, covering management, funding, sickness cover, training, geographical coverage, subject area coverage, structural considerations, all of which would merit consideration from an overview perspective. Instead of atomised individual contracting approaches from 6 separate PCGs, all funded from one central health authority, a composite strategic approach could ensure a more comprehensive coverage and produce efficiencies in all the above areas. The new PCT may lend itself to such a development pathway.

10

11 The consumer perspective

11.1 Aim

Specialist welfare rights advice providers have been placed within a number of GP surgeries across LSL. The perspectives of advice providers and primary care practitioners have been collected, and the views of current and potential consumers should be represented in considering further provision. Specific populations that are likely to benefit from this type of intervention have been identified in both the existing published research literature and in the practitioner data collected in this study (see chapter 4). This stage of the research aimed to gain insight into the views and actions of some members of these populations with regard to welfare rights advice. In addition, patients who had previously accessed a welfare rights advisor within their surgery were interviewed. This population was sampled in order to investigate the processes that led them to accessing the service, and to understand the “value added” or difference between a primary care point of access and other sources of welfare advice.

During the focus groups, the participants were asked to consider previous experience of accessing information, preferred sources of advice, the processes of applying for welfare payments and appealing against decisions, obstacles to obtaining quality advice, the acceptability of accessing providers in surgeries, and confidentiality.

The focus groups looked at three different client groups: two groups with special needs (the elderly and those with English as a second language) and one group who had accessed welfare rights services. Data from the patient group aimed to describe the value added by surgery-based services. The two special needs groups illustrate the significant access difficulties faced by disadvantaged groups.

11.2 Methods

Participants were recruited through community-based health and education organisations. A semi-structured visual topic guide was developed to address the principal areas of investigation, and the focus groups were planned to last for around 1 hour. The groups were facilitated by one of the research team, with additional assistance given by an English teacher who knew the group well in the case of Asylum seekers, and the worker from an elderly health project who also knew participants in the case of the focus group of older people. These additional facilitators encouraged disclosure and assisted in communication.

At the beginning of each session, participants were informed of the content and purpose of the interviews. Each was given an information sheet, and written consent to participate was collected from each focus group member. Following the interview, participants were given a voucher for a high street store to the value of five pounds, and offered reimbursement of travel expenses.

11.3 Procedure

The topic guide was used for each group, although the specific focus and points of discussion varied between groups according to the issues prioritised by participants. All group interviews were recorded and transcribed verbatim. The transcripts were analysed using content analysis, and the data categorised into codes that were peer reviewed within the research team to ensure consistency and validity of data groupings. The within-group analysis was then compared between focus groups to establish common themes and differences between the populations studied.

Data are illustrated with quotes in italics.

11.4 Focus Group 1: Asylum seekers and people whose English is second language.

11.4.1 Recruitment

This focus group was recruited from an adult education college within LSL, and all participants lived within the health authority boundaries. The group consisted of adult members of an 'English as second language' class, and the group consented to have the first half of their lesson taken up by the research interview. All twelve members of the class participated, and the class teacher also assisted in facilitating the group. This ensured that language difficulties could be overcome, and also helped in raising issues in the discussion which had been previously reported to!the teacher by group members.

11.4.2 Participants

Ten of the 12 members of the group were asylum seekers, and 2 had been granted residency. Seven were men and five women. They were from a range of backgrounds including China, former Soviet states, North and East Africa, the Middle East and Turkey.

11.4.3

11.4.4 Result

- Current sources of advice & information

Participants were asked about where they had gained information regarding welfare rights (e.g. housing benefit, income support, vouchers). The sources varied widely from a solicitor (i.e. the advice had been paid for) to family and friends. Family and friends were described as their "community", and were the primary source of information regarding not just welfare rights but also access to GP services. While the community networks appear to be effective in providing information regarding points of access, it raises questions for those who do not have access to communities from their country of origin. This problem was described by the class teacher,

> *"If the students have family members who have been in the country longer than they have usually their family members or their friends can tell them look if you need this you do that.. but if you are alone and you have no family here and you have no community to support you here if you are a remote country like Lithuania or Ukraine it's really difficult to get help and you really need to look at where they're from …it depends on what language they speak and if they don't have family or friends or a community supporting them then they are very isolated and these are the people you do not hear about because they don't know where to go."*

Knowledge appears to be commonly transmitted within communities, and is low cost and by its nature appropriate and accessible source of information. However, the limitations in terms of specialist knowledge (particularly the danger of misinformation) and the lack of developed communities among some ethnic groups are apparent.

In addition to community based information, other cited sources were both the job centre and the college (both mentioned once). The teacher stated that a wide range of students approached her on a regular basis regarding welfare rights and medical services. In response, a welfare rights advisor had been brought in to address the class in an attempt to provide then with the information they needed.

The college, and the teacher in particular, was mentioned as a source of advice when they felt that they were unable to resolve their issues in any other way. As these were a group of people who had easy access to this type of non-specialist advice, the question remains of what actions would be taken by those who do not attend institutions where informal advice may be sought and/or are not part of developed ethnic communities.

- Completing forms, language and translation

All participants reported difficulties in completing forms related to benefits claims. Again, friends and family were the main sources of assistance in completing forms, with one participant gaining support from a hostel worker.

The issue of confidentiality becomes important when the support offered by family and friends is needed in specific case work- whether it be in GP consultation or form completion. When asked if they felt that it was OK for friends and family to act as translators and advocates, the general opinion was that it was necessary but not ideal.

Often, the patient did not have the choice of whether or not to use a professional interpreter,

> *“I would prefer an interpreter, and yes sometimes there is one, though it is difficult but I phone and sometimes they find one and sometimes no…”*
>
> *“When I meet my doctor I think how can I explain to him about my problem and I take my dictionary and I write down and read to him message and come to him and he read then OK but no interpreter, one time only I had*

> *an interpreter. Every time I talk to them I need sometimes the interpreter but I don't have."*

The issue of accuracy was also raised with regard to lay interpreting,

> *"I think I prefer an interpreter because a friend they maybe don't know English so well to talk about medical things"*

The type of psychosocial consultation needed to facilitate the discussion of welfare rights issues is likely to be made more difficult in the light of such barriers. The articulation of solely medical concerns may be a result of such complications.

♦ The primary care setting & welfare rights advice

Clearly, for primary care-based welfare rights provision to succeed, those who are likely to need the service must be registered with surgeries. Of those present, 8 were registered with GP practices (including one registered via a hostel service).

Of those who had used GP services, none had ever asked, or been asked, about welfare benefits. The GP surgery was not seen as an appropriate place to pursue welfare rights issues,

> *R3: "No because you talk to him about your health about this thing but not about the money doctors are about your health"*
> *RH:"OK so you think that's not the place to ask ?"*
> *R3 "Yeah that's right"*
> *RH "What do you think about asking about money and benefits in the GP surgery?"*
> *R1 "You can talk to someone about money and other things but her is just for health."*

> *R3 "No you talk to doctor about…it is separate they give you advice better than a doctor and doctor is only 5 minutes or 10 minutes and he has to see the next patient. People need to go … where there is lots of advice."*

- The benefits of welfare payments

Participants were asked to describe how they would, or are currently, using welfare payments. Their responses were as follows:

> *R1 "I would buy clothes and food."*
>
> *R2 "I am different because I am working but before when I was here without money it wasn't enough because I had nothing nothing for the house and I needed everything, everything for the house because you don't have a thing. For the kitchen for the clothes."*
>
> *R3 "I would get more food and more clothes and books and a computer."*
>
> *R4 "Job centre give me money and I spend on bus pass and food and looking for a job."*
>
> *R5 "I would spend some more money on my family and my children I would take them on holiday."*
>
> *R6 "I think it is like a dream talking about new benefits."*
>
> *R7 "I would buy clothes and food and something for the baby and maybe a computer."*
>
> *R8 "Too much for me my clothes my church helps with shoes and clothes. If I had money I would buy clothes."*
>
> *R9 "I would buy things to put in my house and some clothes."*
>
> *R10 "I will buy more clothes for my family."*

- Future options for seeking advice

Respondents were asked where they would go if they had a need for welfare rights advice.

> *"Job Centre, Some very friendly some no good. I ask my husband. Don't know*
> *I would go and talk to …I don't know."*
>
> *"I don't know."*
>
> *"I don't where to go to for the problems with the money maybe social services."*
>
> *"I talk to the advisor in Lewisham Library, if I have any problems with any forms then someone helps me in Lewisham Library."*
>
> *"I don't know who I would talk to. Social services I don't know?"*
>
> *"If I had to know I don't know I would ask my brother."*
>
> *"I don't know."*
>
> *"I am not sure now."*
>
> *"I do not know about benefit I ask here at the college (her teacher says she is not part of a supported community and she is isolated)."*
>
> *"My support worker at the hostel."*

Of 10 respondents, 2 identified appropriate sources of information (hostel worker and local library) and two identified sources to locate further advice (social services and a family member). Although all had had to find out basic information in the past, they were unclear as to where to access further advice. It is interesting to note that the respondents did not choose "frontline" services, but that they selected less mainstream providers.

11.5 Focus Group 2: Older people.

11.5.1 Recruitment

Participants were recruited from a health advocacy project in a local community centre. The project worker identified local elderly people (of pensionable age) at random, and wrote to them to ask if they would participate. The letter was followed up with a telephone call. Of 8 approached, 5 agreed to attend. The project worker also attended the group, and contributed to the facilitation and discussion of the group in an advocacy role.

11.5.2 Participants

Four of the participants were female and 1 male. They ranged in age from early 60's to late 70's, and all were retired.

11.5.3 Results

- Current access issues for older people

Participants articulated particular difficulties for older people in accessing mainstream services. There was a strong feeling that the current structures for advice provision were not appropriate,

> *"Distance is not the problem if you were going down there* [TOWN HALL] *and you could get served quickly it would be alright but you go in there and you take a ticket and you wait and you wait and you wait and the queue is a mile long even if you've just got a form to hand in and if you're saying that to go into the GP surgery then the service would better then I'd be all for it ……"*
>
> "*But you've only got to go to* [LOCAL AUTHORITY ADVICE SERVICE] *to see all the people waiting and it puts you off."*

However, the tailoring of benefits advice and applications for older people has been noted to have a useful success in the production of an older person's housing benefit application,

> *"The pensioners form is much better cos the form you had before was for everybody and it was 5 or 6 pages long and half of it didn't apply to a pensioner- students and partners and things like that because a lot are widowers and what they've done is a 2 pages much simpler."*
> *"…….I haven't had one of those"*

Despite this development of an appropriate element of welfare provision, other aspects of service provision were found to be entirely inappropriate for older people

> *"There are benefit officers, ……and they come in the evening and they knock on the door and they say they've come to check your benefits and they want to see all your relevant details and most elderly people have got families that have got their details and elderly people are frightened of authority"*
>
> *"..And they don't like opening their doors at night anyway they call in the evening and they don't phone in advance"*
> *"…And they say check but you haven't always got your glasses on"*
> *"…And if they come in the evening the offices are closed and there's nobody to check with anyway."*
> *"I've had this happen to neighbours and they come in the evening and these people ask for their details and they haven't got them and they get worried and sometimes some of them aren't very nice and they send an old person into a state of worry and shock. And so it does seem a bit unfair."*

In addition, the manner of the individual providers was seen as important to the group,

> *"You need someone you can immediately warm towards and you're getting somewhere…..and in fact I suppose it's an attitude."*

Older women were identified as having a specific set of difficulties in dealing with welfare rights.

> *"I think because often wives were used to having things sorted and then they're left alone…"*
> *"…Or they just assume they're not eligible"*
> *" ..But she hasn't had to take an interest."*
> *"The wives' job was to get all the food and things done and the man would do all the paperwork"*

The meaning of welfare rights, and the stigma attached to claimants, was particularly strong.

> *"And of course it's got a dirty name means testing"*
> *"…They used to check what food they had in the cupboard in the old days."*
>
> *"I can remember we even had to sell a table to get anything in the 20's and 30's and you had to sell something to raise money to get anything from welfare."*
>
> *"Of course it's always in the back of my mind that it'll always be like that and of course I come from a generation where it wasn't very pleasant trying to get help. Where it was vouchers or whatever and you wouldn't do it if you could get away with it and my poor parents were on the borderline many times, ….and it's got to be made as if it's human."*

- Self advocacy and accessing welfare rights information

Negotiating benefits advice services was identified as a source of stress.

> *"You often can't stand in a queue……………and as far as I understand with the visits there was a backlog they had to clear. And the longer you leave it as the weeks go on the more you have arrears is the problem."*
>
> *"It takes me from December to June to work out my rent and housing benefit. What about somebody who is older than I am and gets them worried."*

As a result of stigma, stress and the difficulties in making claims, older people were likely not to pursue claims, and if they did it took determination to get payment.

> *"I had an horrendous experience with my state pension and then I was told I wasn't entitled to it- they told me I could have 14p a week- it was horrendous. So I went down to the local offices at the council and they couldn't help me at all and so then I wrote to the local DSS department and they couldn't help me at all and because I knew the departments I was lucky I felt quite confident in what I was doing. I wrote to Nottingham and I wrote to John Major and immediately it was sorted out they were looking into it and I was entitled to £31 a week. Now how many people would have accepted that which they do …so it is a problem."*
>
> *"I'm probably on the borderline and because of that I'd don't want all the hassle so I'd rather do without and I'm sure this is the case with other people and so they are losing out because they might go down to the town hall and they may not necessarily be well treated down there I mean I've met a person down there who couldn't care less and there were people coming in and they were my age or older and they were being treated very brusquely and I thought it was just bureaucracy at its worst."*
>
> *"Somebody sent me an incapacity form and I got two lots and I looked at it and I thought I'm sure I'm not eligible for anything here so I didn't bother…it was about that thick each set of forms….and I looked at it and I'm not stupid but I thought I can't fill this in.."*
>
> *"I only have to see a brown envelope and my blood runs cold."*

The elderly care project worker commented,

> *"…. it really is a problem that people can't be bothered, and the other part of that is when you can be bothered and you do do it older people get really really worried about what's going to happen, will I end up worse off?, which they can."*

Respondents had attempted to get information from other places, but found it difficult to locate the information they needed in a form that they could understand,

> *"People don't know where to get the forms from. You try getting an attendance allowance form from a local social services office. You can't get one. It's really basic information."*
> *"…and sometimes it's in language that you can't understand."*

The participants identified a principal alternative provider as inappropriate as well as inaccessible,

> Interviewer *"I know CAB are popular, has anyone tried to go there for advice?"*
> *"Most people who go there are out of work."*
> *"There are always massive queues and it really is for people who are desperate. There aren't enough people there to help these really and truly desperate people."*
> *"But you just don't have any clue when they'll be able to see you."*

- Welfare rights in general practice

Participants were concerned that it is not currently feasible to raise welfare rights issues in GP consultations, principally due to time constraints,

> *"And the thing is you're not going to get much out of the GPs because they're busy people and the one thought in their mind when you go to see them is how quick can I get rid of him. It's a hassle – you've only got to say one thing off hand and they don't want to know you if you give them a problem they can't solve in about two or three minutes."*
>
> *"But they don't ask that question* [welfare rights] *they only try and deal with a problem you've come in with."*
>
> *"I think it is a good idea but the GPs haven't got the time. And the other problem is how you tell people it's there. If you put a sign up in the surgery and you've got too many signs they're not read."*

Issues of confidentiality appear to be important to older people,

> *"I do feel older people are very wary of other people getting involved in what they're doing. If this is happening from their own perspective and it's advertised and receptionists mention it rather than pointing to them like. Doctors write and tell you things so you can put advertising in with it."*
>
> *"I talk to people and they don't realise there is different bits to benefits like daytime and night-time payments….and I think confidentiality for older people is one of the main problems."*
> *"….And yet they talk amongst themselves quite openly I mean they don't tell each other every little bit they get but it's a point of contact between each other you know so and so and so and it could be revealing quite a bit of information and yes they can be a bit cagey but they can open up actually if they're not official."*
>
> *"One of the things I did object to about most strongly was the original documents you have to provide you have no confidentiality at all even if they say it's covered by the data protection you don't really know you're not sure and anyone can bring information up on the computer."*

However, it was seen as feasible for welfare rights services to be provided in GP surgeries and used among older people,

> *"I can't see a problem with saying to the receptionist that you have an appointment with the welfare officer"*
> *"…yes because then no-one would know what you were seeing the welfare officer for. Like for your bus pass then you have to show them all your ID.."*
> *"...but they're not asking how much money you've got stashed away are they?"*

Again, issues of style and skills within the individual practitioner were mentioned,

> *"… the doctor could say do you have any problems and it comes down to how much the patient wants to open up and you've got to recognise it and you've get to get recognition from the patient that they've got feedback from the patient to discuss it. It comes down to the GP but have they got the time?"*
>
> *"There's a difference between someone who knows you well and one who just writes a prescription and sends you on your way. It depends upon the*

attitude of the doctor and the attitude of the patient if you've got a good relationship with your doctor and you feel it's possible then……."

11.6 Focus Group 3: Patients who have accessed a surgery-based welfare rights advice service.

11.6.1 Recruitment

A surgery in LSL was identified at random from a list of surgeries with specialist welfare rights advice provision. Reception staff at the surgery located a list of the 10 patients who had most recently attended the welfare advice service, and who had at least one welfare issue closed. This criteria was used to encourage informed reflection on the service, including the length of time for which support was offered (e.g. to appeal, payment etc). These 10 patients were written to and invited to attend the group.

11.6.2 Participants

4 patients attended the focus group. 2 were male (1 white, 1 Asian) and 2 were female (both afro-Caribbean). All had accessed the service and had at least one issue dealt with to the point of closure, and 2 had ongoing work with the advisor.

♦ Multi-dsciplinary working in welfare rights advice

Patients described how their benefit issues had been raised in clinical consultation, and dealt with by the welfare rights adviser. The data demonstrate how welfare rights advice can be integrated in primary care,

> *"…he's* [adviser] *trying to get a re-assessment because as far as he and the doctor are concerned the level is too low so he's trying to sort it out"*
>
> *"Dr* [name] *here in the surgery she recommended him to me cos I had stopped working and she said see him and he was very very good because the first time he filled out the forms and I didn't have any problem*

> *"I had a back problem and it got to the point where I was unable to work any more at one stage I was called to see a doctor and they said I was well enough to go back to work and I wasn't so I came to see my GP and she recommend that I appeal and I saw the advisor and he came to the appeal so I find it a very excellent service and I recommend it to anyone"*

However, although the sample was drawn from a population of patients who had successfully accessed advice in the primary care setting, problems were recognised in the raising of welfare issues with GPs,

> *"They don't have time to do that because doctors they are just rushing you and pushing you out."*
>
> *"The only thing is I find the doctors are so busy sometimes they haven't got time really to listen you seem them fidgeting and you're talking too much and they want you to go you do get that feeling….but I just carry on talking I'm not moving til I've finished saying what I'm saying. I'm there for myself."*

- The surgery setting

The added value of providing welfare advice in the surgery was seen to be the reduction of stress and discomfort, and the utilisation of existing patient-practitioner relationships.

> *"Doctor's surgery is like a home you can be looked after it's like coming home to see your doctor it's more relaxing…."*
>
> *"…You feel very relaxed yeah."*
>
> *"It's an environment you know and an environment you feel comfortable in cos you've been here quite a few times, it's not like a strange place it's people you know and you don't feel uncomfortable….."*
> *"But if you're worried an excellent environment is to see your doctor. You see your doctor to see someone and to stop worrying about it."*
> *"….You go into the surgery all of these things you can talk about. When you go out you are in the wilderness."*

> *"You can go to the doctor with stress and what causes the stress and it could be council tax disability and you talk to the doctor about the stress and the doctor says would you like to speak to someone, an advisor."*

> *"It's a happy atmosphere here it's near your home coming to your doctors is like your home and you know everyone and you're confident and it's nice to trust people."*

> *"It's the atmosphere and the place you know the people you know by name you feel so easy and you've got no stress while you're talking In a strange office you're thinking…..stressed and nervous and you forget things when you're stressed and nervous."*

> *"If you go to somewhere for the first time you don't feel comfortable if you come to the surgery you feel relaxed because you've been here before."*

Prior knowledge of the patient and their clinical management was useful in identifying and applying for appropriate benefits,

> *"I went to a disabled centre and the guy there filled in endless forms and I got not even a reply back form the DLA I tried myself others tried and the problem with my disorder is that very few people know about my disorder it's very rare and it's difficult….I saw the notice in the surgery and thought I'd try"*

- Advice provider skills

The interpersonal skills and specialist knowledge of the individual advice provider (as well as those of the GP) were identified as being crucial in the service,

> *"It was too much to try and fill out the form and it was very caring and very understanding having him do it and he said if I needed any more help to come back …….. I recommend it to anyone there's a nice man in the surgery."*

> *"I think [provider] is a people person and he listens and he cares he's not pushing or rushing he takes his time, it was a friendship that built up, I didn't have any fear, it was a confidence there."*

> *“It’s like the forms he turns it over and over until you understand……the system changes so much …..”*

> **“***You feel like he can talk to you and you can explain your situation. I can’t do it myself and they turned me down.. I feel relaxed.”*

- Advocacy and benefits advice providers

The role of benefits adviser as advocate was highly rated, and was seen as a key factor in the high satisfaction with the service,

> *“It just gives you that extra help to have them there* [at appeal]*”*

> *“I found it really hard in the past finding someone to represent me.”*

As found with other populations in this study, assistance with form filling was necessary in addition to the provision of advice,

> *“It was good for me because I was stressed at the time and I wouldn’t have filled that form in no way. I was supposed to fill in a form in October and I was putting it off I didn’t have any help so when the doctor mentioned it I was relieved.”*

> *“The doctor knew my background and I’d applied so many times before and my GP said why don’t you try, cos I’d filled in the forms myself.”*

> *“In 1999 I had a lung removed and I wrote to the DLA, I took it upon myself, I did all the filling in forms on my own back but I wasn’t clever enough.”*

> *"The problem is with the forms you need a degree to get through them cos they're worded so complicated but they've made it so complicated and a lot of people get fed up."*
>
> *"It's so complex…."*
> *"….Particularly if you're under stress or something"*

- Alternative providers

Patients described previous attempts to access benefits advice,

> *"He makes you feel very at home. When you go anywhere else last time we went there we couldn't understand each other and I didn't get anywhere with it."*
>
> *"It's like most places now you've got to get there early cos it's the first 4 or 5 people at the door and no more after."*
>
> *"They don't understand."*
> *"….And all they offer is 5 or 10 minutes of someone to help you fill out the forms."*
>
> *"I was told to phone DSS and I phoned and I couldn't understand what they were saying and they were putting me through to different people and in the end I just put the phone down."*
> *"The thing is with the social is they just turn you away."*
> *"And they say you have to ask your neighbours or your friends to help you we can't help you."*
> *"They don't help you with these things."*

They also described what they felt what have been the alternative to accessing advice in the surgery in this instance,

> *"Probably if it was me I'd have sat down and moped about not doing anything knowing the condition that I was in so I thank God it was there to*

> *help me and to assist me maybe I try myself but it wouldn't have been there and then when the doctor suggested it to me."*
>
> *"At [hospital] there's a unit for my illness as well as a welfare officer but basically he hasn't got time to sit down in his office and help you through he just basically leaves you with it."*

11.7 Summary and discussion

The analysis of the data collected from ***asylum seekers*** found:

- Family and friends (i.e. community based contacts) were the key source of information for health and welfare.
- This source of information is not available to those from ethnic groups with small communities in the UK, whose members tend to be isolated.
- Friends and families also act as advocates particularly with form filling.
- Interpreting services are not widely available, and confidentiality and accuracy of information are threatened with the use of lay interpreters.
- Not all members had a GP, and so would be unlikely to access a surgery-based advisor.
- Their GPs do not currently address welfare in consultations.
- Food and clothes are the items most needed.
- The vast majority does not know where they would go for advice on benefits.

Advice services may be able to enhance the use of communication networks through the provision of informal training within community settings. Also, the mapping of services and institutions currently used by ethnic minorities (for example the educational college discussed in the data) may provide additional routes of information giving. The respondents described their fundamental needs (e.g. food and clothing) that could be met by the successful application for welfare benefits.

It appears that those without fluent English are required to waiver their right to confidentiality by using family and friends as lay interpreters when no professional service is provided. Therefore, the allocation of adequate translation services should be prioritised to ensure that all patients are able to maintain confidentiality in both clinical and welfare rights consultations. It should also be highlighted that children often play a role of translator/advocate, which may compromise the disclosure of sensitive information.

The analysis of the data collected from ***older people*** found:

- Current centralised arrangements are unsuitable, due to queues that require clients to stand for long periods.
- Outreach services are inappropriate when they call on older people in the evening.
- Customer service and good attitude from advice staff are crucial aspects of services for older people.
- Older women have particular advice needs, as they may be unaccustomed to dealing with financial matters.
- Welfare rights carry an historical stigma for older people.

- Attempting to advocate for oneself in benefit applications can be very stressful and worrying.
- Older people find that the complexities, stresses and stigma combine to discourage them from gaining advice or applying for benefits.
- Comprehending the system of advice provision, and the materials provided, is difficult.
- Several sources of information were seen as inappropriate: CAB was seen a place for "desperate" people, and GP consultations as a time for only medical issues to be discussed.

Clearly, for this population with high welfare advice needs, the barriers to appropriate services are embedded in ageism. Providers must find ways of addressing the sense of pride and shame which have greater sway than older people's recognition of entitlement. This is compounded by the pre-existing gender division of labour which excludes older women form being able to undertake welfare matters, and the anxiety and stress caused by inappropriate outreach. Lastly, the environment has been described by older people as a crucial barrier to accessing their welfare entitlement. Attention should be paid to location, facilities and staff skills when providing advice for older people.

The analysis of the data collected from ***patients who had accessed surgery-based welfare rights advice*** found:

- Multi-professional approaches to welfare rights in primary care can work well in terms of raising issues and referring to specialist advisers.
- Patients find GP consultations to be short and pressurised.
- The provider skills of the advice worker were strongly valued.
- The GP surgery is seen a relaxing, comfortable environment, and somewhere to solve anxieties. Confidence and trust already exist in the surgery, making an ideal place for welfare rights to be addressed.
- The pre-existing clinical relationship facilitates understanding of the patient’s illness.
- In addition to advice giving, form filling and advocacy at appeal were important tasks performed by the adviser.
- The appointment system, and not having to queue, enhanced access and the willingness to pursue a claim
- Alternatives to the surgery based advice were to take no action at all, or to use alternative providers that were felt not to understand the patient nor to offer adequate time and support to meet their welfare needs.

Patients describe the advice provided in primary care as both a high status and high quality service. The key elements are described as trust, confidentiality, pre-existing clinical relationships, and confidentiality. The “case approach” as opposed to a generalist advice approach is highly valued in this context.

11.7.1 Conclusions

The data has shown particular access and feasibility issues for the populations interviewed, in addition to the added value described in having surgery-based advisers.

While qualitative research methods do not generate data representative of an entire population under study, the benefits of this stage of the research are clear. The focus group method has both complemented the quantitative survey data, and informed feasible and acceptable service development of welfare rights advice among socially disadvantaged groups.

The data highlights particular issues on the provision of an equitable welfare rights advice service. Not only are there challenges in the promotion of the service (for example asylum seekers may not be using surgeries, and older people do not see posters), but there are challenges to overcome in the perception of primary care as an appropriate setting. Currently, patients describe themselves as unlikely to raise issues, and describe GPs as too hurried and clinically focused to detect welfare needs. Some patients and practitioners are raising welfare rights in clinical consultations, but there is further work to be done in standardising the approach and reformulating welfare rights as an appropriate need to be met.

The resources allocated to welfare rights must be such as to retain the aspects of the service that are adding value over other providers who are unable to give the required service- i.e. an unhurried advocating provider that assists patients at all stages of claiming. Resources also need to be made available to ensure that people whose English is second language have the right to confidentiality afforded to other patients, i.e. can use confidential and professional interpreters. The issues of quality and adequate resources are key in ensuring the necessary depth of support is provided by welfare advisers. The need for advocacy and support was highlighted by each focus group groups interviewed (e.g. for form filling and appealing against decisions).

The advocacy role is also important in addressing the particular needs of older women, who may be less likely to be able to negotiate the benefits advice sector. Targeting of such groups may further enhance the equity of access to advice and benefit payments. Raising awareness of the existence of such services should look to community settings, where our data have shown that much information is transmitted.

Finally, the structures of advice giving need to look at how they may place barriers in front of those they are intended to serve. Access to legal help has been shown to be hampered by poor access (Moorhead Sherr et al. 2001). Issues of access and appropriate provision must be called into question at all stages of service development and provision. These include access to space, languages, provider skills and attitudes and the manner in which welfare rights is presented, to ensure that all those with queries about entitlement can see themselves as potentially eligible and well served by advice providers in primary care.

The focus for future development must be to retain the high quality of the service as currently described, as further expansion may endanger the intervention's current impact. Contracting should specifically address the issues of access and appropriateness described by the older people and ethnic minorities, and the current high status and high quality valued by those who have accessed these services.

12 Summary and recommendations

12.1 Summary

Information from contracted providers of advice in primary case settings

- Adviser time is roughly evenly divided between client contact and administration of cases/doing case work. Advisers used suggest that there is inadequate time to do casework as a result. This is in contrast of PCG representative views suggest that two thirds of adviser time is spent on direct client contact and only one third on case/work administration.
- It is possible that funders are modelling their concept of provision on the medical context, rather than the realities of legal advice work. Assistance and follow up are essential parts of the legal work and are key determinants of its quality and effectiveness.
- Geographical coverage is incomplete
- Levels of demand are high
- Appointment waiting times can be up to 6 weeks
- Different types of advice are provided- from solely welfare and disability to broad generalist advice.
- Facilities within surgeries were described as good or adequate, although the provision of appropriate confidential space was sometimes problematic.
- A lack of availability of interpreting services was reported.
- Monitoring and quality control varied greatly, as did levels of training of advisers.
- There was little evidence of targeting of groups with highest needs.
- Sharing management and managed resources between services could enhance efficiency and the provision.
- A number of “health-welfare synergies” emerged which benefited the work of both practitioners and welfare rights providers and their ultimate clients/patients.

Information from Practice Managers

- The nearest local provider was 10 minutes walk away for one third of practices, and a bus ride away for almost half. One third could not identify the nearest provider.
- Those practices with specialist welfare advisers were more likely to find welfare provision to be adequate; that practice staff could access services for patients; that

patients could access advice themselves; that the process of obtaining advice ran smoothly.

- Lack of space and funding were the principal reasons for not having in-house specialist provision.
- A lack of need for/prioritising this type of service was identified in half of those without specialist provision.
- The majority of practices would like to expand welfare advice in various formats.
- Home visits and interpreting services were only available to patients in half of those surgeries with welfare rights advisers.
- Practices who knew the distance to the nearest local provider were also more likely to believe that they had adequate welfare provision and that they could access services for patients.
- Training/information for staff to update on benefit eligibility and changes in payments was provided in only 8% of surgeries.

Information from practitioners

- 70.6% reported that there had been an element of mental health to their most recent case where welfare rights was also an issue (e.g. anxiety, emotional turmoil).
- Half of the practitioners felt the welfare rights issue to be urgent.
- In more than one third of cases the welfare rights issues naturally arose from the consultation.
- Housing, family and employment were the most common additional issues.
- Medical reports were (or will be) needed in half of all cases.
- Practitioners were significantly more likely to raise a welfare issue with their patients if they had in-house specialist advice provision.
- Patients were significantly more likely to ask for information or guidance from those practitioners with access to specialist welfare advice.
- Practitioners estimated that 1/7 (15%) of their consultations involve welfare rights issues.
- 86% of respondents felt there were patients less able to access the welfare rights advice they needed (identified as people with language difficulties, ethnic minorities, those with mental health problems, and the elderly).

- Those *with* specialist welfare rights provision were more likely to find referring easy, and to be more satisfied with the quality of provision for their patients.
- Those with specialist in-house provision were significantly more likely to agree that welfare rights provision improves the health and wellbeing of their patients.

Information from Primary Care Groups

- Joint funding (health/social services) had been achieved in only 2 PCGs
- Contracting decisions and budgets had been inherited from health authorities
- Monitoring data was not returned consistently
- Contracting did not generally specify proportions of client contact/admin, case continuity or targeted work.
- PCGs are generally very satisfied with provision, though they would like to prioritise expansion
- Equitable access (as opposed to access by postcode), regular monitoring data and funding expansion with funding partnerships are current goals.

Information from patients and high-need individuals

Asylum seekers

- Family and friends (i.e. community based contacts) were the key source of information for health and welfare, and they also acted as advocates or gave assistance, particularly with form filling
- Interpreting services are not widely available, and confidentiality and accuracy of information were weakened with the use of lay interpreters.
- Not all focus group members had a GP, and so access to a surgery-based welfare rights adviser would not service all.
- The majority did not know where they would go for advice on benefits.

Older people

- Current centralised arrangements are unsuitable, owing to queues that require clients to stand for long periods.
- Customer service and good attitude from advice staff are crucial aspects of services for older people.

- Older women have particular advice needs, as they may be unaccustomed to dealing with financial matters.
- Older people find that the complexities, stresses and stigma combine to discourage them from gaining advice or applying for benefits.
- Comprehending the system of advice provision, and the materials provided, is difficult.

Patients who had accessed surgery-based welfare rights advice

- Multi-professional approaches to welfare rights in primary care work well in terms of raising issues and referring to specialist advisers.
- Patients find the actual GP consultations to be short and pressurised. Conversely, the GP surgery is seen as a relaxing, comfortable environment, and somewhere to solve anxieties. Confidence and trust already exist in the surgery, making an ideal place for welfare rights to be addressed.
- The skills of the advice worker were strongly valued.
- The pre-existing clinical relationship facilitates understanding of the patient's problems.
- In addition to advice giving, form filling and advocacy at appeal were important tasks performed by the welfare rights advisers.

12.2

12.3 Recommendations

These are divided into training, management, funding and provision, and development issues.

- Funding of welfare rights through health service primary health care provides two key benefits from the consumer perspective. One is that it considerably increase the likelihood of patients seeking advice with their welfare rights problems. The other is that it enables advisers to provide higher standard of service because of the synergies between welfare rights advisers and health professionals.

- For the health care professionals, it enables their surgeries to provide a better service which is likely to improve mental and physical health but also reduces pressure for non health advice within medical health consultations.

- The evidence is that all stake holders with experience of in service provision are strongly supportive of inhouse welfare rights provision. Those who do not have inhouse provision put a strong case for having inhouse provision.

- The constraints to provision and expansion are complex. At times they are economic, relate to geographic considerations, limited by management, historical and occasionally but not to be overlooked, attitudinal.

- Provision is currently patchy and needs to be extended to uniform levels across the borough.

- Service should be extended across the health authority.

- Attention should be given to all levels of extension, including creation, size of provision, allocation of time and resources.

- Management structures to ensure quality provision should be included

- The pressure on services may leave the most needy least met. Consideration should be given to targeting hard to reach groups either via existing services or the creation of additional services.

- Creativity may be needed in order to enhance promotion and targeting which are likely to produce clear benefits.

- Inadequate provision may backfire and create backlog, access barriers and frustration.

- Co-ordinated monitoring with common data sets will streamline provision, allow different funders to have their information needs met and minimise the burden on providers who may be stretched by the immediacy of client need. Such co-ordination should be at regional and national level, merging the requirements of other funders under the aegis of the Community Legal Service Partnerships.

- Training should be part of provision. This includes training of health care providers to detect and refer adequately as well as legal service provider training.

- There should be co-ordination and provision of training for welfare rights advisers.

- Complaint systems, supervision, and quality management should be developed which in a form which could integrate with the general practice environment.

- Low level information and signposting provision should be made available to surgeries and users in addition.

- Provision must be in a confidential separate room and not in a public waiting room area.

- An office with a telephone, desk and basic storage facilities are minimal requirements.

- General Practitioner support is vital.

- Home visits form a key element in provision, especially for housebound and disabled clients. This has specific funding and resource implications.

- Subject area limitations could impede provision. Flexibility in approach to the needs of clients will ensure a more effective service in meeting unmet need.

- Although provision is couched under the heading of welfare rights, we do not think the service should be confined to advice on welfare benefits problems exclusively. Other advice needs have implications for mental and physical health and often overlap.

- Welfare rights case work needs follow up, engagement with external agencies and institutions and sometimes representation in order to complete cases effectively and to maximise outcomes for patients. Funding systems and work practice need to allow proper time beyond client contact hours to maximise benefit. This model may be in contrast to a health care or therapeutic model of the balance between patient interaction and outcome. This needs to be acknowledged and provided for.

13 Appendices

13.1 Questionnaires

Practice managers questionnaire
Practitioners questionnaire
Topic guide for consumer focus groups
Semi-structured schedule for PCG representatives

Practice Manager Questionnaire
PCG (Please circle) North / South Lambeth / Southwark / Lewisham
Practice size: no. of patients ………………..

How many practitioners in your practice?

	Full time	Part time	Attached
GP Partners			
GPs			
Practice Nurses			
Nurse Practitioners			
Midwives			
Health Visitors			
Counsellors			
Others ………………… …			

With regard to welfare and legal advice, what do you offer?
Advice sessions within the surgery symbol 111 \f "Monotype Sorts" \s 12❑ No
symbol 111 \f "Monotype Sorts" \s 12❑ Yes ………… hours per week

Inform patients of other organisations symbol 111 \f "Monotype Sorts" \s 12❑ No
symbol 111 \f "Monotype Sorts" \s 12❑ Yes

Make referrals on patients’ behalf to other organisations symbol 111 \f "Monotype Sorts" \s 12❑ No symbol 111 \f "Monotype Sorts" \s 12❑ Yes

Which organisations, if any, do you recommend/use?
CAB symbol 111 \f "Monotype Sorts" \s 12❑ Local solicitor symbol 111 \f "Monotype Sorts" \s 12❑ Local council service symbol 111 \f "Monotype Sorts" \s 12❑
Independent local advice service symbol 111 \f "Monotype Sorts" \s 12❑ i.e. ……………………………………………

How far from your surgery is the nearest welfare facility?
……….. minutes walk A bus ride symbol 111 \f "Monotype Sorts" \s 12❑
Don’t know symbol 111 \f "Monotype Sorts" \s 12❑

Thinking about the services available for welfare and legal advice for your patients, please rate to what extent you agree with the following statements, From 1 “strongly disagree” to 10 “strongly agree”.
symbol 172 \f "Monotype Sorts" \s 12① Strongly disagree
symbol 181 \f "Monotype Sorts" \s 12⑩ Strongly agree

We have adequate welfare and advice services available within our practice	symbol 172 \f "Monotype Sorts" \s 12① symbol 173 \f "Monotype Sorts" \s 12② symbol 174 \f "Monotype Sorts" \s 12③ symbol 175 \f "Monotype Sorts" \s 12④ symbol 176 \f "Monotype Sorts" \s 12⑤ symbol 177 \f "Monotype Sorts" \s 12⑥ symbol 178 \f "Monotype Sorts" \s 12⑦ symbol 179 \f "Monotype Sorts" \s 12⑧ symbol 180 \f "Monotype Sorts" \s 12⑨ symbol 181 \f "Monotype Sorts" \s 12⑩
We have adequate services available locally	symbol 172 \f "Monotype Sorts" \s 12① symbol 173 \f "Monotype Sorts" \s 12② symbol 174 \f "Monotype Sorts" \s 12③ symbol 175 \f "Monotype Sorts" \s 12④ symbol 176 \f "Monotype Sorts" \s 12⑤ symbol 177 \f "Monotype Sorts" \s 12⑥ symbol 178 \f "Monotype Sorts" \s 12⑦ symbol 179 \f "Monotype Sorts" \s 12⑧ symbol 180 \f "Monotype Sorts" \s 12⑨ symbol 181 \f "Monotype Sorts" \s 12⑩
We are able adequately to access services for patients	symbol 172 \f "Monotype Sorts" \s 12① symbol 173 \f "Monotype Sorts" \s 12② symbol 174 \f "Monotype Sorts" \s 12③ symbol 175 \f "Monotype Sorts" \s 12④ symbol 176 \f "Monotype Sorts" \s 12⑤ symbol 177 \f "Monotype Sorts" \s 12⑥ symbol 178 \f "Monotype Sorts" \s 12⑦ symbol 179 \f "Monotype Sorts" \s 12⑧ symbol 180 \f "Monotype Sorts" \s 12⑨ symbol 181 \f "Monotype Sorts" \s 12⑩

We lack information on appropriate services	symbol 172 \f "Monotype Sorts" \s 12① symbol 173 \f "Monotype Sorts" \s 12② symbol 174 \f "Monotype Sorts" \s 12③ symbol 175 \f "Monotype Sorts" \s 12④ symbol 176 \f "Monotype Sorts" \s 12⑤ symbol 177 \f "Monotype Sorts" \s 12⑥ symbol 178 \f "Monotype Sorts" \s 12⑦ symbol 179 \f "Monotype Sorts" \s 12⑧ symbol 180 \f "Monotype Sorts" \s 12⑨ symbol 181 \f "Monotype Sorts" \s 12⑩
Patients can access advice service without difficulty	symbol 172 \f "Monotype Sorts" \s 12① symbol 173 \f "Monotype Sorts" \s 12② symbol 174 \f "Monotype Sorts" \s 12③ symbol 175 \f "Monotype Sorts" \s 12④ symbol 176 \f "Monotype Sorts" \s 12⑤ symbol 177 \f "Monotype Sorts" \s 12⑥ symbol 178 \f "Monotype Sorts" \s 12⑦ symbol 179 \f "Monotype Sorts" \s 12⑧ symbol 180 \f "Monotype Sorts" \s 12⑨ symbol 181 \f "Monotype Sorts" \s 12⑩
Advice services are over-stretched	symbol 172 \f "Monotype Sorts" \s 12① symbol 173 \f "Monotype Sorts" \s 12② symbol 174 \f "Monotype Sorts" \s 12③ symbol 175 \f "Monotype Sorts" \s 12④ symbol 176 \f "Monotype Sorts" \s 12⑤ symbol 177 \f "Monotype Sorts" \s 12⑥ symbol 178 \f "Monotype Sorts" \s 12⑦ symbol 179 \f "Monotype Sorts" \s 12⑧ symbol 180 \f "Monotype Sorts" \s 12⑨ symbol 181 \f "Monotype Sorts" \s 12⑩

The process of obtaining advice runs smoothly	symbol 172 \f "Monotype Sorts" \s 12① symbol 173 \f "Monotype Sorts" \s 12② symbol 174 \f "Monotype Sorts" \s 12③ symbol 175 \f "Monotype Sorts" \s 12④ symbol 176 \f "Monotype Sorts" \s 12⑤ symbol 177 \f "Monotype Sorts" \s 12⑥ symbol 178 \f "Monotype Sorts" \s 12⑦ symbol 179 \f "Monotype Sorts" \s 12⑧ symbol 180 \f "Monotype Sorts" \s 12⑨ symbol 181 \f "Monotype Sorts" \s 12⑩

P.T.O. symbol 234 \f "Monotype Sorts" \s 12➪

If you do not have a welfare/legal provider on site, what are the reasons?

Factor	**Major reason**	**Minor reason**	**Not a factor**
Lack of space			
Not funded by PCG			
Lack of need from this practice			
There are adequate alternatives			
The practice has other priorities			
Patients rarely demand such a service			
The practice has never considered providing this type of service			
Other (please specify)			

In terms of the provision of welfare rights, what would you like to see in the future?

Provision	**More**	**As is**	**Less**
Within practice specific service			
System of referrals to other specialist agencies			
Additional funding for welfare provision			
Availability of patient information leaflets			
Internet provision			
Outreach service			
Targeted welfare provision for excluded/vulnerable groups			
Training for providers (GPs and clinic staff)			

Thinking about current provision of information in the surgery, does *your practice* monitor

Requests symbol 111 \f "Monotype Sorts" \s 12❑ No symbol 111 \f "Monotype Sorts" \s 12❑ Yes symbol 111 \f "Monotype Sorts" \s 12❑ Advice provider does this
Action taken symbol 111 \f "Monotype Sorts" \s 12❑ No symbol 111 \f "Monotype Sorts" \s 12❑ Yes symbol 111 \f "Monotype Sorts" \s 12❑ Advice provider does this
Outcomes symbol 111 \f "Monotype Sorts" \s 12❑ No symbol 111 \f "Monotype Sorts" \s 12❑ Yes symbol 111 \f "Monotype Sorts" \s 12❑ Advice provider does this
Service satisfaction symbol 111 \f "Monotype Sorts" \s 12❑ No symbol 111 \f "Monotype Sorts" \s 12❑ Yes symbol 111 \f "Monotype Sorts" \s 12❑ Advice provider does this

Do you provide printed welfare rights information in your waiting areas?
symbol 111 \f "Monotype Sorts" \s 12❑ No symbol 111 \f "Monotype Sorts" \s 12❑ Yes

Is this information provided in different languages? symbol 111 \f "Monotype Sorts" \s 12❑ No symbol 111 \f "Monotype Sorts" \s 12❑ Yes

Does your provider offer interpreters to convey welfare rights information?
symbol 111 \f "Monotype Sorts" \s 12❑ No symbol 111 \f "Monotype Sorts" \s 12❑ Yes

Does your provider offer home visits for welfare rights advice? symbol 111 \f "Monotype Sorts" \s 12❑ No symbol 111 \f "Monotype Sorts" \s 12❑ Yes

Do you have training/information for staff to update on benefit eligibility and changes in payments? symbol 111 \f "Monotype Sorts" \s 12❑ No symbol 111 \f "Monotype Sorts" \s 12❑ Yes

Please add any comments you may have regarding the provision of welfare rights services in your practice or in your locality (e.g. access, obstacles, good practice, suggestions for improvement)

Thank you. Please return in the freepost envelope provided.

Practitioners' Questionnaire - Welfare Rights Project

What is your role in the practice?
Doctor symbol 111 \f "Monotype Sorts" \s 10☐ District nurse symbol 111 \f "Monotype Sorts" \s 10☐ Nurse practitioner symbol 111 \f "Monotype Sorts" \s 10☐
Midwife symbol 111 \f "Monotype Sorts" \s 10☐ Counsellor symbol 111 \f "Monotype Sorts" \s 10☐ Practice nurse symbol 111 \f "Monotype Sorts" \s 10☐
Social worker symbol 111 \f "Monotype Sorts" \s 10☐ Health visitor symbol 111 \f "Monotype Sorts" \s 10☐ Other symbol 111 \f "Monotype Sorts" \s 10☐…………….…………..
Please think back to the *most recent* occasion on which you had contact with a patient where there was a need for welfare rights advice *whether they recognised this or not*.
It is not important whether this need was acted on, or what the outcome was, we are interested in the *most recent occasion*. This way we hope to get a snapshot of patient need.
The consultation

How many days ago was this case? ……………….. days symbol 111 \f "Monotype Sorts" \s 10☐weeks symbol 111 \f "Monotype Sorts" \s 10☐

What was the nature of the medical issue for this patient?
………………………………………………………………………………………………

Was there a mental health element to the consultation?
(e.g. depression, anxiety, emotional turmoil)**?** No symbol 111 \f "Monotype Sorts" \s 10☐ Yes symbol 111 \f "Monotype Sorts" \s 10☐

What was the nature of the welfare rights needs of the patient?
………………………………………………………………………………………

How urgent was the welfare rights problem? *(tick one only)*

Urgent: needed immediate attention	symbol 111 \f "Monotype Sorts" \s 10☐
Urgent: needed prompt attention (days)	symbol 111 \f "Monotype Sorts" \s 10☐
Needed attention (routine)	symbol 111 \f "Monotype Sorts" \s 10☐
Not urgent, could do with attention (time open)	symbol 111 \f "Monotype Sorts" \s 10☐

How did the welfare rights issue arise?

I brought it up	symbol 111 \f "Monotype Sorts" \s 10☐
They asked, didn't know where else to go	symbol 111 \f "Monotype Sorts" \s 10☐
Naturally arose from clinical consultation	symbol 111 \f "Monotype Sorts" \s 10☐
Had been recommended to speak to me	symbol 111 \f "Monotype Sorts" \s 10☐
They asked	symbol 111 \f "Monotype Sorts" \s 10☐

Please describe the patient as follows:
Age group …………. Ethnic origin…………..
Gender symbol 111 \f "Monotype Sorts" \s 10☐ M symbol 111 \f "Monotype Sorts" \s 10☐ F Fluent English speaker? symbol 111 \f "Monotype Sorts" \s 10☐ No symbol 111 \f "Monotype Sorts" \s 10☐ Yes
Disabled symbol 111 \f "Monotype Sorts" \s 10☐ No symbol 111 \f "Monotype Sorts" \s 10☐ Yes

Was the patient any of the following? (*tick as many as apply)*
Elderly symbol 111 \f "Monotype Sorts" \s 10☐ Ethnic minority symbol 111 \f "Monotype Sorts" \s 10☐ Disability symbol 111 \f "Monotype Sorts" \s 10☐
Poverty symbol 111 \f "Monotype Sorts" \s 10☐ Drug/alcohol use symbol 111 \f "Monotype Sorts" \s 10☐ Unemployment symbol 111 \f "Monotype Sorts" \s 10☐
Refugee symbol 111 \f "Monotype Sorts" \s 10☐ Homeless symbol 111 \f "Monotype Sorts" \s 10☐ Mental health symbol 111 \f "Monotype Sorts" \s 10☐

Were any of the following also an issue? (*tick as many as apply)*

Welfare benefits symbol 111 \f "Monotype Sorts" \s 10❑ Housing symbol 111 \f "Monotype Sorts" \s 10❑ Crime symbol 111 \f "Monotype Sorts" \s 10❑ Harassment symbol 111 \f "Monotype Sorts" \s 10❑
Immigration symbol 111 \f "Monotype Sorts" \s 10❑ Injury symbol 111 \f "Monotype Sorts" \s 10❑ Debt symbol 111 \f "Monotype Sorts" \s 10❑ Occupational health symbol 111 \f "Monotype Sorts" \s 10❑
Discrimination symbol 111 \f "Monotype Sorts" \s 10❑ Family symbol 111 \f "Monotype Sorts" \s 10❑ Consumer symbol 111 \f "Monotype Sorts" \s 10❑ Employment symbol 111 \f "Monotype Sorts" \s 10❑

Did the patient request information/guidance? No symbol 111 \f "Monotype Sorts" \s 10❑ Yes symbol 111 \f "Monotype Sorts" \s 10❑

11. How was the need for welfare rights advice addressed?
I advised the patient to seek help symbol 111 \f "Monotype Sorts" \s 10❑
I did not specifically discuss the issue symbol 111 \f "Monotype Sorts" \s 10❑
I gave them details for further information symbol 111 \f "Monotype Sorts" \s 10❑
I made a referral to our practice welfare rights servicesymbol 111 \f "Monotype Sorts" \s 10❑
I made a specific referral to another agency symbol 111 \f "Monotype Sorts" \s 10❑
I completed the necessary report requested symbol 111 \f "Monotype Sorts" \s 10❑
Other (please specify) ……………………………………………………………………………

12. Was a medical report needed / will it be needed from you? symbol 111 \f "Monotype Sorts" \s 10❑ No symbol 111 \f "Monotype Sorts" \s 10❑ Yes

Use of welfare rights

Approximately what proportion of your consultations in your estimation involve welfare rights issues (whether presented or not)? ……………….%

Are there any groups of patients who, in your experience, are less able to get the advice they need? symbol 111 \f "Monotype Sorts" \s 10❑ No symbol 111 \f "Monotype Sorts" \s 10❑ Yes symbol 111 \f "Monotype Sorts" \s 10❑ Don't know
Please describe…………………………………………………………………

Do you have a welfare rights facility for patients within your surgery/building?
symbol 111 \f "Monotype Sorts" \s 10❑ No symbol 111 \f "Monotype Sorts" \s 10❑ Yes

Do you have a named person for access to welfare rights information?
symbol 111 \f "Monotype Sorts" \s 10❑ No symbol 111 \f "Monotype Sorts" \s 10❑ Yes

How would you rate the ease with which you can refer patients to welfare rights services?

Very difficult, with obstacles	Straightforward, but difficult	Fairly easy	Well facilitated and made easy

Please rate your satisfaction with the quality of welfare rights provision for your patients?

Very poor	Fairly poor	Good	Excellent

20. Please rate the extent to which you agree with the following statements, from 1 "strongly disagree" to 10 "strongly agree".

symbol 172 \f "Monotype Sorts" \s 10① Strongly disagree symbol 181 \f "Monotype Sorts" \s 10⑩ Strongly agree

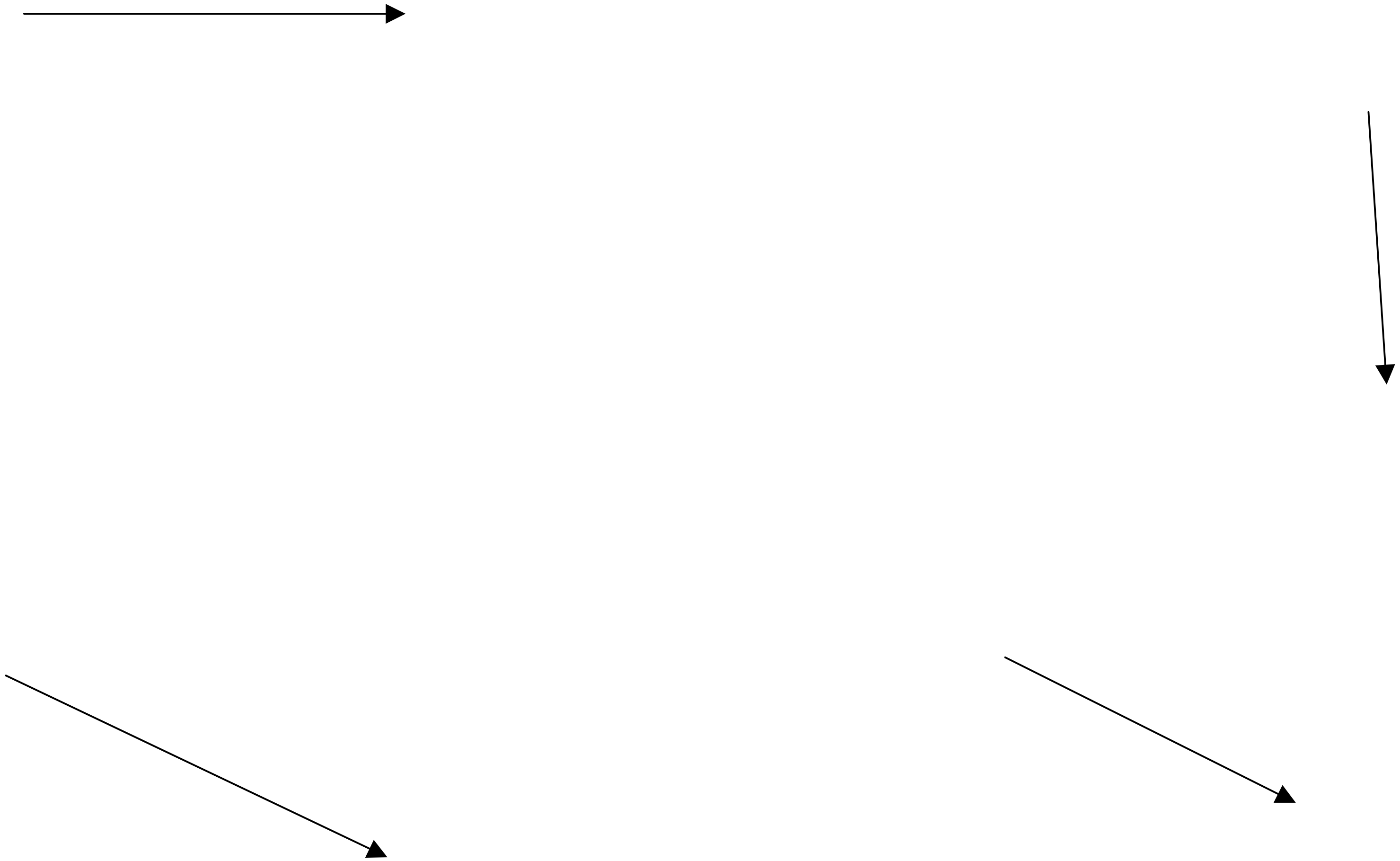
Enough money is spent on welfare benefits advice provision	symbol 172 \f "Monotype Sorts" \s 10① symbol 173 \f "Monotype Sorts" \s 10② symbol 174 \f "Monotype Sorts" \s 10③ symbol 175 \f "Monotype Sorts" \s 10④ symbol 176 \f "Monotype Sorts" \s 10⑤ symbol 177 \f "Monotype Sorts" \s 10⑥ symbol 178 \f "Monotype Sorts" \s 10⑦ symbol 179 \f "Monotype Sorts" \s 10⑧ symbol 180 \f "Monotype Sorts" \s 10⑨ symbol 181 \f "Monotype Sorts" \s 10⑩
Such provision should come out of practice budgets	symbol 172 \f "Monotype Sorts" \s 10① symbol 173 \f "Monotype Sorts" \s 10② symbol 174 \f "Monotype Sorts" \s 10③ symbol 175 \f "Monotype Sorts" \s 10④ symbol 176 \f "Monotype Sorts" \s 10⑤ symbol 177 \f "Monotype Sorts" \s 10⑥ symbol 178 \f "Monotype Sorts" \s 10⑦ symbol 179 \f "Monotype Sorts" \s 10⑧ symbol 180 \f "Monotype Sorts" \s 10⑨ symbol 181 \f "Monotype Sorts" \s 10⑩
Such provision should be funded by PCGs	symbol 172 \f "Monotype Sorts" \s 10① symbol 173 \f "Monotype Sorts" \s 10② symbol 174 \f "Monotype Sorts" \s 10③ symbol 175 \f "Monotype Sorts" \s 10④ symbol 176 \f "Monotype Sorts" \s 10⑤ symbol 177 \f "Monotype Sorts" \s 10⑥ symbol 178 \f "Monotype Sorts" \s 10⑦ symbol 179 \f "Monotype Sorts" \s 10⑧ symbol 180 \f "Monotype Sorts" \s 10⑨ symbol 181 \f "Monotype Sorts" \s 10⑩
Welfare rights provision is beyond the scope of health care	symbol 172 \f "Monotype Sorts" \s 10① symbol 173 \f "Monotype Sorts" \s 10② symbol 174 \f "Monotype Sorts" \s 10③ symbol 175 \f "Monotype Sorts" \s 10④ symbol 176 \f "Monotype Sorts" \s 10⑤ symbol 177 \f "Monotype Sorts" \s 10⑥ symbol 178 \f "Monotype Sorts" \s 10⑦ symbol 179 \f "Monotype Sorts" \s 10⑧ symbol 180 \f "Monotype Sorts" \s 10⑨ symbol 181 \f "Monotype Sorts" \s 10⑩

Welfare providers should be available on site	symbol 172 \f "Monotype Sorts" \s 10① symbol 173 \f "Monotype Sorts" \s 10② symbol 174 \f "Monotype Sorts" \s 10③ symbol 175 \f "Monotype Sorts" \s 10④ symbol 176 \f "Monotype Sorts" \s 10⑤ symbol 177 \f "Monotype Sorts" \s 10⑥ symbol 178 \f "Monotype Sorts" \s 10⑦ symbol 179 \f "Monotype Sorts" \s 10⑧ symbol 180 \f "Monotype Sorts" \s 10⑨ symbol 181 \f "Monotype Sorts" \s 10⑩
Home visits for welfare advice should be available	symbol 172 \f "Monotype Sorts" \s 10① symbol 173 \f "Monotype Sorts" \s 10② symbol 174 \f "Monotype Sorts" \s 10③ symbol 175 \f "Monotype Sorts" \s 10④ symbol 176 \f "Monotype Sorts" \s 10⑤ symbol 177 \f "Monotype Sorts" \s 10⑥ symbol 178 \f "Monotype Sorts" \s 10⑦ symbol 179 \f "Monotype Sorts" \s 10⑧ symbol 180 \f "Monotype Sorts" \s 10⑨ symbol 181 \f "Monotype Sorts" \s 10⑩
It is often easy to miss welfare rights problems	symbol 172 \f "Monotype Sorts" \s 10① symbol 173 \f "Monotype Sorts" \s 10② symbol 174 \f "Monotype Sorts" \s 10③ symbol 175 \f "Monotype Sorts" \s 10④ symbol 176 \f "Monotype Sorts" \s 10⑤ symbol 177 \f "Monotype Sorts" \s 10⑥ symbol 178 \f "Monotype Sorts" \s 10⑦ symbol 179 \f "Monotype Sorts" \s 10⑧ symbol 180 \f "Monotype Sorts" \s 10⑨ symbol 181 \f "Monotype Sorts" \s 10⑩
Welfare providers enhance my ability to practice effectively	symbol 172 \f "Monotype Sorts" \s 10① symbol 173 \f "Monotype Sorts" \s 10② symbol 174 \f "Monotype Sorts" \s 10③ symbol 175 \f "Monotype Sorts" \s 10④ symbol 176 \f "Monotype Sorts" \s 10⑤ symbol 177 \f "Monotype Sorts" \s 10⑥ symbol 178 \f "Monotype Sorts" \s 10⑦ symbol 179 \f "Monotype Sorts" \s 10⑧ symbol 180 \f "Monotype Sorts" \s 10⑨ symbol 181 \f "Monotype Sorts" \s 10⑩

Welfare providers should be located locally but not within the practice	symbol 172 \f "Monotype Sorts" \s 10① symbol 173 \f "Monotype Sorts" \s 10② symbol 174 \f "Monotype Sorts" \s 10③ symbol 175 \f "Monotype Sorts" \s 10④ symbol 176 \f "Monotype Sorts" \s 10⑤ symbol 177 \f "Monotype Sorts" \s 10⑥ symbol 178 \f "Monotype Sorts" \s 10⑦ symbol 179 \f "Monotype Sorts" \s 10⑧ symbol 180 \f "Monotype Sorts" \s 10⑨ symbol 181 \f "Monotype Sorts" \s 10⑩
Access to welfare information should be increased	symbol 172 \f "Monotype Sorts" \s 10① symbol 173 \f "Monotype Sorts" \s 10② symbol 174 \f "Monotype Sorts" \s 10③ symbol 175 \f "Monotype Sorts" \s 10④ symbol 176 \f "Monotype Sorts" \s 10⑤ symbol 177 \f "Monotype Sorts" \s 10⑥ symbol 178 \f "Monotype Sorts" \s 10⑦ symbol 179 \f "Monotype Sorts" \s 10⑧ symbol 180 \f "Monotype Sorts" \s 10⑨ symbol 181 \f "Monotype Sorts" \s 10⑩
There is adequate feedback from welfare services to PHCTs	symbol 172 \f "Monotype Sorts" \s 10① symbol 173 \f "Monotype Sorts" \s 10② symbol 174 \f "Monotype Sorts" \s 10③ symbol 175 \f "Monotype Sorts" \s 10④ symbol 176 \f "Monotype Sorts" \s 10⑤ symbol 177 \f "Monotype Sorts" \s 10⑥ symbol 178 \f "Monotype Sorts" \s 10⑦ symbol 179 \f "Monotype Sorts" \s 10⑧ symbol 180 \f "Monotype Sorts" \s 10⑨ symbol 181 \f "Monotype Sorts" \s 10⑩
Service based welfare advice generates more work for GPs	symbol 172 \f "Monotype Sorts" \s 10① symbol 173 \f "Monotype Sorts" \s 10② symbol 174 \f "Monotype Sorts" \s 10③ symbol 175 \f "Monotype Sorts" \s 10④ symbol 176 \f "Monotype Sorts" \s 10⑤ symbol 177 \f "Monotype Sorts" \s 10⑥ symbol 178 \f "Monotype Sorts" \s 10⑦ symbol 179 \f "Monotype Sorts" \s 10⑧ symbol 180 \f "Monotype Sorts" \s 10⑨ symbol 181 \f "Monotype Sorts" \s 10⑩

I am able to recognise welfare rights issues when they arise	symbol 172 \f "Monotype Sorts" \s 10① symbol 173 \f "Monotype Sorts" \s 10② symbol 174 \f "Monotype Sorts" \s 10③ symbol 175 \f "Monotype Sorts" \s 10④ symbol 176 \f "Monotype Sorts" \s 10⑤ symbol 177 \f "Monotype Sorts" \s 10⑥ symbol 178 \f "Monotype Sorts" \s 10⑦ symbol 179 \f "Monotype Sorts" \s 10⑧ symbol 180 \f "Monotype Sorts" \s 10⑨ symbol 181 \f "Monotype Sorts" \s 10⑩
PHCTs have adequate knowledge of welfare rights	symbol 172 \f "Monotype Sorts" \s 10① symbol 173 \f "Monotype Sorts" \s 10② symbol 174 \f "Monotype Sorts" \s 10③ symbol 175 \f "Monotype Sorts" \s 10④ symbol 176 \f "Monotype Sorts" \s 10⑤ symbol 177 \f "Monotype Sorts" \s 10⑥ symbol 178 \f "Monotype Sorts" \s 10⑦ symbol 179 \f "Monotype Sorts" \s 10⑧ symbol 180 \f "Monotype Sorts" \s 10⑨ symbol 181 \f "Monotype Sorts" \s 10⑩
The provision of welfare rights advice improves the health and wellbeing of patients.	symbol 172 \f "Monotype Sorts" \s 10① symbol 173 \f "Monotype Sorts" \s 10② symbol 174 \f "Monotype Sorts" \s 10③ symbol 175 \f "Monotype Sorts" \s 10④ symbol 176 \f "Monotype Sorts" \s 10⑤ symbol 177 \f "Monotype Sorts" \s 10⑥ symbol 178 \f "Monotype Sorts" \s 10⑦ symbol 179 \f "Monotype Sorts" \s 10⑧ symbol 180 \f "Monotype Sorts" \s 10⑨ symbol 181 \f "Monotype Sorts" \s 10⑩

Thank you for taking part in this study.
Please return this form in the freepost envelope provided



PCG Semi-structured telephone interviews
FUNDING

Describe the funding of welfare rights advice in a GP setting:
Where does the money come from?
How much money?
Who is the money paid to?
What is the aim of the funding?
Who sets the budget?
Who administers the budget?
Are there any other similar projects not funded under this initiative with which you have any involvement/knowledge?

CONTRACTING

How was WRA provider chosen?
What is the contractual arrangement with them?
What monitoring, evaluation or quality assurance systems are in place?
How is this accumulated information used?
Exactly what type of service is funded [i.e. trying to understand if the focus is purely welfare rights – welfare benefits/debt/ housing(homelessness)/employment]?
What is the proportion of casework and contact time if specified?
How is the service paid for, e.g. block of time/case per case etc.?

PROVISION

How do you feel the service is going?
What would you like to see done differently [both in service level, funding, contracts]
Are there any barriers to effective provision? [in terms of processes]
Within your own organisation
Partners
Agencies
Providers

What can be done by whom to mitigate these?
Who do you see as your key providers?
Are there particular people with relevant views/expertise whom we should contact?

13.2

13.3 HAZ/Project Steering Group meetings

Minutes for the following meetings are held at the Health Action Zone office, Lambeth Southwark Lewisham Health Authority. Project meetings were held on the following dates:

7th March 2000

26th May 2000

25th September 2000

13th December 2000

23rd March 2001

2nd July 2001

17th October 2001.

13.4 Dissemination

The following papers have been submitted to peer-reviewed general practice journals.

Harding R, Sherr L, Singh S, Sherr A, Moorhead R. Evaluation of welfare rights advice in primary care: the general practice perspective.

Harding R, Sherr L, Singh S, Sherr A, Moorhead R. Welfare rights advice in primary care: prevalence, processes and specialist provision.

The following abstract has been submitted to the European Conference of General Practice (WONKA).

Harding R, Sherr L, Singh S, Sherr A, Moorhead R, Sandford I. Addressing health inequalities: accessing and funding welfare rights through primary care.

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