

Innovation in the Community Legal Service

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Annex 1 – Welfare Rights Advice From a GP Surgery (Chiltern CAB)

Aims and objectives

The purpose of the project was to provide debt advice from a GP surgery within the Chiltern and South Bucks Primary Care Trust area. The project aimed to target people from ethnic minority groups, in particular the Urdu and Punjabi speakers who make up a high proportion of the surgery's patients.

Background and rationale

Back in 2001 Chiltern CAB (who hold the General Help Quality Mark) began a project, initiated and funded by the Primary Care Trust (PCT), to undertake generalist advice work within a local GP surgery. This was in response to an identified lack of advice provision within the local area.

Despite being a generalist service, much of the existing project's work was in relation to welfare benefits. This in turn revealed a need for debt advice on a scale that the County Council felt required additional resource beyond present capacity. A bid was therefore submitted to the PIB for funding for a dedicated debt adviser to work within the project. The bid was successful and this new element to the project became operational in April 2002.

The project was funded by the PIB for a total of £10,000 over 12 months.

Set-up and operation

Resources

The funding provided for a part-time debt adviser to pick up the debt work generated by the existing GP surgery project, the supervision of the adviser by one of the CAB's full time debt advisers, administrative support and interpretation fees.

There were no training requirements for the project staff as those recruited already had the relevant skills. The adviser had an advice and debt background and the interpreter was already qualified and working within the surgery and the CAB.

Match funding for the project came from the Primary Care Trust, through its funding of the wider GP project, and the local Housing Association, which contributed funding once the PIB element had got underway.

Sessions

As part of the wider project the PCT and Chiltern CAB had held co-ordinated training for the primary care staff to inform them of the work of the CAB, the work of the project and how to identify patients who might have advice needs. Posters and leaflets were also placed in the surgery for patients' information. No external publicity was undertaken. By the time the PIB element of the project had been established the wider project was underway and therefore no further publicity or training was required.

Patients are referred into the project by the primary health care workers, by the generalist adviser working within the wider project or through self-referral after seeing the publicity material or hearing about the service through word of mouth. Self-referral has become the most common route by which individuals access the project.

The receptionist within the surgery books all appointments with the adviser. All appointments are undertaken within the GP surgery or through a home visit, where necessary. In general, where interpretation is required the appointments will take longer to complete than usual.

Where necessary, the project will refer clients out to other specialist services (e.g. local solicitors, the local Council departments (including Trading Standards) and local housing associations).

Impacts

Impacts for the clients

Over the 12-month duration of the PIB element of the project, 35 debt cases were handled resulting in £336,598 worth of financial statements being prepared. Much of the debt dealt with related to consumer debt, although there were some cases of housing debt.

Impacts for the individuals helped either through the PIB element or the wider project include increases to benefits entitlements, debts written off, repayment plans negotiated and improvements in the quality of their housing. This last impact has been achieved through close links between the project and the local Council or housing associations. The overall impact of this for the clients, according to the project, has been to reduce depression and raise their spirits.

A snapshot client survey undertaken by the PCT in November 2003 showed that clients found the time of the sessions convenient and the location of the surgery easier to access than the local CAB, which could be some distance from people's homes. Since it was this lack of local advice provision, which had led to the creation of the service in the first place, it would seem to be usefully filling a gap.

The demand for advice from ethnic minority groups seems to have been much lower than originally anticipated by the project. This may be because admitting you are in debt is unacceptable in some cultures and any borrowing tends to take place within the family rather than via external financial institutions.

Impacts on the surgeries

Most primary health care workers have engaged with the project and have been positive towards it. A survey in 2003 of the primary health care workers operating within the wider project (including the PIB element), found that over half of respondents felt that the project had benefited them by saving resources and time. There was also a positive response to the training programme offered by the PCT and the CAB. Those who attended the training commented that they were now more aware of issues that arise for their patients and had a much better understanding of the services that were available to them.

A number of primary care workers have themselves proposed ways of improving the service further, such as by holding more advice sessions and providing more space within the surgeries, and have requested more feedback about their patients.

The wider project has now been expanded to cover six surgeries, suggesting that the health sector see this as a positive service for their patients.

Impacts on Chiltern CAB

While the PIB element of the project was running there were no significant impacts on the CAB itself as supervision and administrative costs had been incorporated into the funding arrangement. However, once PIB funding came to an end (after the single funding year) the CAB did have to pick up the work of the debt adviser post. This put pressure on the core services of the CAB, meaning that some resources were diverted from other areas of work.

The project has confirmed a growing need for the CAB's debt advice work. In 2003 Chiltern CAB handled £1.9m of debt compared to the previous year's £1.5m, while average client debt rose from £10,500 to £16,500. Although it is not clear whether there is greater indebtedness amongst the local population or that more people are now accessing the CAB's services as a result of the project, debt advice is clearly needed. As a result the CAB is considering working towards the General Help with Casework Quality Mark and focusing more on its provision of debt and employment advice.

Wider impacts

The project has played a part in overcoming some of the CAB's difficulties with particular housing associations. Liaison with housing associations has improved; client issues are being handled more smoothly; and one housing association is even contributing financially towards the project.

Before the project was established there was no advice provision within this particular local area. The CAB went beyond its usual jurisdiction in establishing the service and unearthed a real need for advice within the area. The Local Authority has acknowledged this and asked the CAB to draft a report on whether a permanent advice service should be established in the area.

Challenges, lessons and critical success factors

A critical element of the project was getting the right individual adviser with the appropriate skills. This task was made harder because funding for the post was only for a year. Moreover, as there was only one adviser there was no cover for leave or sickness, which a second adviser would have provided.

The positive approach of the Primary Care Trust was essential to the wider project being established, as it helped the surgery engage with the project. Over time this has had knock-on benefits, with additional surgeries becoming involved in the wider project.

A key to the full engagement of the primary health care staff has been the training that was provided when the surgery first committed to the project. Primary health care staff

are now better able to identify patients' problems and to understand how and where to direct individuals in need of advice.

The actual venue was also important for the project to work successfully. Finding space within the surgery, which has disabled access, was important; without it the service could not have been delivered.

More generally, the growing evidence of, and publicity surrounding, the links between advice and health accelerated the project becoming an established and accepted service.

Future plans

The one-year PIB element of the project came to an end in March 2003. The CAB's core service has picked up this work and hopes to secure replacement funding for the debt adviser post.

The PCT would like to see the wider project, including the debt work, to go into other surgeries within the area. Although it currently has no money to fund this, the PCT has been able to provide a further two years' funding to permit generalist work to continue at five of the surgeries presently involved. Funding for the debt element has yet to be found, however.

Meanwhile, a housing association has offered to contribute to the project and other funding streams are currently being looked into.

Annex 2 – Benefits in Practice (Oxford CAB)

Aims and objectives

The aim of the project was to provide a welfare rights and money advice service to individuals in primary health care settings (GP surgeries) within the City of Oxford. Advice sessions would be provided at nine surgeries where people with advice needs would make an appointment to see an adviser, either on referral from the surgery receptionist, their GP or health visitor, or through self-referral.

Background and rationale

During 2001 Oxford City Council grew concerned that some people were not making use of mainstream welfare benefits advice services, which were concentrated in the city centre. Despite a good park-and-ride scheme and a CAB outreach service in the east of the city, residents were still reluctant or unable to access these services. These concerns were highlighted in the Oxford City CLSP (Community Legal Service Partnership) needs analysis document, which identified welfare benefits advice as a priority need within the area.

The City Council felt that the individuals missing out would however be in touch with their local GP surgery, which might therefore be an appropriate location for them to access advice services. Oxford CAB saw the potential advantages of this and formulated a bid for PIB funding in conjunction with the City Council, Age Concern Oxfordshire and Oxford City Primary Care Trust. Once the bid was approved, the Council took a back seat and the CAB took the project forward. The 'Benefits in Practice' project became operational in April 2002.

The project was funded by the PIB for a total of £127,261 over 36 months.

Set-up and operation

Resources

PIB funding provided for 1.5 full-time equivalent generalist advisers who, although chiefly offering welfare benefits advice, could advise in other social welfare areas of law.

The advisers appointed had previous experience in welfare benefits but the CAB gave them the same training in advice-giving as is usually provided to all volunteers who work for the CAB.

The advisers are employed by Oxford CAB and so have access to the reference materials (e.g. Citizens Advice Electronic Information Service and Child Poverty Action Group Benefits books) and the specialist advisers within the main Bureau. The CAB specialist in welfare benefits supervises the advisers, on a part-time basis, as part of the project arrangements.

The project is managed and run by Oxford CAB, with support from Age Concern Oxfordshire. Both organisations provide in-kind match funding in the form of running costs, equipment, training, and supervision time. Oxford Primary Care Trust gave £10,000 match funding to the project.

Sessions

The Primary Care Trust (PCT) played a vital role in identifying appropriate GP surgeries that were willing to work with the project. Despite initial reluctance from some, the number of surgeries has grown since the beginning of the project. The key to this has been informing the surgeries of what the project is about and how it would work. With the surgeries signed up, the advisers undertook awareness-raising training with the primary health care staff, covering the workings of the project and possible welfare benefits problems that individuals might be encountering. This was vital to ensure the right individuals were referred to the project advisers.

A total of nine surgeries are involved with the project and each surgery provides a room for the advice worker to use for appointments with clients.

Weekly 3 hour advice sessions are undertaken in each surgery, with each client allocated a 45-minute appointment, pre-booked by the surgery receptionists. Clients find out about the service either through referral from the surgery receptionists, GPs or other health workers, or through local advertising (e.g. leaflets and posters in the surgeries, local newspapers and radio reports and word-of-mouth).

Where circumstances prevent a client coming to the surgery, the project will offer a home visit appointment.

All follow-up casework and administration is undertaken by the advisers themselves and is completed outside of the session time. The advisers also monitor the work undertaken by the project and a database has been created for this purpose.

If a client has a specialist debt or employment problem, this is usually referred to the main Bureau, which holds LSC contracts in both.

Impacts

Impacts for the clients

In its first two years the project has seen a total of 394 clients¹, 85% of who have had a welfare benefits problem. Benefits gained for these clients have amounted to nearly £300,000². These figures are well over the initial targets set for the project.

Of the 394 clients seen only 18.5% are employed. The majority are classed as sick (36%) and are therefore not working, 15% are retired, 14% are unemployed, 6% are parents and 5% are carers. A total of 44% have an income of less than £150 per week and only 41% own their own home.

Although the project did not set out to target a particular section of the population it has found that over 40% of its clients are over the age of 50 and 25% are over the age of 60. In one surgery there has been a specific drive to work with the over-80s and this work has been supported by Age Concern Oxfordshire and Oxford City PCT.

¹ All figures as at 15th March 2004.

² This is calculated based on arrears owing to date plus expected benefit over the coming year.

Additionally 16% of the clients seen have mental health issues. Feedback from this client group suggests that they feel much more comfortable accessing advice in a doctor's surgery than in a normal CAB, as no-one within the surgery knows that the individual has a problem to do with, say, benefits or debt. As far as other people waiting in the surgery are concerned they have just come to see their doctor.

The project does therefore appear to be targeting the most hard-to-reach groups in the community who would not have otherwise accessed advice. Furthermore, the project has been receiving positive feedback from clients saying that 'a weight has been lifted' now that they are receiving their entitlements.

Impacts on the surgeries

Although only three surgeries signed up to the project at the beginning, six further surgeries within the area have seen the benefits of the project and have come on board. The project believes that any initial reluctance was overcome by the awareness raising that was undertaken, by encouragement from the PCT, and by word-of-mouth.

One issue for the project was finding space for the advisers to run their sessions. Surgeries seldom have much unused space and each has its own priorities and targets. For some of the surgeries, advice provision was not high on the agenda.

The project has reported that most surgeries now treat the advisers as part of their team and as part of the service they offer. Referrals to the project have increased steadily over time, notably from the GPs themselves. In the early days of the project constraints on the GPs' time meant that they did not engage as quickly as some of the other members of staff. As the project has evolved, however, the GPs have seen the benefit of referral, such as not having to spend time dealing with problems that are not health related, and are therefore increasingly referring their patients to the project.

The project has helped to raise general awareness of welfare benefits problems, the possible solutions and the advice services that are available amongst the health professionals they are working with. This in turn has helped to bring about more effective signposting of individuals into advice services, strengthening the referral network, and hence helping ensure that individuals are receiving the benefits to which they are entitled.

Impacts on Oxford CAB

The CAB feels that the project has had a positive impact on the Bureau. It has raised their profile locally and they have gained a better reputation as a result. The project has not caused any capacity issues within the Bureau, despite seeing a 40% increase in the need for welfare benefits advice, of which the project only deals with 10%. The Bureau views the service provided through the project as a core part of the work that they do for the community.

Wider impacts

GP surgeries come into contact with large numbers of people on a daily basis. Some of these people are faced with problems that are undermining their health, yet are unaware that a solution may be found through seeking advice rather than just addressing medical symptoms. These are the individuals who would not normally access mainstream

advice services but are being identified and helped with the aid of the surgeries they do visit.

Through the project an issue raised by even one individual may have far wider ramifications. As with all CAB services the project has been reporting back to Citizens Advice all cases that could inform the development of national social policy, making the potential impacts of the project go farther than the geographical area within which it operates. By contrast, some social policy issues identified may have only a local focus and in these instances the project can ensure that the information is passed onto those who are able to resolve the issues. For example, after it emerged that the local Council was seeking payment of council tax for one of its own properties exempt from the tax, the project was able to ask the department responsible to hold an up-to-date list of all such properties to avoid a recurrence.

Challenges, lessons and critical success factors

Despite initial reluctance from some surgeries and the lack of space within them, the surgeries within Oxford have engaged with the project over time. This is due to the awareness raising training offered by the project and the involvement of Oxford City Primary Care Trust, whose partnership with the City Council and the CAB made the project possible.

Another relationship – that built up between the advisers and the surgeries - has also been critical to the project's success. The advisers are seen as approachable by the primary health care staff and have come to be seen as part of the surgery team. This has resulted in increasing numbers of referrals coming from all primary health care staff.

A third vital factor has been the advisers' access to the back-up of the CAB, without which the project would simply not be viable.

One point of tension did arise in relation to other advice agencies, feeling threatened by the service being offered within one of the GP surgeries in their area. The project took the view that there was so much need within the locality that there was room for more than one source of advice and that the individuals who were being supported through the surgeries were not those who would be likely to access the mainstream advice provider.

Although initial plans for the project were to cover the whole city this has not been possible and there are still clear gaps within the north and west of the city. For this to happen a further adviser would be needed to cover the additional work.

Future plans

The CAB is hoping to continue the project without making any significant changes to it. Although the project did not initially set out to help any particular client group, there has been an evolving emphasis on working with older people that could in the future become its main focus. It is also felt that there is enough demand to justify an expansion of the service to cover under-provided parts of the city.

Annex 3 – Better Advice Better Health (*Powys CAB*)

Aims and objectives

The aim of the project was to provide a generalist advice service in 13 primary health care outlets throughout Powys, via a combination of outreach services, telephone services, e-mail and video-conferencing and, in South Powys, a welfare benefits advice home visiting service.

Background and rationale

In 1997 Montgomeryshire CAB (which covered today's equivalent of North Powys) ran a project called 'Prescribing Citizens Advice Service' (PCA), which was funded by the NACAB (the National Association of Citizens Advice Bureaux, now Citizens Advice), the GPs, Health Promotion Wales, the Local Health Group and at a later date the Tudor Trust (an independent grant-making charitable trust) and Severn Trent Trust Fund. It was set up in response to research which showed that GPs were spending a large amount of their time dealing with non-medical issues. The service was initially based in three primary health care locations and employed one part-time caseworker to see clients, by appointment, in the surgery, who had been referred by primary health care teams. It expanded to cover seven primary health care locations in January 1999 with funding from the Tudor Trust and the Welsh Office Strategic Development Fund.

In 2001 the project was able to expand to nine locations, including mid-Powys (formerly Radnorshire), with funding from the all-Wales 'Better Advice, Better Health' initiative (BABH). BABH was set up as a result of the PCA Service in Powys. Through a partnership between Citizens Advice Cymru and the National Assembly for Wales, the BABH initiative aimed to provide local and co-ordinated provision of generalist and welfare rights advice by the Citizens Advice Bureaux in co-operation with primary health care teams across Wales. Funding of £2 million, for a three-year period, was given to Citizens Advice Cymru to establish a national programme covering all 22 local authorities in Wales. This additional funding in Powys enabled an increase in caseworker hours, administrative help and the setting of new targets³ for the PCA.

In October 2002 funding received from the PIB enabled further expansion into south and mid-Powys to provide a countywide service and has led to partnership working between Powys CAB, Powys Benefits and Powys Mediation.

The project was funded by the PIB for a total of £280,450 over 36 months.

Set-up and operation

Resources

Funding of the project (including PIB) provides for a county manager to run the project, four part-time generalist caseworkers and one full-time equivalent Diagnostic Information

³ The aim of the BABH is to 'maximise income for those people in deprived areas whose health is likely to be affected by poverty' and 'see 200 new clients, deal with 650 new problems and raise an increased annual income for those clients of £200,000 every year'.

Officer (DIO). An additional adviser worked on a voluntary basis within one of the surgeries.

The caseworkers provide generalist advice in all categories relating to health and well-being, including welfare benefits, debt, employment, housing, relationship breakdown, and consumer problems. Powys CAB previously employed the caseworkers currently working on the project, either to work on the PCA service or in the mainstream CAB service, which meant that there were no additional training requirements. The project also holds the General Help with Casework Quality Mark for the categories of Consumer & General Contract and Employment.

Support and supervision for the project is done on a peer review basis by the project caseworkers reviewing each other's work. Two of the four caseworkers are also employed on a part-time basis by the CAB to undertake legal help work, which means their knowledge and experience remains at a high level. This is vital, as the county manager post is not necessarily CAB trained and so may not be able to provide the necessary supervision.

Overall the project is managed and run by Powys CAB. However, Powys Benefits provides a home visiting service for appropriate clients needing to make disability benefit claims in the south of Powys, and Powys Mediation serves clients with neighbour disputes throughout the county. Match funding for the project comes from the Better Advice, Better Health funding.

Sessions

Prior to the advice sessions being set up the caseworkers held meetings with the practice managers and GPs to explain the work of the project and to get their sign-up to being part of the project. Once engaged with the project the caseworkers then ensured that the primary health care staff were aware of the service being offered, the types of problems individuals might have and how and when it was appropriate to refer patients to the caseworkers. Any training required is done on an individual on-going basis with every new member of staff. The only publicity work undertaken was in the form of posters within the surgeries, since word-of-mouth has proved very effective.

The service is currently running in 11 GP surgeries and one Healthy Living Centre, which does not have a surgery attached. The surgeries are concentrated in north and mid-Powys, with only one surgery currently involved in the south. Two different approaches have been used to establish the service. Approach 1 has been used across the majority of the county, in particular where the original PCA service was operating. Approach 2 is used in the south of Powys, where PIB funding has enabled the further expansion of the service through partnership working.

Approach 1

The CAB caseworkers work on a fixed rota basis, whereby they visit each surgery either weekly or fortnightly, depending on the needs of the individual surgeries. At each advice session two clients, who must be registered with the surgery, will be seen by appointment. Each appointment lasts an hour. The caseworkers usually have a caseload of up to 50 clients at any one time. The caseworkers will not undertake sessions in surgeries where they themselves are registered for reasons of confidentiality

and anonymity. This is particularly important as many of the surgeries are based in small communities.

The majority of referrals made to the service are made via the primary health care staff within the surgeries (including the receptionist) who will identify that the patient has an advice need. A referral form will be completed by the member of staff and given to the individual who will then book an appointment with the receptionist of the surgery, who is responsible for managing the diary. The appointment system is either kept in a diary or on the surgery computer system. Caseworkers – who, because of the size of the area covered, may have to travel a fair distance – will phone in advance of the session to confirm the appointments.

Most of any follow-up work required will be conducted by phone. Again, this is dictated by the size of the area covered by the project and the practicalities of getting to see the individual clients. If follow-up work needs to be conducted on a face-to-face basis, the client will telephone the surgery receptionist and book an appointment.

Approach 2

In the south of Powys the primary health care staff, Social Services and Powys CAB County Advice Line make referrals to a single point of contact, the Diagnostic Information Officer (DIO), based at Powys CAB in Newtown. The DIO will either resolve the matter directly or determine the most appropriate organisation to refer the client to. Referrals for home visits will be made to Powys Benefits, where the problem relates to a welfare benefits issue and more specifically a disability benefits issue.

Whichever approach is being used, the project will refer clients to specialist level advice as and when appropriate. Specialist agencies used include the main CAB service, which holds an LSC contract in Debt and Welfare Benefits, employment solicitors in Wrexham and Swansea, Family Mediation (National Children's Home), local Trading Standards, and Shelter Cymru for housing. Powys Mediation works with the project to offer mediation services, as appropriate, across the county.

Impacts

Impacts for the clients

Between October 2002 and June 2004, 624 new clients were seen by the project and some £886,000 worth of benefits obtained. Only 20 clients had to be referred to a specialist level provider. The project is therefore far exceeding the targets set under the BABH (see footnote 1).

The project has issued questionnaires to clients and feedback has been very favourable. Clients appreciate that they have access to a service that is local to them, something particularly important in such a large rural area, especially for older or disabled people or those without their own transport. A videolink service originally proposed as part of the project did not prove popular, suggesting that clients prefer direct face-to-face advice, particularly in the health care setting where they feel they have anonymity. Many of the clients seen admitted they would not have sought advice from a mainstream advice office. The fact that clients, where possible, only deal with one caseworker has also been received positively.

The caseload for the service is full, suggesting that clients feel comfortable accessing advice through this route. The project also believes that there is more need for the service: in some areas people can wait four weeks to be seen or to see an adviser.

Impacts on the surgeries

Many surgeries feel that the service being offered is now part of their own service provision and there have been positive responses from all the primary health care staff towards the project. This has taken a long time to achieve, but more and more referrals are now coming through to the project, from all participating surgeries, to the point that the caseload is full and there is more need for the service. GPs are also reporting that the service has helped to free up their time and their appointments, enabling them to spend more time treating the medical problems of more patients.

The primary health care staff say they now have a better general knowledge and understanding of advice needs, benefits entitlement and appropriate referral as a result of the project. A knock-on benefit of this is that the medical evidence provided by GPs relating to patients' cases (in particular, disability benefit cases), is now much improved. Letters sent from GPs have also helped to have debts written off for patients.

Impacts on Powys CAB

The overall impact on the CAB is a positive one. There is a clear two-way flow between the project staff and the main CAB workers, with some caseworkers even working for both. That the project caseworkers are experienced, particularly in welfare benefits, means that the volunteer staff and legal help unit at the CAB can make use of this expertise, thereby improving overall knowledge within the CAB.

The Powys CAB Manager reports that the project has complemented the core CAB service and helped to bring in new client groups who would not normally access the mainstream CAB service.

Wider impacts

As knowledge of the project has spread, interest in it has grown. Other health centres within the area are requesting talks, not only on the project itself but also on welfare benefits more generally. Other health sector workers are seeking talks, as too is Age Concern. The service is certainly being seen as part of a wider health and social welfare service within the county.

Challenges, lessons and critical success factors

Expansion of the service across Powys has taken some time to achieve. The level of project funding has permitted expansion only as additional funding has been obtained. Expansion also depends on surgeries being prepared to engage with the project. On this point, the two main hurdles are firstly, the lack of space within the surgeries to accommodate the advice sessions; and secondly, the need to encourage the primary health care staff, especially GPs, to refer their patients to the project.

In order to overcome these issues the project built up good relationships with the practice managers and highlighted to them the benefits of advice to the health and well-being of

the surgeries' patients. On occasion, the project has made use of committed practice managers to advocate the service to colleagues in other surgeries.

Expansion of the service into the south of Powys seems to have been the most difficult. Here the issue of space within the surgeries could not be overcome, meaning that the face-to-face appointment system could not be adopted. Instead, a single point for referral, the Diagnostic Information Officer, either deals with the patient's problem over the phone, or arranges for a home visit to be undertaken or refers the person to a specialist organisation for further advice.

The recruitment and retention of staff can be difficult, principally because short-term funding of the project only allows fixed-term contracts that offer no long-term job security. As a result the project is currently operating without a manager and is one part-time caseworker short. Another reason is the geographical nature of the area. As noted earlier, Powys is a large, mainly rural area with many isolated communities: it lacks service provision, especially in relation to legal advice, and has a poor public transport infrastructure. This was of course one reason for setting up the project, but it does oblige caseworkers to put in a lot of travel in order to get to the outreach posts in the surgeries, and to spend long hours on their own. Although they have telephone support from the CAB, some less experienced caseworkers would prefer to have more contact with their colleagues in order to share information and discuss issues.

At certain points demand for the service has led to appointment waiting times of up to four weeks. While this confirms the relevance of the service, the handling of emergency cases in this context can be a problem. In such circumstances, the caseworker will agree to see an additional patient in the course of a session.

Establishing the partnership working arrangements between Powys CAB, Powys Benefits and Powys Mediation took time. Finalising a service level agreement took eight months, and communication difficulties between agencies initially limited the number of referrals coming through. After these issues had been resolved, and e-mails acknowledging the receipt of referrals by the partner organisation introduced, the referrals system was able to operate as it should.

The project initially planned to use videolink and e-mail to enhance the direct face-to-face and telephone service. Most clients, however, seem to prefer direct face-to-face contact. In some instances e-mail services are being provided, for example where a client has hearing or speech impairment.

The project has concluded that although these technologies may be useful for particular client groups, they cannot replace direct client contact. Telephone follow-up advice has been critical to the project on account of the large distances between advisers and clients. The project does however feel that if a similar project were to be established then combination of outreach services, telephone services, e-mail and video conferencing should be encouraged. This would ensure that issues of travel and isolation for staff were resolved while preserving access for those with advice needs.

The fact that this project has been part of the Wales-wide initiative 'Better Advice, Better Health' has benefited the project's development. Highlighting the links between advice and health across Wales has encouraged the surgeries and the related statutory health

bodies to engage with the project. The establishment of BABH Forums has enabled staff from all over Wales to share their experiences.

Future plans

Since February 2004 the 'Better Advice, Better Health' initiative has been receiving mainstream funding from the National Assembly for Wales' Health and Social Care Budget, as it is regarded as a very successful way of improving access to advice for people on low incomes, especially older people and single parents.

The project is currently seeking match funding to the BABH funding. That level of funding has remained the same while other funding sources, including PIB and Tudor Trust funding, are coming to an end. If the project is to continue as at present, further core funding is required. If it cannot be found, the project will have to restrict its activities to the original BABH service in north and mid-Powys only.

Annex 4 – Community Advice Service (Flintshire CABx/ Flintshire County Council Community Services Team)

Aims and objectives

The project set out to provide a proactive and integrated advice and information co-ordination service to enable the most socially excluded within the community to access legal advice services, statutory services, health services and other voluntary services so as to improve their quality of life. The service would specifically target young people, older people and disabled people within Flintshire. The project would also provide training for the primary care and social services staff who would be referring clients into the service.

The project has been funded by the PIB for a total of £234,115 over 36 months.

Background and rationale

Both Flintshire County Council's Community Services Team (the in-house welfare rights team) and Flintshire Citizens Advice Bureaux (CABx) acknowledged that they were only able to deal with an individual's problem at the time it had reached crisis point and were not able to resolve other issues that the client was beginning to deal with or provide an on going casework facility. There was also an acknowledgement that even when these additional issues were matters for the wider Council there was no real mechanism in place to make sure that the individual had access to all the services that were required.

Flintshire County Council's Community Services Team and Flintshire Citizens Advice Bureaux worked together via the Community Legal Services Providers Forum to consider how an integrated service could be provided. They wanted to provide a service that meant that targeted client groups could access the advice and support services they needed, in order to address all their needs.

The two organisations also wanted to be able to influence the development of policy within the Council so as to ensure that services were being developed in the most appropriate way to suit the needs of the community. They felt that this in turn might help to avoid some of the problems experienced by the individuals within the area. The Community Services Team was already operating within the statutory environment of the Council and so appeared ideally placed to try and influence its policies.

As part of the Welsh Assembly initiative 'Better Advice Better Health', which covered all 22 local authorities in Wales and ran for the three years to March 2004⁴, an initial service was set up through links to GP surgeries. In order to expand this service further, in particular so as to reach young people in need, and to inform the development of the Council's policies (as outlined above), Flintshire County Council's Community Services Team and Flintshire CABx submitted a bid for funding from the PIB. The bid was successful: staff were recruited in July 2002 and the service became fully operational in October that year.

⁴ Each pilot project had its own targets of £200k unclaimed benefits, 650 enquiries and 200 new clients over the three-year period.

Set-up and operation

Resources

PIB funding provides for a project development officer, an administration worker and two project caseworkers, one focusing on younger people, the other on the needs of older people and disabled people (this post was previously funded under the BABH Initiative).

The project workers were employed by Flintshire CABx, but based within and line-managed by the County Council's Community Services Team. All employment issues were handled by the District Manager of Flintshire CABx rather than by the County Council.

Match funding for the project was provided by the 'Better Advice Better Health' initiative, with further support coming from the County Council in the form of accommodation costs for the project workers.

Sessions

Due to the varying nature of the project's client groups there are a number of different access or referral points into the service. The service is promoted either through one of these access points or via word-of-mouth.

Referrals to the Young Persons Adviser come from the local further education college through their own welfare service; from secondary schools via the Educational Social Work teams; and, on a self-referral basis, from the two local community houses. Other referrals are made from Careers Wales, Flintshire Mental Health Advocacy Service (funded through the second round of the PIB) and from the CABx or Council directly. Where appropriate, staff receive training to ensure they know who to refer onto the service.

Referrals to the Older and Disabled People's Adviser come from the primary care staff at five local GP surgeries. Training has increased the staff's knowledge and understanding of the project, the services on offer, the referral mechanism and how to identify an individual that would benefit from the service. This training forms part of their 'protected learning time'.

All appointments with the Young Persons Adviser are booked directly either by the individuals themselves or by the person referring them to the adviser. Appointments for the Older and Disabled People's Adviser are booked through the reception staff at each of the surgeries.

Upon referral, all clients are treated in the same way and receive the same integrated service. Help is provided to access the right services: options for the individual are discussed, including the general provision of advice and information, and support is given in accessing the benefits the individual may be entitled to.

Appointments take place in the location most appropriate for the individual. For older or disabled people this usually means the surgery or, if necessary, via a home visit; young people are normally seen in their college or community house. Sometimes clients,

especially young people, will be encouraged to have their appointment within the CABx so that they can see for themselves that they have access to mainstream services.

If an issue cannot be dealt with by the project directly, the individual will be referred on to other specialist services (e.g. the Council's Community Service Team for welfare rights, Shelter for housing or private sector organisations on issues such as employment).

Impacts

Impacts for the clients

By April 2004, 1,724 enquiries had been received and a total of 573 clients were dealt with through the project. They brought with them a wide variety of social welfare problems, including welfare benefits, money advice, consumer problems, housing rights and employment rights.

The project has helped clients deal with debt totalling £81,019 and has gained additional income for its clients to the value of £98,673. The project reports that it has mainly been helping clients who would not normally have accessed advice services, particularly at the early stages of their social welfare problem.

Both the project and BABH have undertaken client feedback exercises and in the main the feedback has been very positive.⁵

Impacts on the surgeries

Although it took time to prepare the surgeries for their involvement in the project, many of the surgery staff can now see its benefits: an improvement in quality of life for their patients and a reduction in their prescriptions.

Impacts on Flintshire CC Community Service Team and Flintshire CABx

The two organisations' joint working approach seems to have worked well. The project has helped to remove the often uncomfortable and competing relationship between the voluntary and statutory sectors and there is now a far better understanding of each other's roles. The two organisations are now looking at developing joint working practices in other areas.

Through joint working the project workers and the Community Service Team have learnt from one another, ultimately to the benefit of clients. Although the project workers were brought in as generalists their knowledge and experience has grown to such an extent, they are now working at a level above what was initially intended (e.g. now attending tribunals with clients).

The Community Services Team will now routinely take account of where the service can most appropriately be offered to its clients. Whereas all appointments used to be carried out on a time-consuming home visit basis, the project has opened up other channels to

⁵ The client feedback reports were also included in an independent evaluation undertaken by University of Wales (Bangor) in relation to the overall BABH initiative throughout Wales. *Better Advice, Better Health – Final Evaluation Report*, Citizens Advice Cymru, 2004.

provide their service. Moreover, the team is no longer reluctant to forward on clients, now that they have easy access to project advisers located within their own offices.

Again, where once the Community Services Team would only take on clients who had been referred by other departments within the Council, it is now happy to take on cases on a self-referral basis.

Difficulty experienced in recruiting someone for the project development officer post has led to managing the project taking up more time than had been anticipated. As a result, the Manager of the Community Services Team has been diverted from their main role of delivering specialist welfare rights work.

Capacity issues within Flintshire CABx mean that clients of the project cannot be referred to the mainstream CABx workers since they do not have a casework facility. Where appropriate, referrals are therefore made to a range of outside organisations.

Wider impacts

The recruitment problems mentioned have hindered the project's aim of influencing the development of Council policy. General improvements in the delivery of services across the advice and health field have been achieved, however, through the close working relationships within the project and the work of the 'Better Advice, Better Health' initiative more widely. Instead of dealing with just one aspect of a client's needs, a more integrated, inclusive approach has been adopted.

Challenges, lessons and critical success factors

The shortage of skilled advice workers, and consequent staffing difficulties, have had a real impact on the scope of the project and what it has so far been able to achieve. No progress has yet been made in influencing policy development within the Council, and the managers of the two partner organisations have had to put more work into the project than was originally planned.

Recruiting was made harder by the fact that the project could only offer short term contracts due to the nature of the funding. Retention of staff has been a particular problem, especially as future funding has not yet been secured.

The existence of the 'Better Advice, Better Health' initiative prior to the establishment of this project helped with the engagement of the health sector, but obtaining space within the surgeries remained problematic on account of the competing priorities within the surgeries.

Without the shared vision and partnership working of the two organisations involved, the project would not have been able to get underway. The fact that they have been willing and able to understand each other's working practices and gone on to establish a project, has ultimately benefited clients, who now receive an integrated service. This has been key for the client groups being targeted.

Future plans

Both Flintshire County Council's Community Service Team and Flintshire CABx would like to see the service continue to operate under its current structure, with the addition of the policy development officer post and fixed term, rather than temporary, contracts for the project staff.

Currently the work undertaken with older people has been awarded core funding through the now mainstream Better Advice, Better Health initiative, which will enable this part of the project to continue post PIB funding. Funding for work with younger people still has to secure the necessary funding to continue. Other funding streams are under consideration.

Annex 5 – Welfare Rights Advice and Active CLS Referral Points in GP Practices (*Barnsley Metropolitan Borough Council Welfare Rights Service*)

Aims and objectives

The aim of the project was to provide an accessible free welfare rights information, advice and advocacy service to individuals in Barnsley. The service would be provided through GP practices, to ensure that hard-to-reach clients were able to access the service. This category of client includes those with mental health problems, older people and young people. The service would specifically target deprived areas of Barnsley.

The project also aimed to act as a community referral agency for all other categories of social welfare law. It would encourage all health, social service, housing and other statutory and voluntary agencies within the community to refer individuals to the project. The project would then manage the process of referral for its clients to ensure they receive all the advice they required.

Background and rationale

In 1998 the then local Health Authority approached Barnsley CAB to cost up a project based around advice within GP surgeries. This was on the back of reports from other CABs who had been piloting similar services. At the time Barnsley CAB did not have the capacity to undertake such a service, so the Health Authority contacted the Barnsley Metropolitan Borough Council (MBC) Welfare Rights Service (WRS).

At the same time the Social Services Inspectorate had concluded, in a review of Barnsley, that many individuals were unable to access welfare benefits advice within the local area. This was particularly the case for vulnerable, hard-to-reach client groups such as those with mental health issues, who found it difficult to access mainstream advice agencies when it necessitated a journey into the town centre. The WRS thought that by scoping the project for the Health Authority it could help to target these individuals through the surgeries, which were often local and therefore considered accessible.

The WRS researched the feasibility of such a service and consulted local surgeries to gauge whether this type of service would be welcomed and could be accommodated. The Health Authority had no funding to take the project forward, so in 2001 the WRS submitted an application for PIB funding for the project, now expanded to include all social welfare categories. The funding application was successful and the project began in January 2002.

The project was funded by the PIB for a total of £157,348 over 36 months.

Set-up and operation

Resources

PIB funding provided for two full-time advisers and their associated core costs (such as desks and computers). Both advisers appointed had previous experience of providing generalist advice, one from working for the local Housing Benefit Service, the other with the Barnsley MBC's Community Information Service. The latter adviser was also familiar

with all the Council services locally available. The advisers were managed and supervised by the WRS.

Additional funding for the project came as in-kind contributions from the surgeries themselves, in the form of accommodation; from the WRS, in management time for the project; and from the Council, which provided the advisers with office space and administrative resources.

Sessions

Prior to the service getting underway the advisers spent three months liaising with the primary health care staff, including the practice managers, to inform them of the type of individual the service would be able to help and the process for referral, as appropriate to each surgery. The project also devised a rota system based on room availability within the surgeries.

The local General Medical Council was also contacted and, after initial reservations, was persuaded of the value of the project. This was significant, as the project was to place extra pressures on the surgeries, particularly in relation to space, without bringing with them any additional resources.

Work was undertaken with other local organisations⁶ to inform them of the project and to explain who they should refer to the project and who would be signposted or referred to them for advice, if appropriate. This would include people with issues falling outside the scope of advice provided by both the project and the WRS.

Leaflets and posters were produced and placed within the surgeries to advertise the service. Using the information held by the surgeries, a mailshot was sent from the GPs to every local resident over the age of 60.

A total of 10 surgeries are now participating in the project⁷, each holding one session every week except the two largest, which hold two. The advisers cover half the total number of sites each.

Initial appointments with the advisers are booked through the receptionists at the surgeries. If a GP has referred to the project a patient whom they are accustomed to visiting at home, the project will do the same. However, the project does not want to be seen to offer a service, which the surgeries themselves are not able to offer on a regular basis, so appointments take place for the most part at the surgeries.

Follow-up appointments are booked directly with the adviser by the client. Over time the project has seen more and more of these being undertaken over the phone: in fact, this now forms a significant element of the service.

Where the project, or the Welfare Rights Service (which are both covered by the WRS General Help with Casework Quality Mark), is unable to handle clients' issues directly, they will refer them for advice and support to other local services such as Mind, the CAB

⁶ Among them Age Concern, Homestart, Alzheimer Society, Youth Service.

⁷ Eight surgeries were originally involved in the project but a further two came on board after the project received additional funding for further advisers from the Neighbourhood Renewal Fund (NRF).

and Social Services. Referrals to other agencies are recorded and managed to ensure that appropriate help and advice has been received. Where multiple referrals are required, the adviser will act as a 'case manager', keeping a file of all advice given until the outcomes are known and the issues resolved.

Impacts

Impacts for the clients

In total 1,803 individuals were seen by the project up to June 2004, the majority within the surgeries. A total of 790 cases have been closed after achieving benefit gains of £1,323,593.

Most of the clients seen by the project are older people, disabled people or new mothers. The project reported that older people often do not access mainstream advice services due to the stigma attached to seeking help. Accessing services within the surgery does not hold the same fear for older people, who seem happy to do so. Young mothers are another natural target group within surgeries, where they are regular visitors with their babies and more often than not are unaware of the child benefits they can claim. Anecdotal evidence suggests that individuals experiencing mental health problems, one of the original target groups of the project, also make up a proportion of the people it sees⁸.

Follow-up work has been undertaken on an appointment basis and by phone, with 3,481 telephone contacts being made. Telephone advice was never intended to form a major part of the project, but clients clearly feel comfortable using this medium.

The set-up of the project ensures that an individual's problems are recognised and if the project cannot deal with the issues directly (i.e. if it is more than a welfare rights issue) the client is referred to an organisation that can. Up to June 2004 there had been 493 such referrals.

Impacts on the surgeries

Despite some initial reluctance, and (disappointed) expectations of receiving a fee in return for accommodating the project, the surgeries soon identified the benefits of the service being offered.

Positive feedback has been obtained from the primary health care staff at the surgeries, including the recognition that access to good advice can help to prevent many underlying causes of ill health. Through the project many patients have either received increased benefits, or have been directed to other organisations, which have helped them access the goods and services they need. This is particularly true for the old, sick or disabled. By improving their overall quality of life, people's health can be improved, which feeds through to the surgeries in terms of reduced need for their services.

Many of the surgeries are now asking that the service receives more promotion and are suggesting other client groups they would like to see the project targeting. The Service

⁸ There are no statistics on this, as the project did not want to label an individual in terms of their health status.

has convinced the surgeries of the benefits for their patients, to the point where they now see advice provision as part of the overall service they should be offering.

Impacts on Barnsley MBC Welfare Rights Service

Setting up the project was time consuming for the WRS because of the amount of liaison work required to engage the surgeries in the project. Once done, though, the project became self-sufficient and did not divert resources away from the WRS core team.

Overall the WRS feel that the project has been a valuable addition to its core work. Among the staff and patients of the surgeries it has helped to increase the general awareness of its service, and the welfare rights issues that people experience. As a result the core team is now seeing more clients than before, which it sees as a positive outcome.

Another positive aspect is that the close working relationship between the core team and the project advisers means that they are able to share information and help keep each other up-to-date with developments in welfare benefits. This in turn has a positive impact on the clients in that they get the most informed advice.

Links between the statutory and voluntary sectors and the WRS have improved through their connection with the project. The volunteer agencies now sometimes make use of the WRS as a specialist support service.

The project has also played a part in improving access to, and the quality of, the medical evidence that is often needed to help resolve an individual's problem. The project reports significant differences between the evidence provided by the surgeries involved in the project and those that are not.

Challenges, lessons and critical success factors

At the beginning of the project it took a long time to engage with the surgeries. Some wanted to be paid rent for the space that would be used by the advisers and others were just reluctant to refer onto the project. Although training was offered to all the primary health care staff, some were too busy to take up the offer. The general attitude towards the project did improve over time, though: once the practice managers came on board, the other primary health care staff tended to follow. Obtaining their trust and listening to their concerns and requirements was key to this.

If the project were starting today, it would certainly consider offering to pay the surgeries a nominal rent in order to overcome the sticking-point surrounding accommodation. It is felt this would incline surgeries towards prioritising advice provision over other outreach services, which are also after space within the surgery setting. Getting the right surgeries, with the right accommodation and facilities, interested in the first place is critical to the success of the project.

In some places the space within the surgeries is not ideal, but the project has had to compromise in order to get up and running. Some premises are not particularly accessible; and in some there are possible security issues should an adviser need to get away from an aggressive client.

A compromise also had to be made in relation to the project offering home visits, as the surgeries did not want the project offering a service that they did not feel in a position to offer all their patients. The project agreed it would only offer a home visit to those individuals that the GP already saw on a home visit basis.

Although the project has encouraged the referral of all individuals, no matter what their problem or client group, in order to develop the 'community referral agency' element, this is not really happening. There still seems to be a focus on those individuals that the project can offer direct advice to (i.e. those from the target client groups who need welfare rights advice). If all individuals with problems of social welfare were referred to the project, the community referral element could be used to signpost the individual onto other services with the knowledge and skills to tackle the specific issue.

The project has met with overwhelming demand for advice over the telephone. Since people evidently favour this method of delivery, the project has adopted it.

According to the project a critical element to its success has been the flexible approach adopted when engaging with the surgeries. It has been vital to take on board feedback from the surgeries and develop a model that they feel comfortable with and which works for the successful delivery of the project.

Future plans

While the project has been unable to expand the number of surgeries through which it provides services in the way it had hoped, it has won a commitment from Barnsley MBC to fund it for a further year (using Neighbourhood Renewal Fund money) beyond the end of PIB funding. During this year the project will be reviewed.

Annex 6 – Health Outreach Project (Northampton Welfare Rights Advice Service)

Aims and objectives

The aim of the project was to improve, promote and make accessible, specialist welfare benefits and debt advice, to people in Northampton who find it difficult to access mainstream advice provision. Areas suffering from high levels of social and economic deprivation and those that have limited or no community outreach advice provision were to be particularly targeted⁹.

The service would be provided through GP surgeries, and health teams would refer to the service any individual with an advice need. This would be done via e-mail, in person or by phone, with client appointments undertaken either at the health centres, in the clients' homes or by telephone.

The project would also establish a website, providing information to the health teams on the work of the project and on welfare benefits and debt issues, and enabling electronic referrals¹⁰.

Client groups targeted included people experiencing mental health problems, older people, people with sensory impairment and travellers.

Background and rationale

The Welfare Rights Advice Service (WRAS) was aware that individuals within their area were not always getting the help that they needed at an appropriate time, either because of the lack of accessible services or from just not realising that they had an advice need. The service was also aware of the clearly established links between poverty and ill health and began to consider how the two issues could be resolved through advice provision.

WRAS felt that by targeting health centres and their staff a service could be provided specifically to those individuals with welfare benefit and debt problems, who are often those living in poverty. The idea was that health teams would identify individuals with issues and through the provision of advice alleviate their financial worries and improve their overall health and well-being.

At the same time there was a commitment from the local Primary Care Trust (PCT) to provide a broader way of working within the health field, one that went beyond just the delivery of specific health services. WRAS took advantage of this by approaching the PCT with ideas around linking advice and health.

The local Community Legal Service Partnership, of which WRAS is a member, had identified welfare benefits and debt as particular priorities for the area, along with accessing the client groups mentioned above. These elements were pulled together

⁹ Specific target areas include Castle and Delapre, Northampton East, Kingsthorpe and the wards of Dallington and Kings Heath.

¹⁰ Although the website is being produced as part of the project, it will be used across all WRAS projects and services, where appropriate.

when a bid was submitted for PIB funding. The bid was successful and the project became operational in April 2002.

The project was funded by the PIB for a total of £236,008 over 36 months.

Set-up and operation

Resources

The project funding provided for two full-time advisers, one part-time project supervisor and one part-time support and administrative worker. All staff were employed by the Welfare Rights Advice Service and were based at its premises in Northampton.

The two advisers appointed were highly skilled and had previous experience of working in the advice field, so no training was required when they came to work on this project.

All services provided by WRAS, including this project, are undertaken at the specialist level. WRAS itself holds the Specialist Quality Mark and LSC contracts in Welfare Benefits (including one outreach contract), Debt, Immigration and Housing. Although WRAS provides services on a countywide basis, this project has only focused on Northampton and its PCT area.

Apart from the external help needed to build the website element of the project, all work is undertaken by the project team, which is a self-contained team within WRAS.

WRAS was able to secure a number of sources of funding, in addition to the PIB funding, for the project. The PCT and Anglian Water Fund each provided cash funding; Northamptonshire County Council provided funding for computer equipment; and in-kind funding was provided by the surgeries, in the form of the venues, and by WRAS, through management time and supervision costs.

Sessions

The health centres chosen for the project were those that had the greatest level of need (i.e. fell into the priority areas identified) and those that showed a real commitment to joint working.

Project workers began by visiting each health centre to determine the level of knowledge amongst its staff. A basic benefit awareness pack was produced, along with a flow-chart for use with clients, which helped staff decide whether an individual could be advised by the project.

A three-session training and awareness-raising programme for the primary health care staff was devised. The sessions provided an introduction to welfare rights, the scope of the project and how and when to make referrals; a follow-up overview of the welfare benefits system to encourage referrals; and a feedback session outlining numbers of referrals and positive outcomes achieved thereby. This training formed part of the healthcare and support staff's 'protected learning time', which is set aside every month and is compulsory for all primary health care staff. These formal events have received good feedback, but informal contact with the primary health care staff is considered just as important to the project in building effective referral mechanisms.

One half-day advice session per week is undertaken in each of Northampton's six health centres, advisers undertaking three each. There is some flexibility to undertake appointments at the surgeries at other times if need be. This is particularly the case at one of the practices where emergency cases often arise.

Each surgery collates a list of referrals that are then faxed or emailed through to the project or left for the adviser to collect when attending the outreach session. The adviser will then contact the client and arrange an appointment either at their home or at the surgery. One surgery, which has a high number of transient patients (e.g. homeless people, travellers), operates a drop-in system for all its services. These individuals do not have to be registered with the surgery. The surgery works on a triage system whereby a health worker determines a client's needs and refers them on to the GP or the project or elsewhere as appropriate. In some instances the adviser will see clients in this surgery on a drop-in basis in view of the patient group's characteristics and individuals' often acute needs.

It is very rare for the project's clients to be referred to external organisations for further advice, partly because of the nature of the client groups and partly due to the level of expertise that exists within the project and the Welfare Rights Advice Service. Referrals are sometimes made from the project advisers to WRAS if a client's needs can be handled under WRAS's LSC contract¹¹.

The advisers may however refer individuals to other health sector workers or support groups, if appropriate (e.g. back to the GP, to an occupational therapist etc.)¹². This happens as a way of ensuring that an integrated service is being provided.

Impacts

Impacts for the clients

In the first two years of the project to March 2004, 650 clients were seen by the project. Of these, 590 clients had issues relating to welfare benefits only, 39 to debt only and 21 to both. In total £1,519,184 of benefit income has been obtained for clients, with the majority relating to the receipt of Disability Living Allowance (32%) and Income Support (29%). A further £169,596 of client debt has been managed by the project. The figure for benefit uptake is well above the original three-year target of £1 million, serving to highlight the severity of under-claiming among the project's target groups.

Of the clients advised by the project in its first two years, the majority have been those experiencing mental health problems (49%). The second largest group are older people (37%), more than half of them over the age of 65, with the remaining groups¹³ making up the other 14% of people advised.

At the end of the project's first year a client feedback exercise was carried out. The response rate to the questionnaire was only 26% (74 returns), but this was not surprising considering the nature of the target groups. Many will have found it difficult to complete

¹¹ Over the two-year period to March 2004 only 24 clients had been referred onto WRAS.

¹² Over the two-year period to March 2004 107 clients had been referred to another professional organisation.

¹³ Comprising travellers (7%), those with sensory impairment (2%) and carers (5%).

the form on their own, especially those with severe mental health problems and those in the travelling community who may be illiterate or have moved on. Nevertheless, the feedback the project did receive was encouraging. Eighty-two per cent deemed the location of the project in the surgeries, and having the referrals made by a primary health care staff, extremely helpful. Almost as many (80%) had noticed a significant improvement in their everyday routine, and felt that it had accelerated their recovery in health.

Despite the project's limited publicity, which is restricted to the surgery location, the service would appear to be in demand, with the original three-year targets already exceeded after only two. Client groups targeted by the project seem to feel comfortable accessing advice from the surgery location, as there is now a 50/50 split of appointments taking place in the surgeries and at the client's home. Not only do the surgeries provide the access to these vulnerable groups, they appear to offer an environment conducive to them receiving advice.

Impacts on the surgeries

Feedback from the surgeries involved in the project has been very positive. All have managed to accommodate the project despite restrictions on space; and the fact that the practice managers have come on board and been supportive of the project has meant that advice provision has been given a priority.

The highest number of referrals to the project comes from the GPs themselves, 63% over the first two years, followed by those from health visitors (10%). The results of a surgery feedback questionnaire¹⁴ show that two-thirds of the primary health care staff find the referral process quick and easy; 34% used the referral process often, while the other 66% said they would like to refer patients more often but, due to the limited time they had with the patients this was not always possible.

The surgery staff report that the project seems to have had a significant impact for their patients in terms of lowering patients' stress levels and improving their overall health and well-being. GPs observe that they now spend more time dealing with the medical needs of the patient rather than the underlying factors. One surgery cites a reduction in the number of patients requiring support from the counsellor; and another remarks that some of its mental health patients seem to visit their GP less often. Some surgeries are even requesting that the service be opened up to all their patients or extended to other priority groups, such as lone parents.

More generally, the project and its training have led to an increase in the primary health care staff's overall knowledge and understanding of the issues faced by the vulnerable client groups and the services available to them. The surgeries are thus now able to offer a more integrated service that seeks to address all aspects of a patient's problems and the project has put the link between advice, exclusion and health firmly on their agenda.

¹⁴ 138 questionnaires were sent to surgery staff in December 2003 and the response rate was 67%.

Impacts on WRAS

The project has also helped raised the profile of the main Welfare Rights Advice Service. Almost half of the clients seen by the project had never previously heard of WRAS, and the project has gone some way to correcting misconceptions among primary health care staff as to what WRAS actually does.

Referrals are now being made to the main WRA Service in areas such as housing and debt. It is unlikely that these individuals would have accessed the main service if it were not for the project.

In addition, the medical evidence required by WRAS for some welfare benefits clients has also improved with the increased knowledge and understanding of the primary health care staff. The evidence is now sent through much more quickly as a result of the positive relationship that has built up between the project, WRAS and the surgeries.

The project itself was set up to have its own resources and so has not had any negative impact on the main service operation.

WRAS would like to see the surgeries referring all patients through to the project, following which any people not specifically covered by the project by virtue of their client group could be referred onto the main service. Alternatively, clients could be referred direct to WRAS or one of its associated projects. WRAS produces a directory of all its services which could be used as part of the overall referral mechanism.

WRAS has found working with the six health centres very challenging, having underestimated the level of need when establishing the project. This has resulted in less experimental development work than WRAS originally intended, but they nonetheless feel that they have created a good model which could be adopted elsewhere.

Challenges, lessons and critical success factors

Due to the constant demands on space, competing priorities and rapid rate of change within the surgeries, it has been important for the project to maintain effective links and relationships with all the surgeries so as to ensure that advice provision remains firmly on their agendas. The project has identified two approaches for achieving this. Firstly, by just having one adviser going to the same surgery at the same time each week the sessions have become a regular feature: the primary health care staff know exactly when appointments and referrals can be made, making referral to the project as easy as possible. Secondly, the regular awareness raising and training undertaken by the project has enhanced both its profile and the benefits it brings.

These positive outcomes notwithstanding, problems with one of the surgeries involved in the project have necessitated an alternative surgery being identified, one which falls in an area of very high need. Moreover, in spite of having targeted all the primary health care staff, referrals seem to be coming predominantly from the GPs rather than from the other health care professionals. Without individual monitoring data it is difficult for the project to tell whether it is just certain GPs within each surgery who are referring and not all of a surgery's GPs.

Placing the advisers within the surgeries, coupled with a flexible approach towards accommodating individual surgeries' needs in terms of working arrangements and referral procedures, has proved invaluable in reaching both the client groups and the primary health care staff. Standardising procedures as far as possible is also critical to the project working effectively.

A further key issue to the success of the project is the involvement and commitment of the Primary Care Trust. By backing the project it has shown the surgeries that the link between health and advice is important and one they need to acknowledge and act upon. In the long term this should mean that better, more integrated services are offered within the PCT area.

Although a referral website has been established as part of the project, delays arising from technical difficulties have meant that as yet the benefits or problems of using this tool for referral have not yet been determined.

Future plans

The East Midlands LSC Regional Office has given the service a not-for-profit contract covering debt and welfare benefits, which along with some residual PIB money is allowing the project to continue for the time being. Tied into this funding are targets for number of clients seen and amount of benefits gained. An initial bid to the PCT for match funding was unsuccessful, but the organisation are hopeful that the decision will be reconsidered later in the year.

Annex 7 – GP Referrals to Advice (St Augustine’s Healthy Living Centre, Kings Lynn)

Aims and objectives

The aim of the project was to provide an integrated service to patients requiring advice and information within the North End and North Lynn Community Trust area, through the St Augustine’s Healthy Living Centre (HLC). The primary health care staff from the surgery at the HLC would refer patients on to the generalist adviser, who would be based within the HLC, on an appointment or drop-in basis.

Background and rationale

St Augustine’s Healthy Living Centre was set up in 2001 using New Opportunities Funding (NOF). This was a response to a severe lack of health provision and real problems of ill health and depression coupled with high levels of deprivation within the King’s Lynn area. The overall purpose of the HLC was to provide an integrated service that met all the needs of the individuals using the centre.

HLC services include a learning centre, a nursery, a café and an art studio. A GP surgery was also built as part of the complex, but was an addition to the HLC, rather than a part of it (i.e. it has its own separate funding). The HLC’s range of services, augmented by the surgery, meant that the one complex could provide for the range of needs as expressed by its users.

The provision of advice and information was considered a key element to the success of the HLC in meeting the overall needs of its users. In the experience of other surgeries in the area as many as half of their patients had problems that were not specifically health related. One particular surgery had tried to address this by linking up with Social Services, who could offer advice or direct the individual to an appropriate service.

Furthermore, King’s Lynn CAB’s lack of accessibility, especially in relation to disabled access, meant that it was not always a popular place to go for advice and information. The CAB and the HLC came to the conclusion that offering an outreach service within the HLC would increase access to such advice and information, since many individuals would be visiting the complex anyway, and that this in turn would help reduce the time spent by GPs on non-health related problems. An application was therefore submitted for PIB funding to place a CAB advice worker within the HLC. The bid was successful and the project got underway in May 2002.

The project was funded by the PIB for a total of £64,089 over 36 months.

Set-up and operation

Resources

PIB funding has provided for one generalist adviser, who is employed by King’s Lynn CAB, but works from the HLC. The adviser appointed had previously worked as a volunteer at the CAB and therefore had a generalist advice background, with no training needs on taking up the post.

As well as the adviser's salary, the funding covered the purchase of computer equipment, reference books and the cost of renting the office (at a reduced rate) within the HLC. It also covered the costs of management and supervision incurred by the main CAB.

Being employed and supervised directly by the CAB, the adviser has access to the central Citizens Advice Information System and the back-up of experienced staff. The CAB currently holds the General Help Quality Mark.

A small amount of match funding for the project came as cash from the local Primary Care Trust and in-kind contributions by the HLC in the form of reduced rental costs and administrative support.

Sessions

Sessions are provided by the generalist adviser on three days per week, two of these on an appointment system and the other via a drop-in session. People who wish to make an appointment can do so by contacting HLC reception staff, who manage the diary system.

People accessing the sessions find out about the service through word-of-mouth, promotional materials or are directly referred. The physical location of the CAB office next to the HLC's main entrance makes it clearly visible to anyone visiting the HLC. The project has produced leaflets and posters that it has placed in post offices, libraries community centres and the GP surgery itself. The project has featured in a video produced by the Local Strategic Partnership and is regularly advertised in the local press.

Referrals to the project are received through a number of routes. They mostly come from the main CAB office and the other services within the HLC. The original plan that many of the project's referrals would come from the GP surgery has not materialised: very few referrals are in fact made in this way.

The referrals received from the main CAB office are often as a result of the individual having difficulties accessing the CAB site or where a long session is required (Disability Living Allowance checks, for example, often take two hours). The main CAB only offers a drop-in service and so cannot contemplate spending that length of time with one client, when other people are waiting.

The adviser will usually be able to deal with any general queries that reach the project; and all case notes produced as a result of the advice given within the HLC are checked and stored by the main CAB office. If the adviser establishes that an issue cannot be dealt with by the project, that client will be referred to a specialist organisation. For example, specialist employment and family matters are referred on to local solicitors, while specialist debt and welfare benefits matters, if financially eligible, are referred to Norfolk Money Advice (NMA), which holds an LSC contract in both.

Impacts

Impacts for the clients

At the time of interview the appointment sessions were running to capacity and the project was receiving positive feedback from its clients. In particular, the location of the adviser within the HLC is held to provide a welcoming and relaxing environment which the clients felt comfortable using. The drop-in sessions, however, were less busy.

Much of the work undertaken by the project relates to benefits entitlement, in particular Disability Living Allowance claims referred from the main CAB office. The clients seen tend to have multiple problems and the project tries to deal with all these issues.

On occasion the adviser, in the course of discussing a client's problems, will identify a possible health related issue and refer the individual to the GP surgery. This was not the original intention of the project, which was that referrals would travel in the opposite direction. However, since the purpose of being based within the HLC is to be able to offer clients an integrated service, it is right that appropriate referrals, no matter what they relate to, should be made in order to help resolve all of a client's needs.

Impacts on the surgeries

There seems to have been very little impact on the surgery, as the adviser is based within the HLC building and not within the surgery directly. Engagement with the surgery staff has proved difficult and the number of referrals from them has been limited. However, some GPs have started referring patients to the project, and have expressed their appreciation at the opportunity to be able to refer individuals on as previously they would not have been able to help the client resolve all their problems.

Impacts on St Augustine's Healthy Living Centre

The advice service has fitted in well with the HLC, which is now able to offer another service to its users. The main idea behind the Healthy Living Centre is to be able to treat the overall well-being of people using the centre: access to advice and information is considered a key element of this.

Although referrals were supposed to be coming from the GP surgery, the adviser has received more referrals from other services within the HLC, which clearly value the adviser's role.

Impacts on King's Lynn CAB

The outreach service within the HLC has provided an additional resource for the main CAB, thereby alleviating pressure on the main King's Lynn office. It has also helped overcome the disabled access issue and the reluctance of some individuals to access CAB services at their main office. The CAB service has thus been opened up to a wider section of the community.

Wider impacts

By offering advice and information as part of the overall service of the HLC, the project believes that individuals' problems are being recognised and resolved before they have the chance to escalate. An added benefit is that in the longer term this may well save money for the statutory services, who would otherwise be faced with tackling those escalating problems.

Challenges, lessons and critical success factors

The overall aim of the generalist adviser to get patient referrals from the primary health care staff within the GP surgery has proved to be a particular challenge for the project. Early enthusiasm for the service diminished as the surgery was experiencing difficulty in recruiting its own ancillary staff (e.g. health workers), adding to pressure on existing staff, as well as a high level of staff turnover that has affected the links between the surgery and the project.

Another issue was that the surgery saw itself as a separate entity to the Healthy Living Centre, despite being in the same building. Primary care staff were therefore given their own entrance meaning that, unlike all the other HLC staff and users, they did not pass the CAB office every day. This has impacted on the staff's overall knowledge and awareness of the service. Moreover, despite the fact that many of the staffing issues have now been resolved, and although the adviser has tried to organise training events for the primary health care staff, the reluctance to engage has persisted. This lack of engagement has resulted in a shift in focus for the project, with more effort being put into publicising the service among other HLC services and externally.

Some of the issues experienced may have resulted from the service going into a newly established surgery, which had initial problems of its own to resolve. Perhaps going into a more established setting, with established staff, would have helped the engagement between the surgery and the project, but in this particular locality there were no other surgeries to work with.

Sign-up and commitment to the project by the practice manager and the primary health care staff would seem critical to the overall success of this form of service delivery. It may be that the involvement and encouragement of the Primary Care Trust (PCT) would have helped develop the links; but again, staffing issues within the PCT prevented this happening.

Nevertheless, the project has succeeded in achieving what it set out to do in terms of getting advice to individuals who access the Healthy Living Centre, thereby providing an integrated service. The comfortable and accessible location of the office within the HLC has encouraged people to use the service who would not have gone to the main CAB service. A key element to the success of the project has been the close links and partnership that has evolved between the CAB and the HLC. Without the support and back-up of the CAB, including its management of the adviser, it would have been very difficult to establish the service in the first place.

Future plans

The majority of the core funding for St Augustine's HLC came to an end in December 2004. Since then the Primary Care Trust and the Local Authority have agreed to fund the HLC during 2005 and, along with some remainder funding from the Community Fund, are running the Centre. A business plan and action plan have been developed to help secure long term funding. There are ongoing discussions around establishing a children's centre and utilising the centre for adult education. The PCT and Local Authority are keen for the HLC to stay open.

To keep the advice (PIB funded) element going once the PIB funding ends in June 2005 the project is considering producing training packs for other agencies, which will provide an income for the project. Whilst there is some short term funding to continue advice sessions at the HLC, consideration is being given to a longer term integrated approach through the co-ordinated provision of generalist and specialist advice services based at the centre.

Annex 8 - Welfare Rights in Primary Health Care Settings (*Prescot & Whiston Community Advice Centre*)

Aims and objectives

The project aimed to provide a free, accessible professional welfare rights service in the Merseyside areas of Prescot, Whiston and Huyton. Through either outreach sessions held at a number of GP surgeries or home visits, the project would seek to reach those individuals who do not traditionally access advice services, offering them an integrated service.

Background and rationale

The project's origins lie with the Community Involvement Manager at Knowsley Primary Care Trust (PCT), who came to realise that if people's debt and welfare benefits issues could be resolved, many of the health problems that seemed to accompany them could also be alleviated. Moreover, GPs had become the first point of call for many people with problems, not all of which were of a medical nature but stemmed from stress-inducing issues such as debt. It was also felt that the best opportunity to contact the hard-to-reach client groups - those not accessing traditional advice services - would be at the time they visited their GPs.

The PCT, with its access to all the GP surgeries in the local area, was thought the ideal agency to take part in developing a service to tackle these issues. Accordingly in 2001 the PCT and the Prescot & Whiston Community Advice Centre (previously known as Prescot & Whiston Trade Union Unemployed Resource Centre), who hold the General Help with Casework Quality Mark in Welfare Benefits, joined forces to submit a bid for PIB funding. The application was successful and the project became fully operational in April 2002, with PIB funding for a total of £84,723 over 36 months.

Set-up and operation

Resources

PIB funding provides for a welfare rights worker and an administration worker, plus all associated costs.

Other funding for the project came from the Primary Care Trust in the form of cash match funding, which covered the cost of room hire at the surgeries. Prescot and Whiston Community Advice Centre agreed to take care of management and administration costs.

Sessions

The initial contact with the GP surgeries came through the Community Involvement Manager, who introduced the project to the practice managers. An information document was produced for each surgery, describing how to recognise people who might need help, who was eligible for a home visit and suggested appointment lengths depending on client needs. Training for the reception staff at the surgeries was undertaken to help them to identify the patients who would benefit from seeing the adviser. This method was chosen on the grounds that it is the receptionists who see people first and are

responsible for booking any appointment. The service was advertised directly to the patients through posters and leaflets within the surgeries.

The project operates from six surgeries, each having a three-hour advice slot per week. The receptionist within each surgery holds an appointment diary and the project worker contacts each surgery prior to a visit to check appointments. Home visits are provided where an individual is unable to access the surgery and the project worker will book these.

Referrals come from a variety of sources. The majority come to the project on a self-referral basis by the individuals themselves. More often than not these individuals are patients of the surgeries. Some people access the project on referral from the surgery workers, such as the GPs and practice managers; others come from the local Community Health Teams or from Social Services. The project worker also now offers sessions within the local mental health wards on the back of referrals from a local mental health advocate.

Impacts

Impacts for the clients

In the first two years of the project, to April 2004, 448 clients had been seen by the project. That this is significantly below the original target estimate can be explained by the high number of people with mental health problems, whose deep-seated and complex advice needs require a number of visits to establish in detail what their problems are. It often takes two or three visits just to build a rapport with a client and gain their trust. Visits are often undertaken in conjunction with the Community Psychiatric Nurse.

Despite not reaching the planned target of clients seen, the amount of extra benefit income achieved for its clients has far exceeded the initial estimate. That estimate was around £100,000 for the first two years, yet £1.4 million was generated for clients in that period. Most of this relates to disability benefits, in particular Disability Living Allowance and Attendance Allowance. Incapacity Benefit and Income Support also make up a significant proportion of the benefit claims.

The project has also helped many older people and disabled people, who previously could not access the mainstream advice services due to problems of mobility and transport. Knowsley is a large area and it can be hard to get to the services available in the town centre without private transport. A small customer survey of 50 clients, conducted in September 2002, reported 23 of the 34 respondents as saying they would have been unable to access a welfare rights service without a home visit. The same survey found that appointments both in the surgeries and in people's homes were provided in an environment that clients felt comfortable and familiar with and easy to access.

By maximising the income of the clients seen by the project some of the stress and anxiety created by their financial problems has been removed. Their quality of life is now better and their reliance on primary care resources, especially GP services, has diminished, as reflected in fewer GP consultations being required and a corresponding reduction in prescriptions.

Impacts on the surgeries

The project receives a steady number of referrals from three of the six surgeries. One surgery in particular has been working extremely well with the project. Previously in this surgery the practice manager had been spending time helping patients fill in forms, a task now taken over by the project. In the other two surgeries where the project is working well, it is the GPs who have recognised the project's merits and are referring their patients.

The other three surgeries do not account for many referrals. This can be partly explained by surgeries only recently coming on board with the project. In one surgery, however, the project has met with some resentment that the welfare benefits worker is taking up a room that it is felt should be used for medical purposes.

The welfare benefits worker did try to organise further awareness raising training for the practice nurses within each of the surgeries, however, heavy workloads have prevented this, so the worker instead discussed the project with each practice nurse individually.

A positive outcome for the project has been that the charges made by surgeries for producing medical evidence to support a client's claim have been reduced, now that the surgeries can see the longer-term benefits of undertaking this work for their patients.

The welfare benefits worker has also become a 'problem noticer' for the health sector, in that an appointment booked for one ostensible reason often reveals a client's other problems. Some of these problems can only be resolved with the help of other services, such as the Community Psychiatric Nurse or Social Services.

Impacts on Prescot & Whiston Community Advice Centre

The local profile of Prescot & Whiston Community Advice Centre has been enhanced as a result of the project. The Centre has increased its expertise in terms of working with clients who have mental health issues and has now begun to specialise in the fields of welfare rights and benefits.

Managing the project has put additional pressure on the Centre: if the project were starting today, additional funding for this would be requested.

Challenges, lessons and critical success factors

Without the support and partnership working of the Primary Care Trust it would have been very difficult to set this project up. Many of the GP surgeries operate as self-contained services with their own priorities. The PCT gave the project its route into the surgeries and encouraged them to become engaged.

Another major key to the success of the project has been recruiting the right worker, one who is empathetic and patient with the clients. The fact that there is only one worker within the project does cause problems, because if the worker is off sick or on leave the service has to be suspended. This does not sit comfortably with the objective of a service that is continuously available.

The project was originally going to hold drop-in sessions within the surgeries, with individuals being referred to the service by the primary care staff including the practice managers. On reflection, it was felt that time would be lost waiting for patients to turn up, so an appointment system was set up instead. In practice referrals are coming into the project from a variety of sources, not just through the surgeries themselves.

Although surgery staff were offered training and awareness raising to help them identify candidates for referral to the project, in practice the nurses were too busy to spare the time and in the end training was provided, successfully, on an individual basis. Despite meetings with the practice managers, some GPs in a few of the surgeries had still not engaged with the project after a year. Other surgeries have engaged completely and their GPs are the main referrers. Moreover, advertising the service directly to patients, using examples of the kind of problems experienced, has succeeded in generating a large proportion of self-referrals.

The length of time required to deal with certain patients – notably those with mental health issues – was not factored in when determining the targets for the project, particularly the target for the number of clients to be seen. Average times for seeing patients have been greater than anticipated, as has the number of repeat visits needed. Cases are therefore being held open for longer than was originally planned.

Future plans

The project would like to continue providing the service, but with a 100% funding commitment, including all management costs. Initial thinking is to expand the service to cover the whole of Knowsley, involving linking up with all the psychiatric wards, mental health teams and Social Services teams in the area. The project is also considering becoming a more mental health focused service.

However, despite its initial encouragement, the PCT now says there is no funding for the project, which is therefore trying to identify other sources of funding, such as lottery funding and grant trust funding.

Annex 9 – Health Advice Benefits Initiative Team (*Liverpool Age Concern*)

Aims and objectives

The aim of the project was to raise awareness of welfare benefits and other services for Liverpool's older people, largely those over 75 years of age, and to help maximise their income. It aimed to provide an integrated service to its clients, referring on cases where appropriate to other support services locally. The project would also work with primary care staff to raise their awareness of the need for advice amongst older people and to help improve their ability to identify people who could benefit from the available services.

Background and rationale

In 1998 the Merseyline Primary Care Group's (PCG, now Primary Care Trust) Stakeholders Group identified that it had some of the worst levels of poverty amongst its older population. Many were missing out on their entitlement to welfare benefits and other services and as a result their mental well-being was suffering. Older people and their positive mental health became a priority for the PCG and it resolved to set up a service for reducing the risk of depression in older people. With funding from the Merseyline Health Action Zone, the integrated Health Advice Benefits Initiative Team (HABIT) was established in 2000. The funding provided for one HABIT officer and a part time administrator, based on Merseyside. Letters were sent to the surgeries' patients aged 75 plus, informing them of the new service, while at the same time a short programme of drop-in services based in GP surgeries was run for anyone aged over 50 to help reach clients.

Age Concern Liverpool also made a strategic decision to position itself as a provider of outreach services to people who could not access the available mainstream services and became the lead agency for HABIT. The pilot phase lasted for six months from November 2000. A phased roll-out of the project across the five PCG areas in Liverpool (now three Primary Care Trusts) was then initiated. The roll-out consisted of one welfare benefits adviser spending one month or so at each of the surgeries within the PCTs. Patients were able to access the adviser through either a drop-in session at the surgery, through an arranged home visit or at the Age Concern Liverpool premises. Funding for the roll-out phase was only available for 12 months, so a bid for PIB funding was made to complete the roll-out so that it would extend across Liverpool with an officer working in each of the three PCT areas. This was successful and funding began in April 2002.

The project was funded by the PIB for a total of £453,651 over 36 months.

Set-up and operation

Resources

Funding through the PIB provided the project with three full-time welfare benefits advisers, one for each of the new Primary Care Trusts, enabling the roll-out to be completed across all PCT areas and an ongoing service to be established. The funding also provided for the associated management and administrative support.

Support and training for the welfare benefits advisers was provided, on an in-kind match-funding basis, by the Information and Advice Team at Age Concern Liverpool, who hold the General Help with Casework Quality Mark (Older People).

Sessions

In order to encourage the use of the service by the older population, a number of approaches were adopted. Firstly, the CAB and Age Concern Liverpool jointly delivered training and awareness raising to the primary health care staff across the PCT areas. This training covered an overview of the benefits system, the links between sound advice and better health, the services available to older people and the need for medical evidence when applying for certain benefits. A training and information pack was also provided. This training helped the primary health care staff to refer and encourage their patients to use the service, and would help them to deliver a service that contributed to an integrated approach in dealing with clients' overall needs.

Secondly, the project organised a mailshot to all older people aged 75 plus, which went out from their GPs and provided an overview of the service and the contact details of the adviser. The letter invited the patient to contact the adviser to arrange a home visit, or alternatively an appointment either at the surgery or at Age Concern.

Posters and leaflets were displayed within the surgeries, while radio slots, newsletters and word of mouth also helped to publicise the service.

Advice is normally delivered through home visits, with relatives or carers of the client often present. The adviser will discuss a whole host of things with the client, including their health and medication¹⁵. Information and advice on the range of services is covered and a benefits check is completed to ensure that the client is accessing all the appropriate entitlements. This may include information on flu jabs, aids or adaptations to the home, telephone lifelines, free central heating and free locks or smoke alarms. Where appropriate, the adviser refers clients on to other services and will negotiate and liaise directly with statutory bodies on their behalf, a task many clients feel unable to cope with themselves.

Impacts

Impacts for the clients

The project feels that it is achieving what it set out to do in terms of offering an integrated service to older people across the area. Figures collected to the end of March 2004 suggest that 91.5% of the individuals assisted by the project have never previously accessed a mainstream advice service. By that date the project had secured £3,144,287 in extra income for its clients, well above its original target. The project does therefore appear to be reaching those individuals who cannot be accessed through other advice routes.

The project ascribes its success in part to its home visit service, which it believes most older people prefer. This belief is supported by feedback from focus groups with people

¹⁵ A Medication Review Alert form is provided to the adviser, who can refer the patient back to the Prescribing Support Team if there are any concerns over medication and its use.

who have used the service, who say that welfare offices have an intimidating atmosphere.

The focus groups also highlighted that people find the process of applying for benefits difficult and would not have been able to complete the necessary forms without the help of the project. They had also been unaware of many of the services on offer and felt that receiving information via the GP route helped to facilitate access. The increased income has enabled individuals to have better housing and healthier diets, which often leads to improved health, increased social contact with friends and family, which reduces social isolation, and greater independence generally.

Impacts on the surgeries

To date 105 health care teams have engaged with the wider project and overall reaction towards it from the primary health care staff has been very positive. The training, in particular, was well received and many have said that they knew very little about the wealth of benefits and services on offer prior to the training.

Support for the training has also come from Protected Primary Care Education in Liverpool (PROPEL), who have incorporated it in the surgeries' in-house 'protected learning time' (dedicated learning time which is compulsory for all staff).

The GPs themselves report that as a result of the project they now spend less time dealing with patients' non-health related problems, which has freed up their time and resources.

Another outcome for the project has been an improvement in the medical reports provided by the GPs, which is critical when undertaking tribunals.

Impacts on Age Concern Liverpool

The impact on Age Concern Liverpool has been largely positive. The project has helped to reposition the service as an outreach provider and has raised its profile among statutory bodies and other Age Concerns, who are interested in establishing a similar service.

Those working within the project have become multi-disciplinary, gaining knowledge about both the delivery of advice and the Community Legal Service. This can only benefit Age Concern overall.

The one negative impact that they have experienced is in relation to office space and accommodating the project workers in already cramped premises.

Age Concern Liverpool was keen to achieve a Specialist level Quality Mark, but the present system provides only for *category* specific Quality Marks, not *client* specific ones. One of the original aims of the project was to try and influence this policy, something in which it feels it has not succeeded.

Wider impacts

The project acknowledges that benefit take-up is a key concern for local authorities, since under claiming amongst older people increases poverty amongst this vulnerable group. This in turn places additional financial burdens on the local authority. If individuals are in receipt of certain benefits, then the funding received by the authority will increase. Moreover, where people are already receiving benefits - Income Support, say - it is easier for the council to process a housing benefit or council tax benefit claim.

In Liverpool the project has been cited as an example of good practice and helped the City Council achieve Beacon status for Community Legal Services.

The project has also been acknowledged by the wider health sector and in particular by the NHS Executive in the North West, which has recommended the project as an example of good practice as part of its review of the implementation of the National Health Service Framework for Older People. The project has also been cited in the Pensions Service 'Good Practice Guide on Income Take-up'; was nominated in the 2003 Health Challenge Awards; and was Highly Commended in the Health Service Journal Health Management Awards in 2002.

Research undertaken by one of the local universities has found that increased spending power amongst the older population is generally very beneficial for the local economy, as that group tends to buy goods and services locally. The project could therefore be said to be benefiting the local economy.

Challenges, lessons and critical success factors

A challenge for the project was getting good quality staff to deliver the project who had the right combination of skills and knowledge base.

Initial difficulties in getting GPs to attend the training sessions, due to constraints on their time, were overcome when the Protected Primary Care Education in Liverpool (PROPEL) included the training as part of the surgeries' in-house protected learning time. This meant that the staff costs were covered for those attending.

The project feels that a factor critical to its success has been taking time to plan the development of the project prior to recruiting people to work within the project. This has enabled a clear approach to development and a plan of action to be established. The people then employed came into a structured environment with clear targets.

Age Concern Liverpool's huge experience of the services available, particularly within the local area, has enabled a truly integrated service to be introduced. Without this knowledge and background, it would have been difficult to engage with all the necessary people and organisations.

The approach used by the project has demonstrably helped reach one of the most vulnerable groups in society by offering an integrated service responsive to the combined needs of the client group.

Future plans

In 2003 the project secured 12 months' funding from the Neighbourhood Renewal Fund. This has enabled the service to be expanded to target people aged 50+ within two specific areas of Liverpool. Ideally, the project would like to introduce this across the whole of Liverpool, but for this to happen and for the project to continue further funding will need to be found. Applications for mainstream funding of HABIT have been presented to each of Liverpool's three PCTs and the project is awaiting the outcome.