2021

Access to social welfare advice in a hospital setting: integration of services

HEALTH INNOVATION ECOSYSTEM

UNIVERSITY OF WESTMINSTER

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Administrative Justice Council

The Administrative Justice Council (AJC) is the only body with oversight of the whole of the administrative justice system in the UK, advising government, including the devolved governments, and the judiciary on the development of that system. The AJC has the following aims:

- to keep the operation of the administrative justice system under review;
- to consider how to make the administrative justice system more accessible, fair and efficient;
- to advise the Lord Chancellor, other relevant ministers and the judiciary on the development of the administrative justice system;
- to share learning and areas of good practice across the UK;
- to provide a forum for the exchange of information between Government, the judiciary, and those working with users of the administrative justice system;
- to identify areas of the administrative justice system that would benefit from research; and
- to make practical proposals for reform.

The Council is made up of three panels: the Advice Sector Panel, the Pro Bono Panel and the Academic Panel. In addition, various working groups have been established comprising of cross- panel membership. This report has been prepared for the Administrative Justice Council by Lola Afolabi (AJC intern), Diane Sechi (Simmons and Simmons), Naomi Creutzfeldt (University of Westminster), Philip Worrall (University of Westminster), and Heidi Bancroft (AJC).

Acknowledgements and thanks

We are very grateful to all interviewees that have made time to talk to us, especially during the pandemic when they are already working to capacity. We assure you that your time was well spent as your wisdom and experience of working in these settings is invaluable and we hope that we do this justice in our report.

Also, thanks are extended to Hazel Genn, Sarah Beardon and Amanda Finlay for their time and their valuable insight into this topic. We are grateful to the law school at the University of Westminster for funding this pilot project, we are also grateful to JUSTICE for providing the funding for a few extra weeks to support the drafting of this report. Lindsey Poole has been a valuable critical friend in getting this project up and running.

Finally, with thanks for their kind assistance: Michael Bell, Director, MBARC, and Rachel Flagg, Interim Joint Director of Transformation and Commissioning, South West Croydon Health Care Services.

Executive summary

This project looks at the benefits of integrated welfare advice in specialist hospital settings. It is timely as a legislative proposal for a Health and Care Bill is currently underway to remove barriers that stop the system from being truly integrated. The proposed legislation aims to build on collaborations that are existing and that have shaped though the COVID-19 pandemic. The aim is to better serve people in a fast-changing world.

This project sets itself apart from previous research conducted in the UK in that the focus is on health-justice partnerships in secondary and acute healthcare settings which treat patients with a wide range of conditions. We explored how four existing integrated services that provide benefits advice at the health and justice nexus operate and how they continued to function during the pandemic. This project draws on existing research as well as in-depth interviews with practitioners, policy makers and stakeholders to produce a feasible proposal for this kind of partnership and integrated working. These integrated services we showcase here allow especially vulnerable groups access to advice on social welfare matters and sets them on a path that enables them to be more prepared for their everyday lives and achieve beneficial health outcomes.

One of the most obvious advantages of having a partnership arrangement within a hospital setting is that a specialist team is already in place to help the patient deal with existing or arising welfare benefit or other social welfare issues. In terms of welfare benefits, going into hospital can affect a person's entitlement to benefits and some benefits can stop. In addition, patients in receipt of benefits may have been reassessed and disallowed benefits to which they may be entitled. Having onsite services can assist to overcome these issues and to maximise income for these patients on discharge.

Six themes about the benefits of integrated services arise out of the literature and our interviews:

1. ***Cost saving for the NHS:*** by providing integrated services that will help patients to sort out their social welfare needs and then enable them to leave hospital once medically advised, rather than blocking beds due to unresolved social welfare issues.
2. ***Individual personalised approach:*** Co-location enables a holistic approach to patient's welfare. The patient's physical and mental health improves by dealing with all the presenting issues at the earliest opportunity. Thus, co-location does not just improve a patient's discharge experience and wellbeing, but it may reduce readmission rates and can potentially reduce visits to other organisations and institutions longer term.
3. ***Collaboration and integration:*** For the social welfare advice to work well in a hospital setting there needs to be good communication between the various teams.
4. ***Knowledge sharing:*** Co-location leads to a system of knowledge sharing between clinicians and advice workers whereby clinicians become better able to spot issues presenting in patients requiring advice.
5. ***Support structure:*** For these services to continue, there needs to be support from the top (management) and the funding stream and there also needs to be support and buy in from all staff members
6. ***Value of integrated services:*** The value of advice provision within hospitals can be observed as a benefit to all types of hospitals and patients, not only those hospitals dealing with tertiary care or long-term stays.

Background

This report raises awareness of a problem that the NHS has been facing for many years: patients stay longer than they have to in hospitals due to a variety of unresolved social problems. Some of these may be amenable to simple solutions such as assistance with claiming the correct benefits, for example. Others may require additional assistance and may be potentially justiciable in nature. For example, challenges around patients being discharged into unsuitable accommodation or not being provided with housing when homeless. This report therefore also raises awareness about broader consequences for society regarding the health/justice nexus and in particular, the value of having onsite services. The delivery of advice in hospital settings, as integrated services, exists in some specialist settings and is the subject of this report. A bill on *integration and innovation: working together to improve health and social care for all*[1] [The Health and Care bill] is on its way through Parliament. Part of this bill is about integration, partnerships and accountability.

> 'We have seen real advances in recent years in forms of joint working, with a great deal of commitment in parts of local government and the NHS to developing broadly-based 'integrated care systems', many of which are now starting to make a real difference.'

This pilot project explored how four existing integrated services that provide welfare benefits advice and other advice at the health and justice nexus, operate and how they continued to function during the pandemic. This project is informed by a mixed methods approach. We undertook desk-based research and conducted interviews with practitioners and stakeholders to understand better the integrated services we were studying.[2]

The COVID-19 pandemic has had a significant effect on the delivery of advice in England. The lack of face-to-face encounters and the move to remote delivery has exacerbated the gaps in access to advice and access to justice for vulnerable groups who require help with a variety of problems.[3] Specialist advice in areas such as welfare benefits, housing, family, employment and debt are now needed more than ever. The role of the NHS has never been as important and the extent to which health and wellbeing is a vital component of a functioning economy has been thrust under the microscope. It is a well-known fact that the provision of early multifaceted advice and guidance for those who are most vulnerable in society not only assists with immediate problems and crisis situations but is an effective approach to a longer-term solution for problems people face in their everyday lives. Where such advice is available in a health care setting, it can be transformational.

By way of comparison and to inform the findings, this pilot also explored the effects of a lack of advice provision in a hospital setting where there are no integrated services and where geographical location dictated that community services are scarce. This enabled the authors to better understand the whole needs of hospital communities and evidence how a 'person centred' and holistic approach - which includes the provision of social welfare advice - is of benefit to all within that community and beyond.

The goal of this pilot project was twofold. First, to understand how these integrated services have worked in the past and how they are working during the pandemic; and second to

[1] https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version

[2] In this report we use the terms integrated services, partnerships, and hubs interchangeably.

[3] See more on this: Creutzfeldt, N and Sechi, D (2021) 'Social welfare [law] advice provision during the pandemic in England and Wales: a conceptual framework', Journal for Social Welfare and Family Law (43/2 2021) https://doi.org/10.1080/09649069.2021.1917707

develop this model into proposals for similar integrated services in other hospital settings. Ideally this will lead to more collaboration agreements between advice providers to create more advice hubs in hospitals across the UK. These hubs will help build a landscape of early advice for the most vulnerable groups and those most in need at the intersection of health and justice.

To assist our understanding when carrying out this pilot and to further evaluate the benefits of the health and justice intersection, we carried out a literature review which can be found in the appendix. In sum, existing health-justice partnerships in the USA and Australia noted some key findings: integrated services enable timely responses to legal problems; patients become empowered; co-location simplifies and speeds up the process of receiving advice which thereby leads to the establishment of proactive and preventative advice services. A review of partnerships in the UK, suggests that most of the research to date around the health, advice and justice landscape has focussed on health-justice partnerships in GP settings, that is, primary health care settings. Although notably, the review also found research into advice provision in secondary settings in the UK featured the Citizens Advice Bureau at Sheffield Hospital as an example of having the 'core features of a good service.'[4]

Our pilot project sets itself apart from previous research conducted in the UK in that the focus is on health-justice partnerships in secondary and acute healthcare settings which treat patients with a wide range of conditions. We also chose to focus on internal onsite advice services particular to each hospital rather than services provided by CABs or Macmillan Cancer Support which, as identified in the literature review, feature heavily within the extant literature and partnership workings. That being acknowledged, we still decided to include the CAB within the GOSH hospital which is a unique example that has evolved and developed into a bespoke service within the hospital. We focus therefore on the lacuna in previous research into these integrated services within hospital settings in the UK. This focus directed the choice of our case studies in this project.

This report is made up of 6 parts: 1) The UK NHS context; 2) Methodology; 3) The healthcare settings; 4) Common themes; 5) Basic modelling and start of a cost consequence model; and 6) The main findings and next steps.

The UK NHS context

As of April 2020, there were 217 National Health Service (NHS) Trusts in the UK. These Trusts which comprise of acute, specialist, mental health and community trusts, together manage 127,225 available and occupied consultant led beds[5] in over 1910 hospitals.[6] Notwithstanding the pandemic, there is a shortage of beds and the number of available beds has been falling over the years. This has been highlighted by the British Medical Association who have called for and recommended an increase in the core bed stock across the UK.[7] Coupled with this is the fact that the number of delayed discharges is increasing. According

[4] These are: face to face contact with clients to build trust; continuity of the same adviser contact; holistic advice and support i.e., tackling many problems; long and repeated interviews; good access; and workers with experience of both social welfare issues and medical issues to advice and represent their clients. Full report available at: https://www.basw.co.uk/system/files/resources/basw_113418-3_0.pdf

[5] https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2021/02/KH03-Q3-2020-21-Statistical-Press-Notice-FINAL.pdf

[6] https://www.statista.com/statistics/949580/hospitals-in-united-kingdom/

[7] https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/bed-occupancy-in-the-nhs

to the Kingsfund[8] although the number of delayed discharges is not substantial, such delays reduce the number of available beds and also pose challenges and carries costs implications. Therefore, any opportunity or intervention which would alleviate these pressures and improve patient discharge need to be explored.

As already noted, this pilot does not cover primary health care settings where much research has already been conducted, but rather seeks to explore secondary and tertiary health care settings where delayed discharge or discharge without the provision of any social welfare advice may affect both patients' long-term wellbeing, have negative consequences for the hospital and lead to increased costs.

Methodology

In order to explore the case study sites (how they work, which are the most common social welfare issues that need support; who is involved; what works well; where the challenges are in the current system; what role COVID has played) we applied a combination of desk-based research and in-depth interviews. We built on the teams' expansive networks to recruit our interview partners. We received ethics clearance for this project from the University of Westminster's ethics committee in early 2021.

We held 10 interviews in total which lasted between 1 -1 ½ hours and were conducted digitally (MS Teams and Zoom) abiding by the social distancing restrictions of the pandemic. We anonymised our interviewees, however here is an overview of the type of work they do in each setting: 4 interviews with social welfare advisors; 1 with a manager/senior adviser;1 with a member of a Complex Discharge team; 1 with a social worker based onsite; 1 with a clinical nurse specialist; 1 with a Network lead nurse and 1 with a Consultant psychiatrist. This is not a representative sample, but the interviews have provided some valuable insight into how integrated services work for the purpose of this report. Further, the range of interviewees conducted enabled us to consider the pathways to advice for a patient within each setting and how this may inform best practise for co-location models more generally.

Using insight gained from our interviews, and in combination with supporting literature, we identified key aspects of the health care advice system in operation across the different sites and drafted an idealised service model. Methods applied included soft-systems methodology (SSM) and cognitive mapping. This model was then used to highlight the main costs, benefits and potential outcomes of the advice service from the perspective of both the NHS and patients. At the same time, our intention was to understand the interactions between the advice service and other external organisations. Our initial findings are presented in the form of an initial cost consequence analysis (CCA). We envisage that the results of our analysis could help inform and support rollout of advice services to other hospitals and support further research in this field relating to the quantification of the longer-term patient benefits.

Healthcare settings

This section provides an overview and brief background of the different settings we have included in our study. They are:

1. Great Ormond Street Hospital and Citizens Advice Bureau;
2. Springfield Hospital and Internal Advice services;

[8] https://www.kingsfund.org.uk/publications/nhs-hospital-bed-numbers

3. The Royal Brompton Hospital and Internal Advice services;
4. South London and Maudsley NHS Foundation Trust and Internal Advice services;
5. The Leicester Royal Infirmary (no internal advice services).

1. Great Ormond Street Hospital and Citizens Advice Bureau[9]

- The advice service takes the form of a Citizens Advice Bureau (CAB) and is located in Great Ormond Street Hospital, a specialist Children's hospital which treats children with a range of conditions and ailments and takes referrals from other hospitals both in the UK and from overseas. The CAB service has been running for fifteen years since June 2006. The CAB has 2.2/2,4 full time staff equivalent and a varying number of volunteers. Families who have a child as a patient at GOSH can access the advice service. It is managed by a referral-only system and referrals are made by the family support officers, CLIC Sargent, charities, PALS and the chaplaincy. Families can also self-refer.

- The advice services provide face-to-face, telephone and email advice in addition to casework support. Advice is given on housing (29% of referred cases in 2020), benefits, community care issues, disability specific issues and debt. Where necessary, the service will also assist with hearings for clients who need extra input and support from the advice service.

- If the advice service cannot assist, they have referral networks, for example for level 2+ immigration issues and Judicial Review matters. If cases are urgent they get referred the same day and cases that are non-urgent have a maximum of 2 weeks waiting time. During the pandemic the advice provision continued to operate an onsite service at the hospital three days a week with only one advisor allowed in at a time. The service experienced an increase in the numbers, so there were additional waiting times as a result.

- Usually the CAB advises on average 30-35 new families per month. There are though, 100s of ongoing matters at any one time and almost all referrals are taken up and acted upon. Cases can range from one hour to considerably longer to resolve as some families can remain working with the service for a year or more.

- The CAB is funded by the GOSH charity and a law firm. The advice service conducts a 3-yearly survey of 300 people to follow up on those who have received advice from the service. The CAB manager also goes through every case in the process of closing their file and reports the financial gains obtained for the client. The latest survey took place in August 2020 which measured and tracked before and after advice provision. The survey results showed that an overwhelming majority were happy with the service provided, would use the service again, would recommend the service to others and felt that the advice given greatly improved their situations. Before receiving advice from the service, 71% of families felt that their problems affected their lives a great deal. After having received advice, this percentage reduced to 32.5%[10].

[9] https://www.gosh.nhs.uk/parents-and-visitors/clinical-support-services/about-citizens-advice-bureau
[10] Ibid.

2. Springfield Hospital and Internal Advice service[11]

- ◊ The advice service is located in Springfield Hospital which is a psychiatric hospital with a history going back to 1840. The service is for people who are under the care of the South West London & St George's Mental Health NHS Trust either as an inpatient on one of the Trust hospitals wards, an outpatient of the Community Mental Health Team or through the specialist mental health service. The advice service operates on a referral system, where patients can either self-refer (50% of cases) or be referred by ward staff, care co-ordinators or consultants (50% of cases).

- ◊ The advice service has 4 members of staff and currently only one advice worker. The service provides face-to-face, telephone and email advice on debt, housing and welfare benefits advice. If the advice service cannot assist, they have a system of referral and signposting to law centres and other advice providers. The waiting times vary, but usually patients wait no more than 24 hours to hear back from an adviser. Urgent matters are actioned within one hour.

- ◊ During the pandemic the drop-in service was not available, so clients were not seen face-to-face and had to contact the service over the phone or via email. This saw an increase in the number of people contacting the service by these methods. The usual capacity of the advice service assists 400+ patients per month with 450 ongoing cases of varying complexity.

- ◊ Funding is provided mainly by Wandsworth Council and Merton Council with the Hospital Trust providing the remainder. Wandsworth council requests data from the advice centre on the number of people referred and seen and the financial gains made for clients to secure ongoing funding.

3. Royal Brompton Hospital and Harefield Hospital and Internal Advice service

- ◊ The advice service is based at Royal Brompton and Harefield NHS Hospital which are a specialist heart and lung centre and is one of the largest in Europe. Patients who visit the advice service are mainly cystic fibrosis, heart and lung disease and transplant patients. The service has a screening checklist and operates on a referral system, where patients can self-refer or staff members refer via the ICE internal IT system. Referrals mostly come via clinicians, psychologists and discharge team members.

- ◊ The service provides face-to-face, telephone and email advice on benefits such as Personal Independence Payment applications, Universal Credit, housing, finance and other welfare benefits issues. There are 8-9 members of staff pivotal to the advice service and this includes Complex discharge coordinators, occupational therapists and a support worker. There is one Part time welfare advisor who works between the two sites.

- ◊ The waiting times vary depending on the advice required and priority of the matter. Patients within palliative care and the ICU unit are seen within 2 days and patients

[11] https://www.swlstg.nhs.uk/our-services/find-a-service/service/welfare-benefits-team

requiring assistance with DS1500 forms[12] are also actioned quickly, and the welfare adviser will follow-up with patients.

◊ During the pandemic there was an initial increase in the need for advice provision and the workload then reduced as the adviser was just seeing COVID-19 patients. The referral system has not changed as advisers can be contacted via phone and email. The service sees between 50-55 people per month. Cases on average take 1 hour – a full day to resolve depending on complexity.

◊ There is also a separate advice service based at the Royal Brompton Hospital, which sits in a Specialist Complex Discharge team and supports other hospitals with children who are patients who have significant and complex needs. Families requiring advice are referred by occupational therapists, family liaison staff, discharge coordinators and nurses via email. Near 100% of referrals require advice about welfare benefits and 50% of those also require housing advice. Advice is provided face-to-face and over the phone and by email to families and clinicians. All families are followed up after advice provision and receive advice through the duration of their child's stay in hospital until they are discharged home. There is 1 full time Welfare Advisor.

4. South London and Maudsley NHS Foundation Trust and Internal Advice service

◊ The South London and Maudsley NHS Foundation Trust provides a specialist case worker advice service and is based at three hospital sites, Maudsley, Bethlem Royal Hospital and Lambeth Hospital. Advice is provided to inpatients; Home Treatment patients and patients being treated by some community teams as funding allows. It is the oldest psychiatric institution in the world. It provides a wide range of NHS mental health services and treats patients with moderate-severe mental health issues including patients suffering with substance misuse as well as patients with brain injuries and neurological issues. Patients in the psychiatric ward receive a checklist upon admission which includes the details of the welfare rights advice service. Patients can either self-refer (1% of cases) or be referred by a care-coordinator or clinician (99% of cases). Patients requiring advice in the brain and neurological ward are referred by the ward social worker who fills out a PDF form and emails the advice worker. There are 15 advisors that work across the four-hospital trust-sites. The service provides face-to-face advice on solely welfare benefits issues, but works closely with clinical teams to ensure referrals are made to other advice providers for further social welfare matters. The waiting times average at 2-3 weeks and depend on the staffing level. Referrals are managed by a specific allocations person who assigns patients according to priority need.

◊ The advice service also carries out Mandatory Reconsideration requests with a 99% success rate and when the cases do go to the tribunal, the service can attend to represent.

◊ The Maudsley charity also provide discretionary funds to inpatients who have 'no right to recourse to public funds' and the service administer the funds on behalf of the charity.

[12] DS1500 forms are used for patients claiming benefits under the special rules for terminal illness. The form collects details for the DWP about the claimant and details of their condition so that they have a fast track route to claiming benefits.

- ◊ Further, the advice team can act as appointees if an inpatient lacks the capacity to manage their benefits – this would not happen but for the team being onsite.

- ◊ During the pandemic there was a 50% increase in the number of people referred.. They began operating the advice by telephone and digitally via MS Teams and Zoom. Due to the pandemic and increased demand, patients waited longer to obtain advice. The average number of patients assisted and allocated a specialist case worker is 180 new patients per month across the four trust sites. Funding is provided mainly by South London and Maudsley NHS Foundation Trust.

5. The Leicester Royal Infirmary (no Internal Advice Centre)

- ◊ Leicester Royal Infirmary Hospital is the only setting in our study without an advice service located within the hospital serving all patients. The Leicester service provides care for sickle cell and Thalassaemia patients and is based at Leicester Royal Infirmary. Interviews were conducted with 2 out of 9 of the nurses working within the East Midlands Haemoglobinopathy network who work predominately with Sickle-Cell Anaemia patients.

- ◊ The nurses become aware of patients' issues requiring advice during their clinic times or over the telephone where patients will call the nurses if they need advice and support. Patients' family members will also ring the nurses to alert them to any issues.

- ◊ Patients commonly present with welfare benefit issues such as Personal Independence Payment, disability allowance issues and housing issues.

- ◊ As patients do not know where to go to obtain advice and there is a paucity of advice services within the area they turn to the hospital staff and nurses to seek assistance. Although there is a Macmillan advice service this is only available for Oncology patients and despite the sickle cell and Thalassaemia patients being cared for in the same building, the Macmillan advice service is not available to them.

The next section summarises the main themes that derived out of the interviews.

Common themes in the settings

One of the most obvious advantages of having a partnership arrangement within a hospital setting is the opportunity for patients in that a specialist team is already in place to help deal with existing or arising welfare benefit or other social welfare issues. In terms of welfare benefits, going into hospital can affect a person's entitlement to benefits and some benefits can stop. In addition, patients in receipt of benefits may have been reassessed and disallowed benefits to which they may be entitled. Having onsite services can assist to overcome these issues and to maximise income for these patients on discharge.

Integrated services of advice workers in secondary and tertiary healthcare settings facilitates easier access and saves time and therefore money in the long-term, for instance, by way of freeing up social worker and discharge workers' time. 'Having an onsite advice service also means that the advice workers are more trauma-informed and knowledgeable of the ailments

presented by the patients.'[13] As a result, advice workers have greater awareness of the patients' individual needs and requirements and are more equipped to tailor and approach issues such as benefit and housing applications with this bespoke knowledge on behalf of patients.

Sadly, we do not have the space in this report to share all our interviewees experiences and stories, we are very grateful for the time they gave to speak with us and tell us about their amazing work. Building on the literature review, we decided to draw together common themes to explore the integrated services in our study and highlight the similarities and differences, informed by the interview data, in five themes: (1) individual personalised approach; (2) knowledge sharing; (3) collaboration and integration; (4) support structure; and (5) cost saving.

1. Individual personalised approach

Co-location enables a holistic approach to patient's welfare. The patient's physical and mental health improves by dealing with all the presenting issues at the earliest opportunity. Thus, co-location does not just improve a patient's discharge experience and wellbeing, but it may reduce readmission rates and can potentially reduce visits to other organisations and institutions longer term. As one interviewee mentioned "I think the longer you're in hospital, the more problems you're likely to have"[14] referring to the negative, somewhat cumulative effect on a patient's social welfare the longer their hospital stay, thus demonstrating the advantage of co-location in being able to tackle and resolve multiple issues when the patient is most in need.

The foundation of the onsite service is that patients can learn to trust the social welfare team. As one interviewee put it: 'it is good to be on site otherwise the follow-up would not be good. It is important to see patients and meet with them to gain their trust.'[15]

Most of the interviewees reported housing as one of the main issues they were supporting the patients with. Some of the interviewees reported that many of their patients do not have suitable accommodation to return to following a stay in hospital, and for many patients, having suitable accommodation is of primary concern for their health. Further, suitable placements were stated as being of vital importance to those young patients who may need support once in the community to aid their recovery. However, problems were also identified in terms of lack of support for the vulnerable once discharged. Homelessness was cited as a problem facing patients, as well as examples where housing was not sorted out prior to a discharge, discharge could be delayed, for even up to 3 months while a placement was found. One of the interviewees expressed relief that the eviction process had been stayed during the pandemic as private landlords were prevented from seeking to evict whilst patients were in hospital. Overwhelmingly, the interviewees were of the opinion that the shortage of housing and availability of suitable accommodation was a major concern affecting discharge.

[13] This corroborates with a study done on a Macmillan cancer support service in Manchester which showed that the service was effective, as due to their co-location in the hospital advisers were better equipped to navigate the welfare system with patients given their specialist knowledge of the impact of a cancer diagnosis. Full case study is available at: https://www.macmillan.org.uk/documents/aboutus/research/researchandevaluationreports/benefitsadviceservice-manchestercasestudy.pdf

[14] Interviewee A – 09.03.2021.

[15] Interviewee D – 04.03.2021.

In terms of dealing with welfare benefit issues, Universal Credit was noted by the interviewees as being problematical. Universal Credit is a benefit which calls for a claimant's identification and very often, patients enter hospital without this. Not having the necessary identification means that claimants cannot get advanced payments and so cannot pay their rent during their hospital stay.

All of the interviewees were of the view that receiving benefit advice in the hospital setting improved wellbeing and enabled them to have additional income upon discharge. For instance, there were reports of discharged patients being able to afford to improve their diet or have income to support them with tasks such as gardening.

Interviewees reported that this individual personalised approach was greatly appreciated by the patients and their families and they often were the biggest champions of the service and often show their appreciation through Thank You cards.'[16]

We attempted to illustrate here how the individual and person-centred approach taken by the teams of advisers and medical practitioners can provide the patient with the best possible support for their often-complex needs to then make the step out of the hospital into their lives. It is crucial to think of the advice provided as a collaborative project and part of the hospital journey and a pathway for patients who need social welfare advice.

2. Collaboration and integration

The Collaboration and integration varied across the settings we looked at. In some settings there is an excellent referral and communication system and in others, some interviewees felt that it could be improved to make the service even more efficient.

For social welfare advice to work well in a hospital setting there needs to be good communication between the various teams. In general, our interviewees advocate for a more visible service; a service that could address anything outside of the physical or mental health problems for which the patient was in hospital. This would act as a general advice hub which would be able to cover legal issues, advocacy and welfare benefits. This, advised some interviewees, would be easier and better than relying on signposting to external services where patients may not follow up. This was thought to be really important as people often present with a cluster of problems such as welfare benefits, housing issues, employment and financial issues. However, as with the current services, any such advice hub would need to be well communicated to all relevant staff as some interviewees reported a reluctance by some nursing staff to submit referrals – possibly as the service was not properly understood and also as a result of rotating staff members.

Where the referrals work well, it can be of huge benefit for the patient on discharge. For example, interviewees reported assisting patients with applications for Personal Independence Payments and Attendance Allowance and receipt of this benefit would affect readmission rates and also the quality of life for individuals. Many interviewees stated that some patients would not be able to complete these benefit forms due to ill health, age, and not being digitally savvy. Therefore, this kind of assistance would ensure optimum support and continued social wellbeing.

A further importance of collaboration and integration was identified as being the need for timely advice. All of the interviewees noted the need to get the advice at the right time (and

[16] Interviewee D– 04.03.2021.

each site had different ways of achieving this) otherwise, if a social welfare problem is not picked up, then the issue can be more complicated and it may also impact on the advice given. It may also mean people losing out on money and also add to already existing stress.

Concern was raised by some interviewees about the need for more understanding between the NHS and local authority social services. Dealing with welfare benefits on site has been demonstrated to be of great advantage, however, often the hospital will have to rely on social services for further support and assistance. For instance, when housing is required before discharge, despite the very best endeavours of the onsite services and the hospital staff, the provision of suitable accommodation, or simply accommodation, is often only available through the local authority and social services and where this does not materialise, then hospital delay is inevitable.

The benefit of integrated services has been visible throughout the pandemic and although there were in some instances, an increase in patients wanting advice and assistance, plus waiting times may have increased, there were more opportunities for joint working and collaboration. For instance, it enabled increased communication through patient talks, dissemination of knowledge through training and articles and a closer connection to NHS England. This notion of joined up thinking and inclusiveness was a key message throughout the interviews.

Finally, a common thread was the need for continued and more funding to keep these valuable services going. Many of the interviewees reported the continued struggle for funding and that when cuts were needed, then as a non-statutory service, their funding could be cut. Some interviews reported needing more staff to satisfy demand and it was generally accepted that with more funding, more could be done to increase collaboration and integration.

The overwhelming view of all interviewees is that partnership arrangements can only work well if there is sharing of knowledge and good communication with all staff within the setting. This leads to the next theme of sharing knowledge.

3. Knowledge sharing

Co-location leads to a system of knowledge sharing between clinicians and advice workers whereby clinicians become better able to spot non-medical issues presenting in patients requiring advice. One interviewee mentioned providing training sessions for their colleagues and sharing relevant changes to benefits such as Universal Credit as part of their integration in their hospital. Another interviewee mentioned providing training sessions for clinicians and new staff members (particularly junior doctors and consultants due to their additional time pressures) to increase awareness of the advice service and its offerings within the hospital.

Although the pandemic meant that most advice provision transferred to remote services, it was generally accepted amongst the interviewees that being on site was preferable and that it is easier to have connection to patients and the staff. Further, being on site facilitated knowledge sharing. Some of the interviewees mentioned that having onsite services available made them feel more confident and as they themselves had knowledge of the services, they were able to better manage the expectations of the patients. This can be vital in reducing the distress surrounding social welfare needs and possibly indirectly improve medical outcomes.

In turn, not having knowledge of the advice services or not having advice services on site can lead to negative consequences. For instance, lack of knowledge of the service or lack of any

service may mean that patents either have to wait for advice, or they do not receive any advice and get discharged without advice; or in some instances, discharge can be delayed due to not having the advice, as mentioned before.

Another important value identified through the interviews was knowledge sharing with the patients and how, by empowering them, may provide patients with confidence and enable them to stay well thus preventing a return to hospital. This is especially important for those long-term patients who may have lost work and risk losing their home and getting into debt. If people are not empowered and provided with the knowledge to manage and cope once they have left hospital, then there is a higher risk of patients being readmitted, not necessary to the same hospital, but to a different institution.

Knowledge that the services exist are an important part of the patient journey and the question of funding was expressed by some interviewees as they noted that the staff and other team members always supported any request for repeated funding to keep the services going. In this way, measurement and evaluation tools can be effective in proving the value of the advice service. Wellbeing surveys[17] can be conducted prior to and after receiving advice to gauge outcomes.

In one hospital setting[18], the advice service uses a similar method of Lickert scale questions which is used to assess the progress of the health and wellbeing of individuals. Before receiving advice, clients are assessed and given a baseline on a scale of 1-5. Following advice provision, clients are then asked questions regarding the effect of the given advice on their lives and their subsequent ability to deal with their problems. Not only are financial gains recorded, which gauge the quantitative and cost-benefit value of the service, but the improvement in wider social determinants affecting patients. Thus, the importance of robust, appropriate and credible approaches to measuring the impact of advice services cannot be understated, particularly in proving the value of the service against the common backdrop of insecure and unsustainable funding.

4. Support structure

For these services to continue, the infrastructure needs to be in place and this means that they need to have buy in from across the staff, departments and hospital and also from the funding body, the Trust and where appropriate, the Clinical Commissioning Group.
This feeds into collaboration and integration and also to knowledge sharing outlined above. From the interviews we conducted the departmental and staff alliance was clearly present and the longevity of the services within this pilot study exemplifies how an integrated and supported approach can benefit the hospital community. However, without higher level support and without funding, such services would not exist. Therefore, data from the services, and knowledge sharing of the benefits of the services is integral to their continued existence.

Although each of the advice services within this pilot varied in the terms of the model and structure (and also in terms of their reporting requirements for funding) the commonality was the support and stakeholder engagement acknowledging the value of the service which enabled them to continue.

[17] (n 1), pp. 62-63
[18] GOSH Hospital

5. Value of integrated services

The value of advice provision within hospitals can be observed as a benefit to all types of hospitals and not only those dealing with tertiary care or long-term stays. As one interviewee[19] suggests in relation to the issue of general hospital discharges:

"People are identified for discharge and they are discharged from hospital ruthlessly, within a matter of hours, often. I think there is less awareness and interest in peoples' housing and welfare needs. The more you know about them [social welfare needs] the more you need to do to sort them out. I think they [advice services] would have a very important role to play in a general hospital."[20]

Not only does advice provision within hospitals offer the opportunity for welfare needs and wider social determinants of patients to be addressed, but also underlying it are the potential costs savings by reducing hospital admissions and subsequent bed-blocking in the first place. Indeed, this issue of bed space is a pertinent issue in all hospitals but especially general hospitals who are faced with greater demand and pressures on bed space.

6. Cost savings

We will expand on the point of saving costs for the NHS below and explore some modelling options. Here we continue to build on our data to provide evidence from the settings we looked at. Some of our interviewees stated that they would love to see benefits advisors in hospitals in the UK, particularly in mental health units, or, as the example from Leicester shows, for those patients with conditions that may be less well known, but nevertheless have long term impacts on people's ability to cope. Interviewees stated that many people are unaware of disability benefits they are entitled to and are therefore not claiming them. The biggest problem advisers faced is keeping up with the changes of the benefits system. There was concern amongst the interviewees that if advisers had difficulty keeping up with legislative changes, then how could patients possibly do so. People are unaware of where to access advice or where to seek help.. The lack of early advice for social welfare problems can lead to problems escalating and becoming more complex and such problems can ultimately end up in the judicial system. The consequences can be dire and include being plunged into poverty, being rendered homeless and in the long term can even lead to death and suicide. Ultimately, intervention at the right time is not only for the social good but it would save the public purse.[21]

It was further noted that in the short-term patients would receive money, which would allow them to reduce the stress of daily living such as bills and food in the long-term benefits are 'about having put them in a place for stability and a platform to deal with clinical issues (no data but pretty clear to me).'[22]

In sum, there are many cost-saving arguments for integrated services, three are highlighted here:

1. *Co-location frees up bed space.* In one setting, a night's stay in a hospital bed costs on average £500. One interviewee mentioned several instances of patients having to stay

[19] Interviewee J – 26.04.2021.
[20] Interviewee D – 04.03.2021
[21] Interviewee E - 03.03.2021.
[22] Interviewee D – 04.03.2021.

in hospital for 2-3 months due to outstanding housing and benefits issues preventing their discharge. Hence, these delayed discharges can lead to costs of £30-40,000 in each case. Notwithstanding that there are statutory mechanisms for hospitals to reclaim for delayed discharge, these are not often used. The co-location of advice in healthcare settings can aid in resolving the apparent divide between the NHS and social services and enable efficiency. The lack therefore of co-location can end up costing the public purse in the long-term due to delays.

2. *Cost saving in the long term.* Although there are costs associated with the provision of advice onsite and to maintain a partnership hub, the longer-term benefits are very worthwhile. If people leave the hospital setting with their benefits and other social welfare matters sorted then there is a higher likelihood that they will stay well, will hopefully have the knowledge of how to seek help in the future and are less likely to return to hospital. The next part introduces a discussion about economic benefits and outcomes.

3. A further concern is the potential of *using up valuable clinician time and costs* in trying to assist with social welfare issues. In our pilot survey on the hospital site with no advice service provision, patients were turning to the nursing staff to seek assistance. Whilst the nursing staff do their upmost to guide and assist, there is a time element involved with this and either this time is taken from valuable nursing time, or, the staff put in extra time which then has consequences for their own wellbeing.

Economic benefits and outcomes

Using feedback from our interviews we conducted a preliminary cost-consequence analysis (CCA) to evaluate the potential economic costs, patient benefits and outcomes associated with welfare advice services in the broader sense. In carrying out this economic analysis our aim was to understand the potential for integrated advice services to add broader economic value.

CCA is a form of economic evaluation that details the costs, and potential outcomes, associated with an activity or intervention across several distinct categories. CCA is particularly suited to the evaluation of pilot studies[23], interventions involving multiple stakeholders or viewpoints[24] and provides a transparent way of identifying where costs and benefits are likely to be realised[25]. CCA is one of several approaches recommended by NICE to evaluate public health interventions [26] and has been applied in numerous healthcare related evaluations. [27]

[23] Hunter, R., & Shearer, J. (2018, September). *Cost-consequences analysis - an underused method of economic evaluation.* Retrieved from National Institute for Health Research: https://www.rds-london.nihr.ac.uk/wpcms/wp-content/uploads/2018/09/Cost-consequences-analysis-an-underused-method.pdf

[24] Brazier, J., Ratcliffe, J., Saloman, J., & Tsuchiya, A. (2016). *Measuring and Valuing Health Benefits for Economic Evaluation (2 ed.).* Oxford: Oxford University Press.

[25] Trueman, P., & Anokye, N. K. (2012). Applying economic evaluation to public health interventions: the case of interventions to promote physical activity. *Journal of Public Health*, 32–39.

[26] McIntosh, E., & Edwards, R. T. (2019). *Applied Health Economics for Public Health Practice and Research.* Oxford: Oxford University Press.

[27] Taylor, R. S., Bentley, A., Campbell, B., & Murphy, K. (2020). High-frequency 10 kHz Spinal Cord Stimulation for Chronic Back and Leg Pain : Cost-consequence and Cost-effectiveness Analyses. *The Clinical Journal of Pain*, *36*(11), 852–861; Charles, J. M., Harrington, D. M., Davies, M. J., Edwardson, C. L., Gorely, T., Bodicoat, D. H., . . . Edwards, R. T. (2019). Micro-costing and a cost-consequence analysis of the 'Girls Active' programme: A cluster randomised controlled trial. *PLOS ONE*, *14*(8), 1-17; Tsiplova, K., Zur, R. M.,

Insight collected via our interviews was supplemented with indicative costings gathered through peer reviewed publications, relevant grey literature and reference costs published by the NHS.[28]

Perspective

The perspective taken for our analysis is from the point of view of hospital trusts. In this case five hospital trusts, of which four are situated in the Greater London area and one in the Midlands. Four of the five hospital trusts currently operate a formal welfare advice service whereas, as stated previously, one hospital trust provides advice through existing clinical and social support teams.

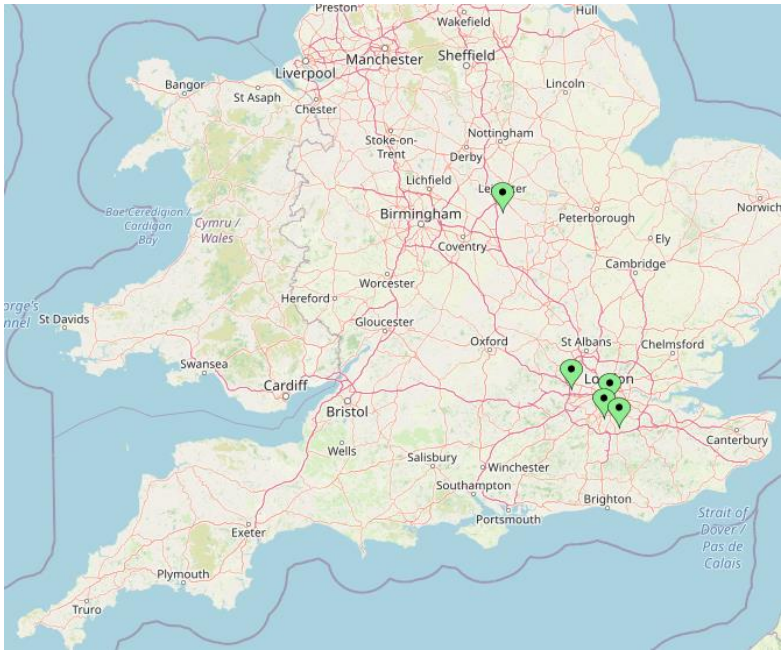


Figure 1 Map of hospital trusts included in the study

Whilst the advice services share several common elements, there exists substantial variation in both the scope and configuration of each service. Not least with respect to the size of the advice team and its composition, the level of integration with other hospital services, the extent to which each advice service actively signpost external support and the welfare benefits covered by the service. These differences may in part be explained by the lack of a national framework for partnership hubs and reflect substantial differences in the local population served and hospital specialisms.

To accommodate these differences, we consider a model of delivery and service configuration that is based on common aspects of each of the advice services studied. At the same time, we have attempted to consider some of the more unique elements of each service. Our reference case on the other hand represents a situation in which no formal advice service is provided (The Leicester Royal Infirmary). Here we assume that many patients either seek advice

Marshall, C. R., Stavropoulos, D. J., Pereira, S. L., Merico, D., . . . Ungar, W. J. (2017). A microcosting and cost–consequence analysis of clinical genomic testing strategies in autism spectrum disorder. *Genetics In Medicine, 19*(11).

[28] NHS Improvement and NHS England. (2020, November). *2020/21 Annex A: The national tariff workbook.* Retrieved from NHS England.

informally or through other external means – such as via the Citizens Advice Bureau (CAB), the local authority or GP services.[29]

The intervention

Figure 2 (below) depicts a map of main processes, entities, issues, and outcomes associated with the advice service at Great Ormond Street Hospital. The map is characteristic of the service in place at other hospital trusts that operate an advice service. The intervention consists of welfare and housing advice that is given to the patients, and or families, that are identified as being in need and eligible for one or more social welfare schemes. In the case of GOSH, this can include the families of children with life changing and/or extremely rare medical conditions. Royal Brompton & Harefield on the other hand is more likely to advise patients that have undergone transplant or have long-term conditions such as Cystic Fibrosis.

[29] The Health Justice Landscape in England & Wales: Social welfare legal services in health settings, Beardon, S. & Genn, H. (2018), available at: https://www.ucl.ac.uk/access-to-justice/sites/access-to-justice/files/lef030_mapping_report_web.pdf,

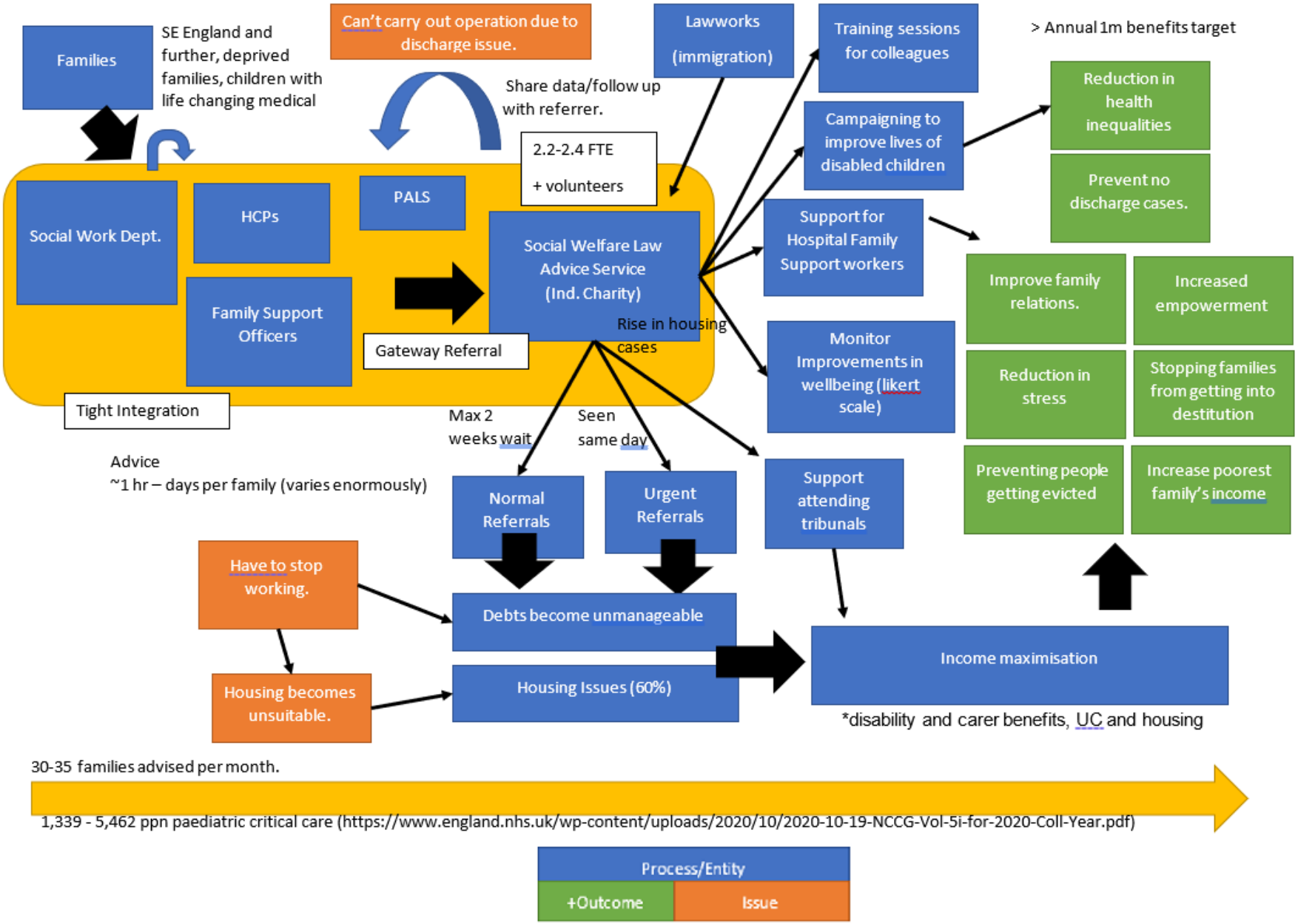


Figure 2 : GOSH Map

Although there is scope for self-referral, a common theme across all services is that patients and their families typically access the service by one or more referral routes. This can include through charitable organisations, social support, family support officers and health care professionals (HCP). Upon referral patients and their families are prioritised according to the urgency of their needs. Urgent cases can include those patients without appropriate housing, which can impact upon the hospital's ability to safely discharge them and lead to delays. At the same time complex operations, for instance those involving transplant, may be postponed until suitable housing is available post-operation. In such cases the advice service will aim to ensure that they are handled on the same day or within 24 hours. Less urgent cases may have a lead time of 1-2 weeks. Advice may be given over the phone, by email or through face-to-face appointment. Excluding volunteers, advice teams themselves mostly consist of small teams (between 2-8 FTE employees) including advisors, social workers, and administrators.

As a comparison, Figure 3 (overleaf) depicts the main elements and processes of the informal advice service in operation at Leicester Royal Infirmary. In this case, advice is provided by a nursing team operating across the local network. Patients will typically access the service following a clinic appointment or through doctor referral. Common forms of support include help filling in welfare benefits application forms and the drafting of supporting letters. As with the formal advice service, key outcomes relate to reducing stress and anxiety due to financial concerns and increasing the likelihood of a successful claim.

Key activities of the advice service

In addition to providing advice, the activities undertaken by the advice team where there on onsite services might also include but is not limited to:

- training for other members of staff;
- raising awareness of eligibility of different benefit schemes;
- keeping up to date with relevant changes in local and national government welfare policy;
- help with the preparation and completion of welfare applications;
- support in the appeals process and attendance at tribunal hearings;
- coordination of medical and non-medical evidence to support welfare applications;
- drafting letters of support for housing applications;
- liaising with external organisations offering specialist support (e.g., debt welfare or immigration advisors);
- conducting annual or semi-annual post-advice surveys as part of overall monitoring and reporting;
- following up referrals with HCP.

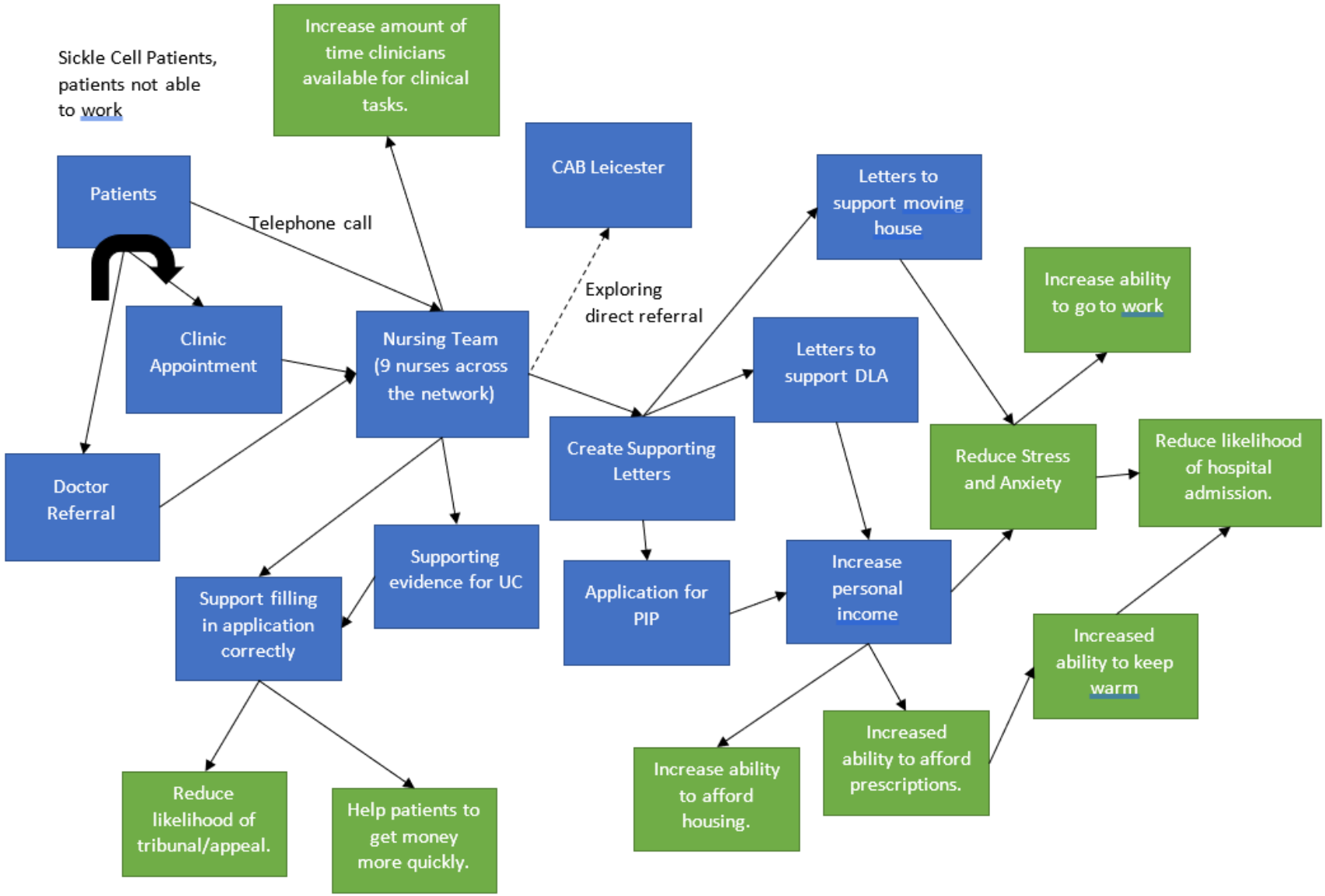


Figure 3 Map of the Leicester advice service

Patient demand and service characteristics

In terms of demand, the approximate number of new patients that access the service per month, together with their high-level characteristics, is depicted in table 1 (below). Note that this number does not include ongoing casework or follow up advice. At the same time, raw patient demand is not directly comparable across the hospital trusts due to differences in hospital size and the fact that advice services are not necessarily available in all wards. As our interviews took place during the pandemic it is also not clear that these figures represent the long-term average demand for the service.

Springfield University Hospital was found to have the highest number of newly referred patients compared with Royal Brompton & Harefield which had the fewest. Most hospital trusts indicated that there was a high probability of patients using the advice service multiple times.

From our interviews the types of patients that were identified as being most likely to use the service include:

- those with life changing medical conditions.
- those of working age that are unable to work due to illness.
- those with mental health disorders[30], including personality disorder, paranoid schizophrenia, or obsessive-compulsive disorder.
- those on low incomes experiencing difficulties paying for necessities such as food and heating.
- younger people with low paid jobs or on "zero hours" contracts.

The time required to provide advice (service time) was found to vary considerably depending on the complexity of each family's or patient's individual case. For less complex cases it was estimated at being in the region of 1-2 hours but could take several days. For some patients providing advice could consist of forwarding key literature and online materials, whilst for others it may involve helping them to prepare the relevant welfare application. The maximum amount of time patients and families were expected to wait (lead time) to receive advice was two weeks, however patients would likely be supported much earlier than this.

[30] This would tend to be corroborated by mental health charities. See https://www.mind.org.uk/media-a/2930/money-mental-health-2016.pdf

Table 1 Details of Patient demand and Service Characteristics[31]

NHS Trust	Patient Demand (monthly ex. casework)	Patient/Family Characteristics	Service Time	Lead Time
South London and Maudsley NHS Foundation Trust	180	A wide range of Mental Health illness,	1h consultation + 3h casework	Urgent: within 1week Non-urgent: 1-2 weeks
Great Ormond St Hospital for Children	30-35	Deprived Families, Children with Life Changing Medical conditions	1h – days per family (significant variability)	Urgent: aim for same day Non-urgent: Max 2 weeks
Leicester Royal Infirmary		Sickle Cell Patients, those unable to work due to health		
Royal Brompton & Harefield hospitals	50	Patients with transplant surgery, Lack of money for food and/or heating. Cystic Fibrosis Patients, young adults with complex health needs, and low income individuals and families.)	1h – half day per patient	Urgent: within 2 working days Non-urgent: within 7 working days.
Springfield University Hospital	400	Mental Health Patients, Low Income Groups, Carers, All Ages	Up to 1.5h appointments	Urgent: within 24h.

[31] Patient demand is based on data obtained through interviews and is not directly comparable due to differences in advice service availability.

Generalised service model

Figure 4 (below) depicts a generalised service model capturing the main patient flows through the advice service, from arrival at hospital (at the top) to post discharge (at the bottom). It is intended to illustrate how patients interact with the advice service, the type of financial welfare schemes that the patient and or family might receive, and the longer-term benefits of the advice given. For instance, HCPs may refer a patient to the welfare advice service following a routine clinic appointment that raises welfare concerns. According to factors such as their age, their income or medical or physical disability the patient may be eligible for one or more welfare benefits. In this case the welfare advice service can help preparation of the relevant application and support the patient in gathering the required medical and non-medical evidence. This may culminate in the successful award of a welfare benefit and a corresponding increase in personal income. The model also highlights how for specific areas not routinely advised on, such as debt or immigration issues, the advice service may need to refer the patient to external organisations such as the CAB.

Intervention costs

Costs associated with the advice service primarily relate to staff time, including for the provision of advice and in carrying out other fundamental activities of the advice service. As an illustration, we assume a 37.5h[32] working week and an average service time of 4h (1h for initial consultation and 3h of casework) per patient. An advice team comprising of 3 FTE AfC[33] Band 5 advisors would have a maximum theoretical patient capacity of 99 patients per month. Assuming 15% of the advice team's time is allocated to training and development then a more conservative estimate would be 85 patients per month. Using 2018/19 estimates of NHS staffing unit costs[34] we arrive at a direct cost of £54,110[35] per advisor, yielding a total cost of £162,330 or approximately £159.24[36] per patient. Note that in practice year one, costs of the advice service would also incur additional costs associated with setup, e.g., initial training and recruitment.

Benefits and outcomes

The benefits and outcomes are discussed for hospital trusts, patients and families, central and local government, external advice centres and partnerships.

Hospital trusts

From the perspective of the hospital trust the main financial benefits of operating the advice service were found to relate to the reduction in bed blocking. This includes cases where the hospital is unable to discharge a patient due to lack of housing or housing that is unsuitable. Such cases may arise where a patient has fallen into rent or mortgage arears due to prolonged hospital stay or experienced a life changing event that requires adaptation of their home. Similarly, a hospital may face costs associated with the cancellation or postponement of operations in cases where there is uncertainty surrounding the ability to safely discharge a

[32] We are assuming 1599 hours worked annually.
[33] We are assuming that the welfare advice team would be paid under the NHS Agenda for Change scheme.
[34] See https://www.pssru.ac.uk/project-pages/unit-costs/unit-costs-2019/
[35] This figure includes wages/salary in addition to overheads, estates, and salary oncosts such as national insurance.
[36] The cost per patient would rise by 32.5% to £211 and fall by 11% to £141.96 in the case that the advice team was comprised exclusively of Band 6 or Band 4 employees, respectively.

patient to their home. Secondary financial benefits may arise from the reduction in the amount of time taken by HCPs in providing informal advice and freeing up time for clinical activities.

Patients and families

From the perspective of patients and families, the main financial benefit of the advice service is the successful award of one or more social welfare payments, including back-payments and increases in existing benefits. This can include Personal Independence Payments (PIP)[37], Universal Credit (UC)[38] and Disability Living Allowance for Children (DLA)[39]. The amount awarded under these schemes varies considerably according to various factors including level of disability, age, employment status and the level of existing savings. Secondary financial benefits would relate to a reduction in fees associated with debt collection and interest payments.

Whilst not all claims will ultimately be accepted, and similarly a small proportion of families and patients may choose not to take up support, a key assumption is that the advice given increases the probability of a successful claim. This is largely due to (1) the advice team's ability to identify the most relevant welfare scheme according to patient eligibility criteria; (2) greater knowledge and understanding of the claims and appeals process; and (3) support in gathering required evidence and documentation.

Local and central government

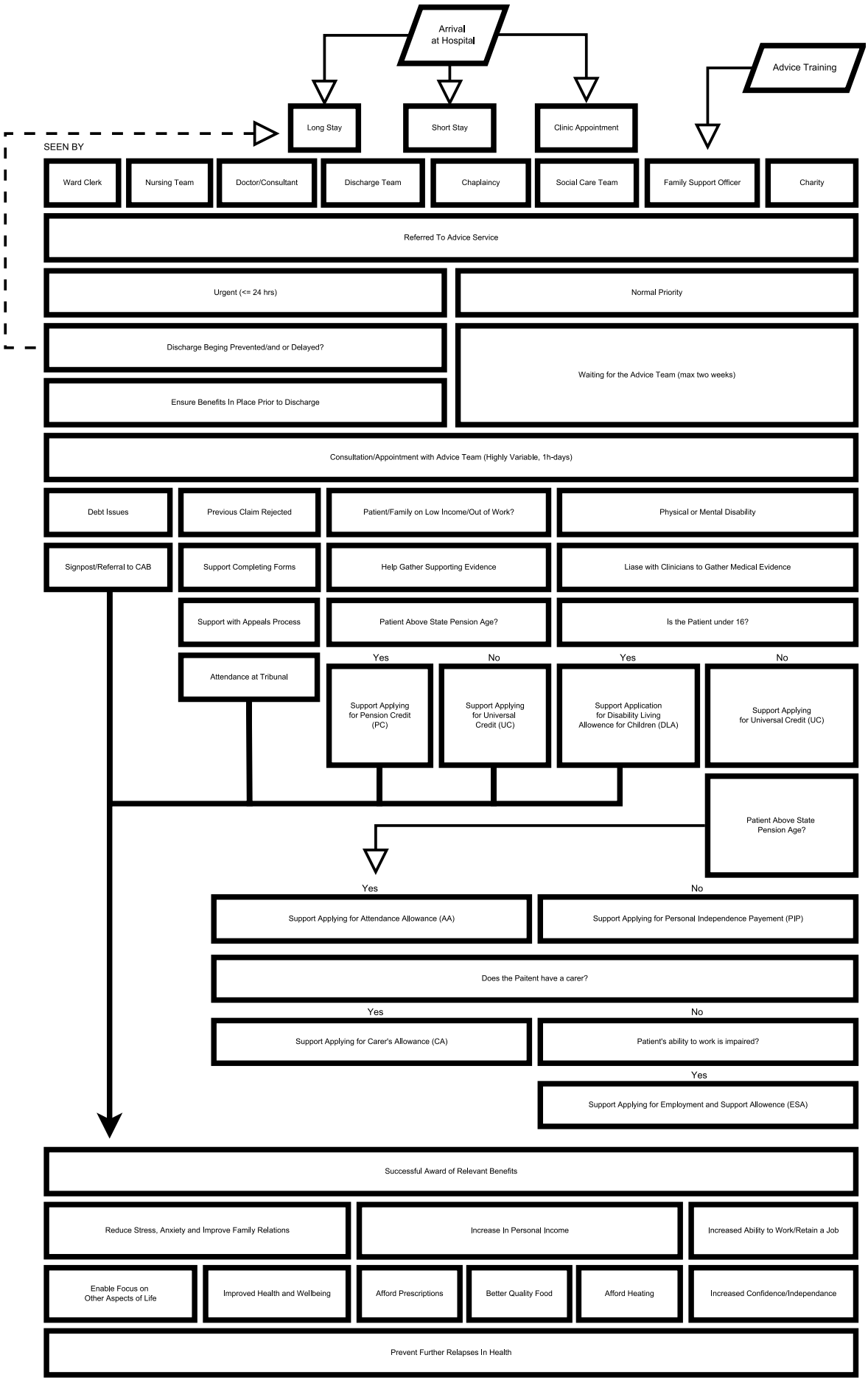
From the perspective of government, we expect that the main financial benefits associated with the co-located advice service to be associated with the reduction of court and legal costs associated with the appeals process. This would arise because of the increase in quality of submitted welfare benefits applications, including those that are supported by valid medical and non-medical evidence. Such costs could include those arising from first tier tribunals, such as tribunal judges' time and the expenses of the tribunal panel, and the costs associated with litigation of tribunal appeals. A secondary financial benefit for the government could relate to the reduction in time spent processing incomplete or invalid welfare benefits applications.

External advice centres and hubs

From the perspective of external advice centres and hubs, such as the CAB, we anticipate financial benefits associated with the reduction in the demand for advice from patient cohorts that are advised internally by hospital trusts. This would include a reduction in the number of appointments handled and time spent following up welfare applications requiring input from the hospital. Even in cases whereby patients and families still follow up advice given by the hospital advice service with external advice centres, we anticipate a reduction in the amount of time spent on each case due to the hospital advice service helping to initially progress or bootstrap the application process.

[37] See https://www.gov.uk/pip
[38] See https://www.gov.uk/universal-credit
[39] See https://www.gov.uk/disability-living-allowance-children

Figure 4 Characteristic patient pathway through the advice service



Outcomes

Notwithstanding the direct financial benefits, all hospital trusts interviewed identified a range of non-direct patient benefits associated with the operation of the welfare advice service. Many of which are corroborated by our literature review.

Key benefits cited included improvements in mental health and wellbeing, largely because of the reduction in stress associated with being in debt or experiencing housing uncertainty (Jones, 2011); (Dalkin, et al., 2018). The overall reduction anxiety would likely contribute towards reducing depression, helping to improve family relations, and lead to more time being available to focus on other aspects of their life.

The increase in personal income would also enable individuals to take better care of themselves and their family by ensuring that they are able to meet rent or mortgage payments to prevent homelessness and eviction, afford basic medical necessities, such as prescription medicines, and raise the quality of their diet. Furthermore, the increased financial support would enable a greater proportion of working age individuals to keep working and retain their employment, leading to an increase in personal confidence and independence.

Welfare advice service, through links with charities, are also sometimes in a better position to offer financial support to those with no recourse to public funds that would otherwise not be able to get support. Being collated within the hospital setting also enables advisors to take a more holistic view of each person's needs with input from different teams, including clinical and social care professionals.

Summary of findings

In Table 2 we bring together the findings of our initial cost consequence analysis. The two scenarios include the case where there is a co-located advice service and one in which there is only informal advice.

Table 2 Summary of our initial cost consequence analysis

	Scenario	
COSTS	**Co-located advise service**	**Informal advice**
Hospital Trust		
Direct costs of the welfare advice service	Estimated at £141.96 - £211 per patient based on 3 FTE advisors seeing 85 patients/families per month	
Costs of informal care by HCP (e.g., ward nurses)	Can potentially be avoided or reduced.	Nurse time estimated at £92-£113 per hour[40].

[40] Cost per hour of band 5-6 nurse contact, see: https://www.pssru.ac.uk/project-pages/unit-costs/unit-costs-2019/

	Requires clinicians to be integrated into the advice service and refer where appropriate.	Potentially 2-3x costlier per hour than the advice service Less time available for clinical activities
Cost of delayed discharge due to unsuitable housing/no housing	Can potentially be avoided or reduced. Increases the likelihood that benefits are in place beforehand.	Significant variation according to hospital type and speciality £400-500 per night (on average) £1339 per night for paediatric critical care beds[41]
Cost of postponement or cancellation of operations due to lack of suitable discharge destination	Can potentially be avoided or reduced. Increases the likelihood that benefits are in place beforehand.	Estimated at £15,701 per cancelled operation[42] Reduced hospital occupancy
BENEFITS		
Patients and Families		
Assistance completing application	Access to support completing application for a range of difference schemes (including PIP, DLA for children, Universal Credit) For example, PIP ranges from £1232.4-£7911.8pa Support in gathering medical and non-medical evidence, potentially this can be done more quickly due to colocation.	Patient makes application by themselves or with the support of external organisations (CAB) Patient must coordinate their own medical and non-medical evidence. Annual cost of homelessness estimated at £24,000 - £30,000pa[43]
Financial support for those with no recourse for public funds	Advice service has the potential to have greater knowledge of alternative avenues of support (for example, benevolent charities or local schemes)	Greater reliance on the patient/family conducting their own research. Might not have awareness of alternative financial support schemes
Review of existing benefits	Yes, the advice service has an opportunity to perform a review of current circumstances.	Yes, if the patient seeks assistance from external organisations.

[41] https://www.england.nhs.uk/wp-content/uploads/2020/10/2020-10-19-NCCG-Vol-5i-for-2020-Coll-Year.pdf

[42] Based on £400m total costs of lost operating time in England in 2018 and 24,475 cancelled operations, see https://bjanaesthesia.org/article/S0007-0912(18)30643-3/pdf

[43] Based on studies reviewed by the Department for Communities and Local Government (2012). See https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/7596/2200485.pdf

	Can conduct a Mandatory Review to enable the patient to appeal a previous DWP decision.	May still need input from the hospital with regards to medical evidence.
Support in the appeals process	Yes, through mandatory reviews and through attendance at tribunal hearings. Preparation of letters in support of appeals	Will need to seek external assistance
Local and central government		
Reduction in court and legal costs	The advisor's greater knowledge of the welfare benefits system and application process helps to reduce the number of cases that require further appeal by ensuing appropriate documentary evidence is included. Potentially fewer claims are rejected and therefore appealed.	Relies on the patient applying to the relevant welfare scheme and submitting appropriate documentation.
Reduction in time spent processing incomplete or invalid applications	The advisor's greater understanding of the application process contributes towards reducing the number of incomplete or invalid applications.	Relies on the patient to complete the necessary application appropriately or with assistance from external organisations
External advice centres		
Reduced patient demand	Potentially, due to an increasing proportion of patients access advice through the advice service. This may potentially free up capacity to provide more extensive support in other areas. Even when cases as still referred externally there is a greater probability that some of the initial steps in the application and been completed	

OUTCOMES		
For Patients		
Reduction in stress, anxiety, and depression	Fewer fears over being in debt or experiencing housing uncertainty. An overall increase in wellbeing.	
Improved family relations	Less pressure on families More time being available to focus on other aspects of their life	
Increase in personal income	Enable individuals to take better care of themselves and their families. Able to meet rent or mortgage payments. Prevent homelessness and eviction. Afford basic medical necessities, such as prescription medicines, and raise the quality of their diet.	
Increased personal confidence and independence	Help working age individuals to keep working and retain their employment	

Main findings and next steps

This pilot had two aims; firstly, to understand how integrated services work and secondly, to seek to develop a model into proposals for similar integrated services. From our pilot, our main findings are:

1. Integrated advice services within hospital settings can assist at the juncture of people's lives when they are most in need. This need is linked to vulnerability. Individuals who might otherwise cope and not be considered vulnerable can be vulnerable in clinical settings.
2. Patients are treated holistically which can lead to optimum health and wellbeing.
3. The onsite service provision offers multifaceted benefits:

- There are ***benefits to the patients*** which can be financial, social and of benefit to their health. These benefits extend to family members and friends.
- There are ***benefits to the staff*** as they have a referral route for issues not related to health.
- There is a ***benefit to the hospital*** as staff time is taken up caring for patients, and staff are not being overburdened in having to deal with social welfare matters.
- There is a ***benefit to staff wellbeing*** as they can focus on their core functions without feeling they are letting patients down by being confident that systems are in place to support vulnerable patients.
- There is a ***benefit to local government*** as onsite services can liaise with them about patient discharge, discussions can be had around housing and resolving these issues can affect discharge time and affect wellbeing around patient discharge
- There are ***costs savings*** at various levels including avoiding delayed discharge and use of staff time. There is also arguably a cost saving to the wider community as if social welfare problems are not dealt with in a timely manner, then problems can cluster and the consequences can involve other institutions and agencies including the judicial system
- Providing advice in a hospital setting and ***empowering patients*** to deal with their own issues can also lead to a reduction in demand for external advice within the community.
- Is there also a benefit (albeit unquantifiable) about ***aiding patient recovery beyond the hospital setting*** by alleviating stress and worry – which can have physical as well has mental impacts.

Next steps

We plan to carry out a larger evaluation across the UK of the provision of onsite services. Our pilot was only able to consider five sites and it was abundantly clear that the Royal Leicester, where there is no onsite advice service, would greatly benefit from those advice services found in our other pilot sites.

In order to fully understand the landscape, and to assess the long-term cost savings of onsite advice services, we would need to interrogate the NHS hospital landscape to identify how many onsite services already exist and the extent to which, they mirror the main findings in our pilot study. This would enable us to do a more in-depth analysis of the real potential for costs savings. To be able to do this we need to quantify some basic elements of these services:

- We need a census to establish how many advice services exist;
- We need to quantify the impact on hospital services saved (this is not fully understood in the literature, wellbeing outcomes whilst vague are explored much more);
- How much faster do patients get their benefits compared with using the CAB? i.e. time to collect medical evidence is reduced as it is in-house;
- Quantify the numbers of people going through each stage in fig 4, proportion getting each benefit and for how long etc.

Further, as our pilot only looked at the actual settings, we were not able to properly factor in the true value of such onsite services for the patient. A larger project would enable us to interview patients after discharge to understand how the advice had impacted on their wellbeing and their ability to integrate back into society (especially for those who have been in hospital long term). This would enable us to understand the wider societal value of onsite advice services and partnership arrangements as exemplified in The Health and Care Bill.

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Appendix

Literature review

In this brief literature review we provide an overview of existing medico-legal partnerships in Australia / America and emerging agreements in the UK. We chose to look at Australia and America as they have established integrated services we can learn from. It is apparent that the emerging literature in the UK is in its infancy and mainly focusses on health justice partnerships within GP settings.

Australia and America

Medical-legal partnerships (MLPs) have existed in the USA for almost 30 years[44], whilst the Health Justice Partnerships (HJPs) system in Australia came into inception in the early 2010s and has since rapidly expanded into almost 100 sites across the country[45]. MLPs and HJPs are both collaborations between legal and healthcare services, whereby legal advice is provided in healthcare settings. Their purpose is to address legal needs which can create or otherwise exacerbate the wider social determinants encompassing mental and physical health problems such as financial problems, inadequate housing and unstable employment.[46]

From existing medical-legal partnerships and health-justice partnerships in the USA and Australia we organised the review of the literature into the following main themes:

***Partnership arrangements enable timely and quick responses to legal problems*:** Patients receive advice at the right time, which is especially important when dealing with time-critical applications such as housing and welfare benefits. Co-location of MLPs focus on preventative rather than reactive care. For example, having lawyers and advice workers[47] embedded in the setting means they can prevent an eviction rather than react to an eviction.[48] A proactive, preventative approach thus establishes efficiency in the system whereby lawyers and advice workers are able to help more people with fewer resources and ideally address legal problems timely and effectively.

***Clinicians are better able to spot legal and social welfare issues*:** Through co-location, clinicians were able to identify legal issues and refer them to the specialist team. Clinicians could promptly contact advice workers with queries and with time and exposure developed a knowledge base due to witnessing repeat and common issues amongst their patients. Increased awareness of legal issues and the wider social determinants of health can also encourage clinicians to dig deeper into why patients may not comply with medical treatments

[44] Medical Legal Partnerships: A Key Strategy for Addressing Social Determinants of Health - McCabe, H. & Kinney, E. available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2847113/#:~:text=Medical%20legal%20partnerships%20(MLPs)%2C,been%20established%20at%2081%20sites.&text=Medical%20professionals%20are%20taught%20to%20get%20people%20healthy%20and%20send%20them%20home.

[45] Health Justice Partnerships in New South Wales (Mental Health Commission of New South Wales report), available at: https://nswmentalhealthcommission.com.au/sites/default/files/publication-documents/Position%20Paper%20-%20Health%20Justice%20Partnerships%20-%20Oct%202017%20-%20web.pdf

[46] Available at: https://www.ucl.ac.uk/laws/news/2017/nov/centre-access-justice-holds-international-workshop-health-justice-partnerships

[47] Used interchangeably.

[48] Available at: https://www.ruralhealthinfo.org/project-examples/929

and improve their health outcomes in the long run. This holistic approach forges better understanding and consideration on the part of clinicians, enabling them to account for all factors involved in improving patient health and make adaptations to care plans if necessary.

Clinicians in health-justice partnerships end up well-versed in the issued faced by clients which thus enable efficient legal referrals for patients.[49] Clinicians are also able to engage with legal services by directing their queries to the resident lawyer or advice workers and conduct "corridor conversations" receiving quicker responses to issues requiring advice.[50] This system establishes regular and smooth communication where health workers remain confident in referring patients and seek clarification[51]; this reinforces a flexible and informal service, which is able to adapt to the needs of the clinic. Other professionals working in healthcare settings, such as social workers, are also able to gain confidence in understanding the legal/advice services and thereafter assist patients due to exposure through co-location and reduce their stress levels in the long-term.[52]

Co-location can lead to bi-directional, cross-referrals: This occurs where lawyers identify concerns and relay onto clinicians, circumstances that may need medical attention among patients such as a mental health issue.[53] As a result, a 'continuous flow' emerges between health and legal services that optimises health and wellbeing.[54]

Due to the efficient, informal training and multidisciplinary approach, better health outcomes for patients can be achieved. *The Mercy Mental Health Adult inpatient unit* in Australia found that receiving advice reduced stress for patients and reduced readmissions to hospital. Patients were then able to take control of their financial problems, reduce stress and improve their health outcomes in the process.[55]

Patients are able to be supported continuously and with the same contact (e.g., in-house advice worker or lawyer): Co-location enabled patients to develop trust, rapport and confidence in the advice service. The presence of lawyers in the co-located space also facilitated ensuring confidence among patients. Essentially, this meant the advice services are able to utilise trusting relationship between clinicians and patients to identify and efficiently address social and legal issues. A trusting relationship can be vital where patients are sceptical about the presence of a lawyer in the clinic which can be helped by clinicians accompanying patients to appointments. Co-location can also build trust among marginalised communities - who may have complicated relationships with state institutions - by creating a safe place where a lawyer is embedded in a familiar and frequented setting.[56] Co-location necessitates

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[49] Available at: https://justiceconnect.org.au/wp-content/uploads/2018/11/HJPs_Toolkit_final_new_brand_20181023.pdf, pg. 26

[50] https://justiceconnect.org.au/wp-content/uploads/2018/08/HJP_impact-report_year-2_web_FINAL.pdf), pg. 2

[51] See: https://imcl.org.au/RMH_Evaluation%20Report%202018.pdf, pp. 8-11

[52] Partners in care: the benefits of community lawyers working in a hospital setting – Report on the Cross-Site Evaluation of Health Justice Partnerships Between Three Metropolitan Melbourne Hospitals with Inner Melbourne Community Legal (2018) (https://apo.org.au/sites/default/files/resource-files/2019-03/apo-nid227441.pdf), pg. 8

[53] https://justiceconnect.org.au/wp-content/uploads/2018/11/HJPs_Toolkit_final_new_brand_20181023.pdf, pg. 19

[54] Available at: https://medical-legalpartnership.org/wp-content/uploads/2018/09/Using-the-Law-to-Inform-Empowered-Patient-Care-in-Austin.pdf pg.4

[55] https://westjustice.org.au/cms_uploads/docs/westjustice_health-agency-to-court_nov2020_digital.pdf), pg.6

[56] See for example: https://medical-legalpartnership.org/wp-content/uploads/2018/09/Using-the-Law-to-Inform-Empowered-Patient-Care-in-Austin.pdf; see also: https://imcl.org.au/RMH_Evaluation%20Report%202018.pdf, pg.8

multi-disciplinary involvement and investment. Consistent multidisciplinary support from all areas of the hospital is vital. The absence of which can mean that lawyers and advisers spend a large amount of their time providing multi-disciplinary 'warm' referrals and broader case management involving many non-legal issues.[57]

Establishing lawyers and advice workers in healthcare settings also enables consistent support throughout a patient's in-hospital stay. For example, at the *Calvary Public Hospital Bruce HJP* in Australia, a lawyer from the Women's Legal Centre worked in the antenatal clinic of the maternity ward and operated a legal practice on site. Through the on-site service the lawyer was able to support women at all stages of pregnancy and in the postnatal period and immediately respond to all of the legal issues arising during those periods[58]. Particular cohorts – for instance, those suffering from ill mental health - can often face issues which encompass a range of legal issues where a more holistic legal service embedded in the healthcare setting can be important.[59]

Having to otherwise refer patients out for advice can mean clinicians lose the ability to follow up which can be critical in ensuring patients continued optimal health and wellbeing.[60] Co-location means delays in addressing social-welfare issues reduce or disappear as the typical long-waits, by having to refer out and deal with different people with each contact, are eradicated.[61] Indeed, as the *Calgary Public Hospital Bruce HJP* in Australia found, co-location means that when legal advice is offered immediately and the task of contacting an external service or having to explain the patient's situation repeatedly is removed, patients are more likely to receive the help they need.[62] Indeed, having an in-hospital advice centre can often be the first opportunity a patient has to see a lawyer/advice worker due to: unfamiliarity surrounding the cost and logistics of obtaining advice; not knowing that their problems are legal issues; and fears around obtaining advice.[63]

Patients become more empowered: As they receive advice and become informed about their rights and the options available to them and thus feel better in control of their matters, patients become more empowered.[64] Consequently, patients' distress is reduced thus positively affecting readmission rates, issues of relapse[65] and an individual's ability to control

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[57] full report available at: https://westjustice.org.au/cms_uploads/docs/westjustice_health-agency-to-court_nov2020_digital.pdf pg. 62

[58] available at: https://www.communityservices.act.gov.au/safer-families/family-safety-hub/health-justice-partnerships/partner-perspective-calvary-hospital-and-womens-legal-centre

[59] full report available at: https://westjustice.org.au/cms_uploads/docs/westjustice_health-agency-to-court_nov2020_digital.pdf pg. 62

[60] https://medical-legalpartnership.org/wp-content/uploads/2018/09/Using-the-Law-to-Inform-Empowered-Patient-Care-in-Austin.pdf

[61] https://justiceconnect.org.au/wp-content/uploads/2018/08/HJP_impact-report_year-2_web_FINAL.pdf)

[62] available at: https://www.communityservices.act.gov.au/safer-families/family-safety-hub/health-justice-partnerships/partner-perspective-calvary-hospital-and-womens-legal-centre

[63] Partners in care: the benefits of community lawyers working in a hospital setting – Report on the Cross-Site Evaluation of Health Justice Partnerships Between Three Metropolitan Melbourne Hospitals with Inner Melbourne Community Legal (2018) available at: https://apo.org.au/sites/default/files/resource-files/2019-03/apo-nid227441.pdf, see pg. 25 for top reasons patients had not previously seen a lawyer.

[64] Ibid. pg. 7

[65] Relapse refers to a significant increase in symptom severity, significant decrease in social functioning/major change in the pattern of care such as hospitalisation. Using Schizophrenia as an example, where the probability of relapse in a year is 40%, this translates to costs to the NHS of £18000 per episode. Welfare advice can thus reduce the risk of relapse by acting directly on an immediate cause of acute stress such as negotiating debt-write offs or repay schedules to prevent debt problems from reaching crises points e.g. legal action which can trigger relapse. Full report available at: https://www.basw.co.uk/system/files/resources/basw_113418-3_0.pdf, pg. 31

not just their physical or mental health issues but the wider social determinants of health such as their finances, housing and employment.

Co-location simplifies and quickens the process of receiving advice: Clinicians can email, call or attend in-person the onsite advice service. Individuals can, therefore, access direct service provision through places they frequent.[66] This is pertinent amongst harder to reach communities such as those wary of state institutions, those living in rural areas or those with mobility issues, so, co-location can close this gap by enabling ease of access.[67]

Top-down support and secured funding is critical in ensure a sustainable and successful health-justice partnership: Regular multi-disciplinary communication (i.e., between the hospital, lawyers, and health professionals) is a key feature of what makes an HJP successful. For instance, this includes updates and working group meetings to resolve minor issues.[68]

The UK

The majority of the findings from our review of the literature in the UK were based on the workings of health justice partnerships within GP settings. The following publications highlight the benefits of co-location of advice services more generally in healthcare settings within the UK, we grouped them into four themes: (1) mapping advice services in UK healthcare settings; (2) The role of integrated services in healthcare settings; (3) The benefits of integrated services in healthcare settings; and (4) Measuring the impact of integrated services.

Mapping advice services in UK healthcare settings

In 2015 Parkinson and Buttrick[69] conducted a mapping study of advice services in healthcare settings. It called for examples of existing or recent projects which generated 58 examples of advice services working in healthcare settings. More than fifty per cent of mapped examples are based in, or work predominantly in, primary care settings. The mapped study was not intended to provide a census of all advice centres working in healthcare settings but rather provides a cross-section of projects reflecting the scale, scope and diversity of available services.[70]

Beardon and Genn conducted a mapping study in 2018[71] on the health justice landscape in England and Wales. They identified more than 380 services in the UK which encompass national and local charities, local authorities, healthcare services, independent organisations and partnerships of providers. The most common advice organisations working with healthcare services were Citizens Advice (CAB) and Macmillan Cancer Support. CABs make up 43% of the services identified as working in healthcare settings, whilst Macmillan Cancer Support came in as the second most common provider, making up 25% of the identified

[66] ttps://medical-legalpartnership.org/wp-content/uploads/2018/09/Using-the-Law-to-Inform-Empowered-Patient-Care-in-Austin.pdf pg. 19
[67] Nick GOSH report
[68] (n 37) pg. 10
[69] The Role of Advice Services in Health Outcomes: Evidence Review and Mapping Study, Parkinson, A. & Buttrick, J. (2015), available at: https://www.thelegaleducationfoundation.org/wp-content/uploads/2015/06/Role-of-Advice-Services-in-Health-Outcomes.pdf, pg. 57
[70] Ibid.
[71] The Health Justice Landscape in England & Wales: Social welfare legal services in health settings, Beardon, S. & Genn, H. (2018), available at: https://www.ucl.ac.uk/access-to-justice/sites/access-to-justice/files/lef030_mapping_report_web.pdf,

services. These were followed by local healthcare services (15%), other charities and partnerships (14%) which include the likes of Mind, Law Centres, and independent services. Local authorities were identified as the smallest group of advice providers (3%). The majority of social welfare legal services partnered with GP services (49%), followed by mental health services (34%) then hospitals (34%) and lastly community healthcare services (30%).[72]

The role of integrated services in healthcare settings

Beardon & Genn further note that the bulk of previous and continuing research is focused on the element of social prescribing. This is the process by which clinicians such as GPs and nurses refer patients on for services outside of the hospital to deal with social welfare issues presenting amongst patients.[73] Social prescribing 'link workers' then triage referrals connecting individuals referred by medical professionals to wider sources of support in the community.[74] Support includes help with filling in application forms for benefits, representing people at tribunals and taking direct action on behalf of individuals[75]. Similarly, work done by health-linked social welfare legal services included providing training, information and consultancy services for healthcare staff such as educating staff on welfare law, on courses of action and providing information to pass on to patients.[76]

Often, these co-located advice services can be the first time that many individuals seek or receive independent welfare rights advice and, therefore, these services can reach people who would not otherwise have sought advice or may otherwise turn to their GP for support.[77] As such, these services are heralded as being 'in the right place and at the right time'[78] to help individuals.

The benefits of integrated services in healthcare settings

Healthcare services recognise the importance of taking care of and addressing 'practical health' concerns in improving the health of patients.[79] Advice services in healthcare settings were found to reduce the time GPs spend on benefits issues by 15%, reduce prescription costs and appointment times thus freeing up time for more patients[80]. The Royal College of General Practitioners estimates that the average number of consultations carried out by each GP in England per year is currently 10,714 and has increased by 16% since 2008[81] so, this finding is welcomed. The author[82] further points out that early and effective welfare advice provision reduces demand on the NHS, especially amongst people using secondary mental health services. This in turn reduces the length of in-patient stays, prevents homelessness

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[72] Ibid. pg. 22
[73] Ibid.
[74] Ibid.
[75] Ibid. pg. 7
[76] Ibid. pg. 27
[77] Impact of co-located welfare advice in healthcare settings: prospective quasi-experimental controlled study – Woodhead, C. Kondoker, M., Lomas, R., Raine, R. (2017). Available at: https://www.cambridge.org/core/journals/the-british-journal-of-psychiatry/article/impact-of-colocated-welfare-advice-in-healthcare-settings-prospective-quasiexperimental-controlled-study/6A924BB98D8AF5FBF9B8CB9F7C6A1CCE
[78] (n 62), pg. 45. sourced from *Great Ormond Street Hospital & CAB Camden (2013) 'Providing advice in the right place at the right time'. Citizens Advice.*
[79] Ibid. pg. 7
[80] Ibid, pg. 9
[81] Ibid. pg. 38, cited from: *http://www.rcgp.org.uk/news/2014/february/34m-patients-will-fail-to-get-appointment-with-a-gp-in-2014.aspx*
[82] Ibid. pp. 9-10

and reduces the chances of relapse for severe mental illness. Co-location was also found to increase health professionals' awareness of the link between health and welfare as a result of interactions with advice workers in the healthcare setting.[83]

Advice services within GPs can enable effective support for patients to address health inequalities. Indeed, patients often present with several issues encompassing statutory sick pay, housing costs, employment rights and carers' allowance, hence without effective support, navigating the benefit rules which for instance govern hospital stays can be extremely complex.[84] Appropriate and effective advice is particularly crucial for individuals accessing secondary or tertiary care services, which can help mitigate the impact of their medical needs on their longer-term health and wellbeing.

As mentioned above, many studies have been undertaken with Citizens Advice and Macmillan Cancer support services. Consequently, a lot of the previous studies are based on advice provision in local communities or - in the case of Macmillan Cancer support – specific demographics such as those diagnosed with cancer. A recurrent finding in these studies is that integrated advice services are helpful in assisting patients to get all the bespoke information and resources they are entitled to. Cancer patients otherwise accessing advice through conventional channels can find that advisers have a lack of understanding of cancer, it's treatments and so miss some of the available financial help available to patients.[85] As a result of co-location, advisers become knowledgeable in the health situations of patients whilst healthcare workers simultaneously become more 'benefit aware' and are able to signpost and advise patients accordingly leading to a reduction in appointment times.[86]

Measuring the impact of integrated services is likely to be key in ensuring their sustainability

Parkinson and Buttrick's report found that the perception of advice services as 'preventative services' presents a further challenge to measuring and demonstrating impact in this area for providers, funders and councils due to fewer tangible outcomes[87] and the reality that physical health benefits may take longer to show up following advice intervention. Indeed, Beardon and Genn, identify a major issue in the precarious, short-term nature of funding whereby most is sourced from charities and local authorities and 37% of services have funding for less than a year and 68% for less than 3 years.[88] Commissioners were additionally faced with difficult trade-offs often requiring proof that the services would achieve financial savings.[89] Hence, collaboration between commissioners and advice providers in healthcare settings would be useful to ensure that local health and advice needs are indeed being met.[90]

Parkinson and Buttrick's report further highlighted a lacuna in extant research: having outcome measures and evaluation tools agreed jointly by health and advice services would be helpful. This would provide ongoing evidence of the cost and efficiency savings that can be delivered through the co-location of advice services in healthcare settings.[91] Such services

[83] Ibid. pg. 42
[84] Ibid. pg. 44
[85] Ibid. cited from: Moffatt, S., E. Noble & M. White (2012) 'Addressing the Financial Consequences of Cancer: Qualitative Evaluation of a Welfare Rights Advice Service'. Plos One 2012, 7(8)e42979.
[86] Ibid. pg. 46, cited from Noble, E., S. Moffatt & M. White (2011) 'The impact of a dedicated welfare rights advice service for people affected by cancer'. Newcastle University.
[87] Ibid.
[88] (n 64).
[89] Ibid.
[90] (n 62).
[91] Ibid. pg. 11

often need external input and funding as advice centres are particularly vulnerable to cuts and insecure funding as they are not statutory services.[92] In fact, evidence from the mapped services showed that advice providers did not have a requirement to gather evidence of health outcomes or service efficiencies to report back to funders.[93] Jointly agreed measurement and evaluation tools may thus be key in proving the value of integrated services and ensuring their sustainability.

[92] Ibid.
[93] Ibid. pg. 62