

**Nuffield Portfolio Programme Report No.17**

**WELFARE ADVICE IN PRIMARY CARE**

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**January 2002**

The Northern and Yorkshire R&D Portfolio Programme at the Nuffield Institute for Health is funded by Northern and Yorkshire NHS Executive to support the development of health services research in the region. The Programme includes commissioned research and health technology assessments, research collaborations with the NHS and other academic units and research skills development for NHS staff in the Northern and Yorkshire region. For further information see the Portfolio Programme web site at <http://www.leeds.ac.uk/nuffield/portfolio>, telephone 0113 233 6964, or email [nuffield.portfolio@leeds.ac.uk](mailto:nuffield.portfolio@leeds.ac.uk).

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ISBN 1 903475 14 7

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Leeds  
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## **Acknowledgements**

The authors would like to thank all the people who have provided information for inclusion in this review, and in particular, Stephen Abbott for his help in keeping us up to date.

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# 1. INTRODUCTION

## 1.1 The growth of welfare advice in primary care

In 1999 the National Association of Citizens Advice Bureaux reported that health authorities were providing £2 million to fund Citizens Advice Bureaux (CAB) welfare advice in health care settings (NACAB, 1999: p.2). In addition, local councils are also funding projects throughout the country to provide welfare advice for patients in primary care. Typically, the model these projects adopt involves placing an advice worker within a GP surgery for one session each week. Patients may be referred for advice by the GP and other health care staff or may be able to make an appointment directly themselves.

The rationale and impetus for locating advice workers in GP practices is to address the needs of a patient population who might not otherwise access advice services which are usually situated in town centres. Problems of access may be due to ill health, lack of transport, or simply a lack of knowledge about advice services and benefit entitlement. From the perspective of primary care professionals these services may also be seen as expanding the scope of primary care to address patients social and health related welfare needs, particularly in deprived areas. As Jarman (1985) has put it:

“Many people do not receive the full state welfare benefits to which they are entitled. Roughly two thirds of the population consult their general practitioners at least once a year. General practitioners and community nurses are exceptionally well placed to detect those who are suffering genuine financial hardship but they are not well equipped to give advice about the complex system of state social security benefits. Imparting such advice in suitable cases, particularly where the lack of it is detrimental to health, might be regarded as a proper function of general practitioner and health centres.” (p.522)

On a more fundamental level, the model of welfare advice in primary care may be seen as addressing concerns about inequalities in health relating to socio-economic status (see, for example: Benzeval et al., 1995; Acheson, 1998; Department of Health, 1999; Lynch et al, 2000). Indeed, a specific recommendation of the Acheson report (1998) is to increase the uptake of benefits in entitled groups, and a suggested method by which to achieve this objective is placing ‘welfare counsellors’ in primary care centres in disadvantaged areas (p.35). This would be especially beneficial to pensioners, of whom it has been estimated that about one million, roughly one in four, do not claim support to which they are entitled (Department of Social Security, 1998; quoted in Acheson, 1998: p.35).<sup>1</sup>

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<sup>1</sup> National surveys have shown that mortality rates at all ages in Britain are two to three times higher in lower compared to higher social groups (as measured by social class, economic status, housing, education etc.). Higher levels of illness and disability are also experienced amongst people in lower socioeconomic groups. Similar differentials are found in other countries. The causal mechanisms for these differentials are complex and difficult to determine. Whilst ‘social selection’ may play a minor role in these variations (i.e. poor health may result in lower socioeconomic status), the primary factors appear to be material circumstances and resources, and related behaviours/lifestyles (e.g. smoking). Low income, for example, limits resources for ‘adequate’ housing, food and heating (Fox & Benzeval, 1995; Benzeval & Webb, 1995). Relative income, rather than low income *per se*, may also have psychosocial consequences in terms of the stress derived from not being able participate in social activities (social exclusion), low self-esteem etc. (Wilkinson, 1996). Increased levels of stress may in turn influence susceptibility to somatic disease (see, for example, Elstad, 1998; Watkins, 1997; Wilkinson, 1996).

An exemplary model of welfare advice in primary care is provided by Birmingham District CAB, which offers an extensive service to GP practices throughout the district. During 1997/8 they dealt with 27,010 enquiries and assisted clients to access £1,778,409 of which £1,383,646 was increased regular income and £394,763 was in one off payments. Whilst the majority of the advice work related to welfare benefits (55%), other issues included debt, housing, employment, consumer, legal and relationship problems (Birmingham District CAB, 1998).

Since Jarman's proposal in 1985 there has been a steady growth of projects throughout the country providing advice in GP surgeries. Whilst this reflects the interests of advice agencies and primary care professionals in meeting the needs of patients, it also reflects the developing role of primary care service provision, in a move towards a more holistic and integrated approach to health and social wellbeing (e.g. counselling in primary care, health promotion, well person clinics). For example, Sibbald et al. (1993) reported that about one-third of general practices in the UK provided a counselling service; this estimate has now risen to 50% (Mellor-Clark, 2000). Hoskins & Carter (2000) also report on policy recommendations to widen the scope of community nursing to identify and address welfare benefit needs amongst their patients.

Primary care has seen many organisational changes, most significantly the shift first to fundholding and then to Primary Care Groups and Trusts (PCGs/PCTs). The 1989 White Paper *Working for Patients* (Department of Health, 1989) created a group of General Practitioners who could purchase care for their patients. Some chose to use this facility to either employ other professionals to join the practice team or to purchase specialist help from other agencies. The 1997 White Paper *The New NHS: Modern, Dependable* (Department of Health, 1997) sought to refocus primary care towards the promotion of health as opposed to just the treatment of illness. It also set up the reorganisation of primary care into geographic units under first Primary Care Groups and then Primary Care Trusts. These new organisations would have the responsibility for commissioning services for their population and it was envisaged that they would have some opportunity to prioritise particular local needs. The enhancement of health promotion within primary care via campaigns and clinics has been one way services have developed, with the aim here of meeting targets set for people contacted and included. But within this framework there is also the possibility of a closer link between local circumstances in terms of inequality and deprivation and the pattern of care the PCG/T evolves. It is here that a developing recognition of the validity of linking welfare advice and primary care encounters a potentially supportive organisational framework. For the first time within the NHS there is a single body that combines care for individuals with a responsibility for engaging with population based health needs. (We can note in pre NHS London the success of the Peckham Health Centre 1935-1950 which offered a unique response to health in its totality (Scott-Samuel 1990)).

The need for partnership between health and social care systems, providing a seamless service for patients, has been one of the key messages of recent policy recommendations, e.g. the White Paper *The New NHS: Modern, Dependable* (Department of Health, 1997) and the Green Paper *Our Healthier Nation – A Contract for Health* (Department of Health, 1998). In *Partnership in Action* (Department of Health, 1998) emphasis is placed on 'cross-sectoral working', viewing it as "essential that health and social services authorities, and Primary Care Groups/Trusts [...] regard it as part of their core business to work together towards shared objectives" (1.7).

More recently, *The NHS Plan* (Department of Health, 2000) highlights the need for integrated health and social care provision, “recognising that good health also depends upon social, environmental and economic factors such as deprivation, housing, education and nutrition...” (p.5), and outlines proposals for “500 new one-stop primary care centres”, and new Care Trusts to commission health and social care, to prevent patients “falling in the cracks between the two services” (p.12). It is further proposed that,

“In future, social services will be delivered in new settings, such as GP surgeries, and social care staff will work alongside GPs and other primary and community health teams as part of a single local care network. This co-location of services will make easier the joint assessment of patients’ needs” (p.71; 7.3).

## **1.2 A review of the literature**

The provision of welfare advice services in primary care gained momentum during the 1990’s. Numerous projects throughout the country are now in existence, many of which have reported their results and recommendations. In this review we will examine the outcomes of existing studies in five key areas:

1. The problems raised by clients and help provided by advice workers
2. Income generated through welfare benefit claims
3. Effects of advice on the health and quality of life of patients
4. Effects of advice on patients’ use of health services
5. The benefits of providing this service from the perspective of primary care professionals.

In addition, Appendix 1 provides a brief annotated outline of projects that have sought to offer welfare advice in primary care as identified through a review of the literature. Our aim is to provide the reader with a quick reference to reports and articles including the context of the project, method of evaluation (where reported) and the main results.

The literature reviewed is varied in terms of the source of the material, which includes academic journals, brief reports in popular journals, and unpublished reports. Consequently, the level of detail available about the projects (e.g. problems presented by clients, outcomes) varies widely, as does the level of evaluation incorporated into the project.

The following databases were searched: Medline, Cinahl, Helms, Cochrane library, BIDS, Psychlit, Assia, National Research Register. The terms used in the searches were combinations of the following: ‘welfare benefits’, ‘general practice’, ‘family practice’, ‘citizens advice’, counselling, socioeconomic, income, inequalities (including searches that mapped onto related subjects headings in particular databases). However, since many of the projects have not published reports in academic journals or health periodicals, a substantial number of references are reports obtained through personal contacts with agencies and people responsible for particular projects.

This is not a systematic review – such an enterprise now has specific conventions and we believe that there is not enough robust evidence yet available in this field to meet the thresholds set by, for example, the Cochrane Collaboration (1994) or the NHS Centre for

Reviews and Dissemination (1996). At present our area of investigation offers a wide range of studies of which very few are experimental. There are no randomised control trials and no controlled patient preference trials. There is also, as yet, no meta-analysis. We summarise what is available and give some background to the evidence that exists for the impact of welfare advice in primary care. It should be noted that the absence of firm evidence before service innovation is not unique to this area. Indeed it is commonplace in innovations in primary care (as in many other areas of health and social care).

When one looks at the projects outlined it is clear that the impetus to develop services, identified above, continues. While the link between poverty and ill health has been well established since the Black Report (Townsend and Davidson, 1982) it is the combination of the specific suggestions of the Acheson (1998) report together with the structural changes in primary care that have been a further spur to this increase in schemes. A growing area of service provision needs to draw on both evaluative research and on a systematic review of available evidence. Without this accumulation of evidence we will only be able to claim an intuitive or indicative assumption that linking welfare advice and primary care is likely to positively impact on the health of primary care patients and their families. We will certainly not know what sorts of service make what sorts of impact, who benefits most, if benefits are short or long lasting, if this sort of intervention is the best way to use resources and if there are any negative effects.

This review also discusses the general sense of the demand for and experience of welfare benefits in primary care before concluding with what has been, so far, identified as positive outcomes for such initiatives.

In a study that commenced at the end of 2000 the present authors are in the early stages of undertaking a detailed assessment of one welfare advice initiative, "Health Plus", located in Bradford City Primary Care Trust. We will report on the design of both the initiative and evaluation in this review. Once complete our study will provide some of the information needed to help this area of innovation towards a more secure evidence base. Until this and other evaluative reports are complete those planning, designing, delivering, receiving and studying services can look to this annotated review of the literature currently extant. We offer this work as a resource they can build on.

## **2. PROBLEMS RAISED AND HELP PROVIDED**

Advice agencies, such as the CAB, are able to offer assistance and support on a wide range of issues, including: benefits and social security, debt, housing, tax, employment, consumer rights, family and personal matters. The level of help provided can range from the simple provision of information to representation at court or tribunals.

In the literature reviewed, the majority of issues dealt with by advice workers in GP surgeries relates to welfare benefits, particularly disability benefits such as Disability Living Allowance (DLA) and Attendance Allowance (AA).<sup>2</sup> This ranges from 39% of enquiries (Paris & Player, 1993) up to 80% (Emanuel & Begum, 2000; Coppel et al, 1999). For example, in the project conducted by Middlesborough Welfare Rights Unit

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<sup>2</sup> Since these benefits feature significantly in primary care advice work, a brief outline of them is provided in Appendix 2.

(1999), 527 patients were interviewed during the course of 1 year and 231 (44%) claims forms were completed: 47% of these related to DLA, 19% AA, and 9% incapacity benefits. Other projects have reported a preponderance of disability related benefit enquiries (e.g. North Derbyshire RDA, 1998; Porter, 1998).

This emphasis on disability related benefits reflects the health status of the patient population using these services. For example, in the study conducted by Coppel et al. (1999), 59% of new clients reported that they were disabled. Where other studies report patient health conditions, there is high level of chronic conditions (Abbott & Hobby, 1999; Emanuel & Begum, 2000; Middlesbrough Welfare Rights Unit, 1999; Veitch, 1995). The preponderance of benefits advice may also, however, reflect the focus of the service (i.e. providing benefits advice), and the types of referrals made by primary health care workers. For example, Emanuel (2002) found that referrals tend to broaden over time as primary health care staff become more aware (through training) of the variety of issues that may be dealt with by the advice workers.

Fleming & Golding (1997) report a study of 4 CAB Health Units serving a total of 21 practices throughout South Birmingham. From Table 1 we can see that whilst the majority of enquires related to benefits, a wide range of other enquires were raised relating to consumer, housing, employment, and relationship issues. They also note large variations in the types of enquires across the practices, e.g. enquiries about benefits ranged from 25%-65%, housing 11%-27%, and consumer issues ranged from 1% to 45%.

**Table 1: Client Enquiries Across 4 CAB Health Units in South Birmingham General Practices (1995-6)**

<i>Category</i>	<i>Enquires</i>	<i>%</i>
Benefits	4164	54
Consumer Issues	905	12
Housing Issues	729	9
Employment Issues	394	5
Legal Issues	389	5
Relationship Issues	259	3
Tax Issues	256	3
Utilities	135	2
Other	502	7
Total	7733	100

Galvin et al. (2000) also report a wide range of problems raised in their study of CAB services provided in 7 general practices. They point out that, whilst the “majority of consultations related to financial and social problems, they were not dominated by benefit claims alone. Rather a whole range of problems was addressed which could contribute to ill-health both directly and indirectly. The introduction of citizens’ advice into primary care,” they conclude, “created an opportunity to work within a social model of health addressing poverty, bad housing or poor working conditions and environmental hazards” (p.281).

### 3. INCOME GENERATED

It has been estimated that about one million pensioners, roughly one in four, do not claim the support to which they are entitled (Department of Social Security, 1998; cited in Acheson, 1998: p.35). It is also believed that only 40-60% of eligible claimants take up their disability living allowance and attendance allowance (Craig & Greenslade, 1998; cited in Hoskins & Carter, 2000).

In the studies reviewed a significant number of patients were found to be either not claiming or under-claiming benefits to which they were entitled. Paris & Player (1993) conducted a study of 150 consecutive referrals and found that 39 (26%) were “owed money, due benefit or community charge rebate.” More recently, Coppel et al. (1999) found that 40 out of 270 (15%) patients were owed money because they had been assessed incorrectly or because of changed circumstances. Middlesbrough Welfare Rights Unit (1999) interviewed 527 patients with the result that 231 claim forms were completed. Moore (1999) reports on a project in which it was found that 70% of patients seen by the advisor were entitled to more benefits than they were claiming. Pacitti & Dimmick (1996) report on a MIND welfare benefits service at a local mental health resource centre where it was found that 51% of people attending the centre were not receiving the welfare benefits to which they were entitled. Table 2 provides some examples of the substantial amounts of income that can be raised.

A number of projects have conducted benefit take-up campaigns targeted at pensioners registered with the practice. This approach has been extremely effective in identifying unclaimed benefits and has raised substantial amounts of income. Table 3 presents the outcomes for three such schemes.

The following case study, taken from NACAB (1999: p.4), provides an example of the type of help provided and the income generated through benefits claims:

Mrs A aged 86 has arthritis, hearing problems and weakness in her right side following a stroke. (She lives with her son.) Her income was £77.55 per week. I helped her apply for Attendance Allowance and she was awarded £51.30 per week. Her income is now £128.85 per week.

In the course of the interview she revealed she suffered with urinary incontinence. I referred her to the District Nurse for a continence assessment. She has since been provided with free pads and a commode.

She also had difficulty using the bath and toilet. I referred her to Occupational Therapy for an assessment. Her bath now has been replaced and she finds it easier to manage.

Abbott & Hobby (1999) conducted a survey of 48 patients whose income increased as a result of benefits advice. 69% reported improvements in their health and well-being (reduction of stress and worry) as a result of the extra income, which was used to improve their diet, increase their social activities through the ability to pay for transport, and to pay household bills promptly rather than falling into arrears (p.20).

Access to appropriate advice and assistance for people with mental health problems is of particular concern (Bird, 1998; NACAB, 1999; Pacitti & Dimmick, 1996; Warden, 1996). Paris & Player (1993) found that mental health problems featured significantly in those

patients found to have a claim. Similarly, Jennings & Veitch (1993) report that “significantly more people mentioning mental health problems, rather than any other, were found to have unclaimed benefits” (p.31). NACAB (1999) highlights a number of issues that may face people with mental health problems: emergency admission to hospital can cause disruption to benefits; a stay in hospital can lead to accumulated correspondence and debt; the benefit system is not flexible enough to respond to the fluctuating mental health of some benefit recipients; mental health crisis can be precipitated by practical problems and recovery is aided by their resolution. Since high street CAB services may not be appropriate for some people with mental health problems, specialist services have been developed to address their needs (e.g. advisors placed within community mental health teams).

**Table 2. Examples of income generated for patients by advice workers in GP practices**

Project	Income Generated
<p><b>Jennings &amp; Veitch (1993)</b></p> <p>CAB advice provided in 6 surgeries, 11 health centres and 2 local authority social services department (mental health) sites, as well as offering a specialist service to clients living with HIV/AIDS. North &amp; South Birmingham.</p>	<p>Total inquiries during 1992-3: 5,500.  Total income generated: £331,000 benefits take up  Total cost of funding scheme: £43,000  Average benefits take-up per inquiry = £60.  Average cost per inquiry = £7.79.</p>
<p><b>Veitch &amp; Terry (1993)</b></p> <p>Context A: CAB workers at 10 practices in Birmingham.</p> <p>Context B: Caseworker in post for 12 hours a week between August 1991 and March 1993.</p>	<p>Over three years:  Total inquiries: 7751  Total benefits raised: £447,865  Average per inquiry: £57.79  Total cost of funding scheme: £81,400  Average cost per inquiry: £10 50.</p> <p>£180,077 in extra benefits for 3042 inquirers.</p>
<p><b>Paris &amp; Player (1993)</b></p> <p>CAB workers in 10 Practices in South Birmingham.</p>	<p>Study of 150 consecutive referrals (314 issues).  39 (26%) owed money, due benefit or community charge rebate.  50 claims made on their behalf totalling £58,300, for 1 year, of which £55,000 was recurring.</p>
<p><b>Middlesbrough Welfare Rights Unit (1999)</b></p> <p>2 Welfare rights officers for 1 year to provide benefits advice in 13 GP practices.</p>	<p>527 patients seen; 231 claim forms completed.  Income generation: £1,448,714 raised in unclaimed benefit or increase to existing levels of benefit.  Note: A proportion of this amount relates to benefit awards calculated for the length of the award, e.g. for DLA or AA this could be the total amount in benefit for 3 to 7 years.</p>
<p><b>Coppel et al. (1999)</b></p> <p>Two Welfare Rights Advisors (10hrs/week) based at one Inner city health centre (4 GPs) in Nottingham for 11 months.</p>	<p>40/270 (15%) owed money because they had been assessed incorrectly or changed circumstance.  24 received one-off payments totalling £16,000 (average £666 per person).  16 obtained regular payments totalling £539/week (average £34/person).</p>

<p><b>Sherratt &amp; Jones (2000)</b></p> <p>CAB Welfare Officer in 7 general practices in Gateshead (fortnightly sessions in each surgery). Included dedicated telephone line to enable direct access to CAB worker and latterly restricting referrals to housebound patients.</p>	<p>Total patients seen (March 1995 – March 1998): 693. Cumulative total income generated (actually gained) during 3 year study period: £1,641,865. Main categories: DLA, Income Support, AA. 32% of all referrals received additional benefit (55% of housebound referrals).</p>
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**Table 3. Examples of income generated for patients by benefit take-up campaigns**

<b>Project</b>	<b>Income Generated</b>
<p><b>North Derbyshire RDA Project (1998)</b></p> <p>Mailshots to all patients 60+ over two years (April 1996 – March 1998).</p>	<p>233 claims. 127 won; 6 pending; 73 lost. New entitlement: £250,000. Arrears: £32,000. Total: £282,000.</p>
<p><b>GP surgery in Camden Reported in NACAB (1999: p.5)</b></p> <p>CAB advisor wrote to all registered patients over 80years.</p>	<p>206 patients contacted. 93 (45%) received a benefit. £137,820 in extra annual income. £11,440 generated in one-off payments and arrears. The most common benefit received was Attendance Allowance.</p>
<p><b>Lancashire County Council Welfare Rights Service (2000)</b></p> <p>Benefits check to all listed pensioners at 3 GP practices in Clitheroe Health Centre.</p>	<p><u>Project 1: Contacted all 80yrs+</u> 769 letters sent; 199 (26%) responded; 188 benefit checks conducted; 83 (44%) potential claimants identified. Total 128 claims made. Total unclaimed benefits obtained: £3,856/week or £200,554/year. Range: 65p - £150/week. Main unclaimed benefits: attendance allowance (48%); income Support (23%); council tax benefit (20%).</p> <p><u>Project 2: Contacted all 75-80yrs</u> 775 letters sent; 182 (23%) responses; 174 benefits checks conducted; 109 (63%) potential claimants identified. Total 196 claims made. Total raised: £5,839/week or £303,660/year. Range: 70p to £172/week. Main unclaimed benefits: attendance allowance (47%); council tax benefit (23%); income support (18%). Note: Higher income from Project 2 due to more couples (two claims) and home visits.</p>

#### **4. EFFECTS OF ADVICE ON THE HEALTH AND QUALITY OF LIFE OF PATIENTS**

Many of the projects listed in Appendix 1 report anecdotal evidence illustrating the benefits of advice on patients' health and well-being as a result of increased income, resources obtained and problems addressed with the assistance of advice workers. Three studies have, however, further attempted to evaluate the benefits of welfare advice on the health and well-being of patients over time using standardised health outcome measures: Veitch (1995); Emanuel & Begum (2000); Abbott & Hobby (1999; 2000).

Veitch (1995) administered the Nottingham Health Profile (NHP) to 52 patients at referral to an advice worker and 6 months later.<sup>3</sup> Whilst there was a trend towards improvement in health status, there were no statistically significant differences for any of the NHP categories (p.17). Veitch considers a number of reasons that may account for the absence of a significant effect:

- 1) the sample size was too small to show significant differences
- 2) the NHP may not have been sufficiently sensitive as an outcome measure to reflect the benefits of advice to patients
- 3) extraneous factors relating to social, psychological and economic circumstances may well have affected patients' health and quality of life over the course of the study
- 4) the 6 month follow-up may have been too early to allow the outcome of advice to have an effect on health and quality of life (p.40)

Abbott & Hobby (1999; 2000) did, however, find statistically significant improvements in the following areas of the SF-36 health profile when administered to 48 patients' 6 months after receiving an increase in income as a result of welfare benefits advice:<sup>4</sup>

- vitality (levels of energy and tiredness)
- role functioning – emotional (the limits which emotional problems put on the range and extent of all types of work)
- mental health (degrees of nervousness/calmness, happiness/sadness)

However, when the SF-36 was administered 12 months after referral these improvements had not been maintained (i.e. the differences were not statistically significant – although most of the scores were higher than at referral). Abbott & Hobby (2000) suggest that this improvement may not have been maintained over time due to the high levels of chronic morbidity in their sample: “Given the levels of chronic morbidity and co-morbidity, it is not unexpected that the rate of improvement in health lessened over time” (p.326).

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<sup>3</sup> The Nottingham Health Profile is a self completed measure of perceived health. Part I of the questionnaire, as used by Veitch, requires yes/no responses to 38 statements (e.g. 'I'm tired all the time') grouped into 6 sections: pain, social isolation, physical mobility, energy, emotional reactions, sleep. See Bowling (1997) for further details.

<sup>4</sup> The SF-36 (Short-Form-36) contains 36 statements measuring health status across 8 dimensions: physical functioning, social functioning, role limitations due to physical problems, role limitations due to emotional problems, mental health, energy/vitality, pain, and general health perception. See Bowling (1997) for further details.

Emanuel & Begum (2000) administered the Hospital Anxiety and Depression Scale (HADS) to 40 patients, at referral to an advice worker, and 9 months later.<sup>5</sup> Whilst there was a slight reduction of anxiety and depression, this was not statistically significant. A patient generated index of health and quality of life, Measure Yourself Medical Outcome Profile (MYMOP) (Patterson, 1996) was also administered to patients (31 valid returns) at referral and 9 months later. In this measure, patients are able to specify one or two symptoms (physical or mental) and one activity (physical, social or mental) which concerns them most. They also rate their general feeling of well-being during the previous week. Again, however, whilst there were improvements for symptoms 1 & 2, Activity, & Well-being, these were not statistically significant. (Further analysis was conducted differentiating between those patients whose income did and did not increase, but this involved very small sample sizes from which it is difficult to draw any valid conclusions.)

The lack of a statistically significant effect may be accounted for by a number of limitations in the design of the study. Like Veitch (1995), Emanuel & Begum express concern about the small sample sizes, and whether the outcome measures were sufficiently sensitive to measure the impact of the CAB services on health. They also add that “there can be no doubt that it is very difficult to isolate the CAB intervention from other factors that may influence health status between recruitment to the study and nine months later” (p.33). Finally, in light of the results found by Abbott & Hobby (2000) they also consider the possibility that the 9 month follow-up may actually have been too long, i.e., deterioration in chronic morbidity may have cancelled out any improvements that may have been brought about through advice outcomes.

## **5. EFFECTS OF ADVICE ON PATIENTS' USE OF HEALTH SERVICES**

The studies by Emanuel & Begum (2000) and Abbott & Hobby (1999; 2000) also examined the effect of providing advice to patients on their subsequent use of health services (e.g. GP consultations, practice nurse contacts, prescriptions, referrals to secondary care).

Emanuel & Begum (2000) examined patients' use of services 9 months before and after advice. From Table 4 we can see that for the 9 months prior to referral, the advice group had a much higher rate of GP consultations and prescriptions than the 'comparison group' (the next person on the practice register of the same age and sex). In the 9 months following the advice we can see that there was a slight reduction in the number of GP consultations for the advice group compared to a large increase for the 'comparison group.' The differences between the two groups were not however, statistically significant. The number of prescriptions rose similarly in both groups. Numbers in the other categories were too small to indicate any meaningful differences.

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<sup>5</sup> The Hospital Anxiety and Depression Scale consists of 14 statements relating to anxiety or depression which the patient rates on a 4 point scale. See Bowling (1997) for further details.

**Table 4. Use of health services 9 months before/after advice**

Service	Advice Group (N=39)		Comparison Group (N=39)	
	9 months before	9 months after	9 months before	9 months after
GP consultations	187	165 (-12%)	70	111 (+58%)
Prescriptions	239	278 (+16%)	122	146 (+20%)
Referrals to secondary care	21	18	3	5
Visits to A&E	1	0	0	2
Practice nurse contacts	12	11	13	6
Home visits	3	3	5	1
Out of hours calls	3	5	2	3
Referral to social services	0	0	0	0
Cervical cancer screening	1	7	1	5

Abbott & Hobby (2000) compared use of health services for those patients receiving advice whose income increased and those for whom it did not increase. The hypothesis there was that higher rates of GP consultation follow the debilitating effects of struggling to cope with life on a low income. There were no statistical differences within or between the two groups. However, from Table 5 we can see that there was a trend towards reduction of GP consultations and new drugs prescribed for those whose income increased (compared to little change for those whose income did not increase). We can also see that whilst there was no change in prescriptions and practice nurse contacts for the group whose income increased, there was a substantial increase for those whose income did not increase.

**Table 5. Use of health services 6/12month before and after advice\***

Service	Income increased (N=48)		Income not increased (N=19)	
	Before Advice	After Advice	Before Advice	After Advice
GP consultations	353	308 (-13%)	105	110 (+5%)
Prescriptions	290	283 (-2%)	84	111 (+32%)
New drugs prescribed	131	101 (-23%)	32	33 (+3%)
Referrals to secondary care	58	61	12	16
Visits to A&E	18	11	2	1
Practice nurse contacts	42	43 (+2%)	13	24 (+85%)

\*Abbot & Hobby note that this analysis combines data for 6 and 12 months before referral and follow-up: use of services for those who replied to the 12 month follow-up was recorded for the 12 months before; use of services for those who replied to the 6 month follow up only was recorded for the 6 months before (p.30). 28 patients were followed up at 6 months only.

Abbott & Davidson (2000) investigated the impact of a Primary Care Development Initiative (PCDI) team, consisting of an experienced nurse and two primary care support workers, who provided advice and support relating to health and social care needs to patients in 3 Health Centres (serving 5 Practices with a total of 10 GPs) in inner city Liverpool. Quantitative data on health service use for up to 12 months before and after referral were recorded for 153 patients, e.g. number of consultations with GPs, prescriptions.

From Table 6 we can see that there was a significant reduction in the number GP consultations and new prescriptions for those followed up at 12 months (compared to 12 months prior to referral). Since there were no significant differences for the group followed up at 6 months (compared to 6 months prior to referral), Abbott & Davidson

suggest that it may take more than 6 months before health and social problems are alleviated through advice and support to address health and social care needs.

**Table 6: Changes in NHS usage by PCDI patients before and after advice**

	6 month group (n=36)			12 month group (n=67)		
	Before	After	Change (%)	Before	After	Change (%)
GP consultations	348	329	-19 (-5.5)	558	423	-135 (-24.2)*
Prescriptions	1068	1131	+63 (+5.9)	1355	1431	+76 (+5.6)
New Drugs	266	218	-48 (-18.0)	307	233	-74 (-24.1)*

\* Statistically significant difference (one-sample t-test; level of significance 0.05).

Data was also collected for GP home visits and out of hours contacts, contacts with other members of the primary health care team, investigations, referrals, A&E visits and screening contacts. However, these involved much lower numbers and did not show statistical significance, nor was any pattern of increase or decrease apparent.

## 6. BENEFITS TO PRACTICES

Whilst many GPs and primary health care staff may welcome the provision of advice services within their practices, concern has been expressed about their appropriateness, their efficacy in terms of health gains, and the extra workload that may result as a consequence of the service. As Abbott & Hobby (2000) comment:

“It is not surprising that the prospect of extra and unrewarded work in supporting welfare benefits claims may discourage GPs from welcoming advice services into their practices. More broadly, many GPs do not believe that it is appropriate for patients to discuss social problems with them, even if such problems may influence their patient’s health” (p.324).

A survey of GPs throughout the Mersey region found that social problems, housing and welfare rights were all deemed inappropriate for presentation to and management by a general practitioner. This is despite recommendations by the Royal College of General Practitioners to adopt a ‘biopsychosocial’ approach (Dowrick et al., 1996). Chaggar (1993) expressed concerns about the implications that such services would have on the perceived expectations of GPs as being “responsible for, and indeed expert on, every welfare, social and medical issue that affects their patients” (p.261).

The model of welfare advice in GP practices does not, however, promote the idea that GPs should become experts in this subject. Indeed, the provision of advice workers actually serves as a resource for GPs and other health care staff to deal with these issues. As Veitch & Terry (1993) found:

“The generation of extra income from take up of benefits is by no means the only positive characteristics of the citizens’ advice sessions to date. Doctors and practice staff have welcomed the presence of the advice worker in their surgeries; access to an advisor trained in a wide range of subjects relevant to the everyday problems of their patients has given rise to a great deal of non-medical referral. This has provided a valuable resource to practices working in areas with high levels of deprivation, where a significant proportion of consultations from patients have a psychosocial, rather than physical origin.” (p.261)

Nevertheless, it is clear that GPs involved in the project reported by Abbott & Hobby (1999; 2000) did not approve of the service. Telephone interviews revealed that only one of the nine GPs was in favour of the scheme (p.33), and seven complained about extra paperwork. (GPs supply diagnostic and functional information to the Benefits Agency for attendance allowance, disability allowance or incapacity benefit. They are also required to submit a letter of support if patients appeal.)

These negative views were not, however, shared by other primary care staff. Interviews with an office manager, 2 practice nurses, and a receptionist revealed a positive attitude towards the service: staff appreciated the help provided to patients (counselling and help with completing forms) and liked the fact that they themselves could consult with the advice worker regarding patients circumstances. Emanuel & Begum (2000) similarly report that most admin/reception staff did not feel that the CAB service had an impact on their workload, and that they found it supportive for report writing and referring problems.

Indeed, it would appear that the negative views expressed by GPs in the study reported by Abbott & Hobby are an exception, since other studies report a positive attitude towards the service from GPs and other primary health care staff. For example, Coppel et al. (1999) found that GPs were positive towards the service, despite any extra workload: two of the four GPs interviewed said they did not mind the extra work if it resulted in an increase in benefit uptake. Overall they actually felt that their workload was reduced (p.133). GPs felt that the service was advantageous to them in so far as it “allowed them to refine their medical skills, rather than become involved with more technical welfare rights issues” (p.134). Porter (1998) also found that the service was regarded as an important resource for doctors:

“The surgery CAB presence is also a direct resource for doctors themselves, since they receive many queries from the Benefits agency, and there is much time saved in being able to consult directly with someone holding appropriate and accurate information” (p.10).

A letter providing feedback from one surgery in York (York CAB, 1998) expressed the value of having an advice worker to help patients and the benefits this resource had on the staff:

“In a location where many patients presenting with physical and psychological complaints also have a high incidence of social, financial and housing problems, it has had a huge effect on improving morale of the staff working at Minster Health to have a known person available in the building each week to whom these patients can be referred.”

## 7. GENERAL DISCUSSION

There is no doubt, from the literature reviewed, that patients value the provision of a welfare benefits service in primary care. It is also interesting to note that a survey of patients in Scotland identified the provision of advice about welfare benefits as an area of substantial need in primary care (Hopton & Dlugolecka, 1995a). Registered patients (Total: 3,482) were asked to rank the importance to them of 36 categories of help or advice related to primary health and social care. Overall, 'help or advice about getting benefits you may be entitled to' was ranked 12<sup>th</sup>. However, further analysis of those with the lowest 10% of scores on the general health scale (352 patients) found that this category rose to the rank of 7<sup>th</sup>. (Help or advice about coping with stress was ranked 3<sup>rd</sup>, and 'having the opportunity to talk through a problem at length with someone was ranked 4<sup>th</sup>.) A further study by Hopton & Dlugolecka (1995b) reported a high level of psychosocial difficulties (e.g. problems with money, housing, threat of violence) in the patient population; 20% (76/384) of those reporting a problem spoke to their GP about it, but 28% (104/369) said that they were unsure where to get help. As Hopton & Dlugolecka (1995b) conclude, this clearly indicates that a strategy should be developed to increase awareness and use of different sources of help and advice.

Whilst some GPs have expressed concerns about the additional workload that may ensue as a result of placing such services in practices, most primary care staff appreciate the support provided in dealing with socio-economic issues related to health, particularly in areas with high levels of deprivation. Porter (1998), commenting on the increasing frequency with which doctors are being called upon to assist patients with benefits and debt problems, adds that:

“Doctors have always recognised that many of the health problems they are presented with are stress related, and that many of those stresses are related to the financial and social circumstances of their patients. Whether this presents specifically as a request for help to fill in a benefit form, or as a more general difficulty with debt or relationships, the facility to refer such patients directly, and know they are going to be seen shortly by someone with the precise and appropriate knowledge, lifts a burden from the doctor in surgery” (p.9).

In this respect it is interesting to note that a survey of primary health care workers from 9 practices in Sheffield found that 75% were being asked for help with sickness and disability benefits on a regular basis; 40% reported being asked more than once a week. 61% said that they would like some training, particularly relating to sickness and incapacity benefit, and attendance allowance (Scully, 1999).

As primary care increasingly becomes the centre of health care provision, and expands the range of services to meet the needs of patients, we might imagine more extensive implementation of these services to address the health and social care needs of patients. In this context, Neuberger (1998) discusses the growth of counselling services, physiotherapy, podiatry and osteopathy in primary care as a priority for patients. But, she points out, it is not only health care services that the public wishes to see:

“As primary care expands its range of interests and skills, it becomes more essential that we should see primary care centres as one-stop shops for those services which are determinants of health. These include housing, and some social services...” (p.43)

NACAB (1999) reports on a health project in Tipton, Sandwell (Neptune Health Park) which brings together medical and social services under one roof, including a GP surgery, chemist, optician, day care facilities, a CAB and a wholefood café.

The impending opportunity to offer proposals to establish Care Trusts allows for the commissioning of health and social care from one source. This enables further integration, going beyond Neuberger's vision. Care Trusts can build on examples of other innovations that have brought health and social care together in terms of planning and service delivery – Joint Finance Agreements and, more recently, Health Improvement Plans and Health Action Zones are examples. As with all alliances, how the various collaborators agree on prioritising services, and how different organisational cultures coalesce remain challenges.

Hoskins & Carter (2000) review the role of nurses in addressing patients' welfare needs citing Royal College of Nursing (1996; 1998;) recommendations that community nurses and health visitors should be actively involved in 'poverty profiling' by collecting information about welfare benefits and encouraging their uptake. They argue that community nurses are in an ideal position to address these issues since they are trusted by patients and gain intimate knowledge through daily contact in their homes. This provides an excellent opportunity to collect information about their benefits status and make appropriate referrals to experienced welfare advice workers.<sup>6</sup> New NHS structures, such as Health Action Zones and primary care groups/trusts, enable community nurses to address health inequalities by arguing for welfare benefit uptake projects to be placed high on the commissioning agenda.

Tessa Jowell (Minister for Public Health), when asked about her views on the growing practice of basing CAB advisors in GP Practices, responded:

“Let's hope that in ten years time it's commonplace, so that going to your doctor is not just going to have a short consultation with your GP, but also may be going to see a money advice person, or go to an exercise class, or talk to a nutritionist about balancing your diet” (NACAB, 1999: p.3)

One note of caution can be raised here. Perhaps the expansion of services under the remit of doctor led primary care is problematic because it expands the scope of this form of intervention in a person's life. Ease of access and administrative neatness or efficiency might carry with it some costs. These costs can be in the concentration of knowledge, and scrutiny into, the various aspects of a person's life in one organization. This expansion of the realm of primary care might also detract from a rights based idea of countervailing powers. That is, one organization can act as a check on another, for example by going to a Citizens Advice Bureau one may also pursue a legal claim of redress against one's doctor. Thus, while welfare advice in primary care might be seen as a good thing it also might have costs with respect to privacy, independence and rights. The argument might be that it is better to have

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<sup>6</sup> Hoskins & Carter (2000) refer to a project at Strelley Health Centre in Nottingham where health visitors conducted a poverty profile of their area that highlighted the current inadequate provision of welfare benefits advice. As a result, welfare rights training was organised for the health visitors to enable them to give basic advice and make appropriate referrals to an experienced money advice worker (Boyd et al, 1993). Reading et al. (2000) also report a study of CAB in primary care for mothers with a child under 1 year in which health visitors have a role in identifying financial difficulties and making referrals.

welfare rights advice in primary care in the context of present structures. But perhaps present structures that make access difficult and do not effectively tackle low take up could be modified so that we both offer an effective welfare rights service and do not concentrate the power of intervention into various aspects of a persons life in one organization. (Similar ways of considering the implication of scrutiny draw on the work of Foucault and those many people who have developed his critique of power and resistance, see for example Bunton and Petersen 1997.)

## 8. CONCLUSION

The growth of welfare advice services in primary care meets the needs of patients and primary care staff alike. In conclusion, the following advantages of providing advice services within general practices have been identified in the literature:

1. The service is local & accessible compared to High Street Bureaux; home visits can be arranged (Jennings & Veitch, 1993). Thus advice workers in GP surgeries facilitates access for people who would otherwise be effectively excluded due to age, poor health, poverty, lack of transport, or psychological barriers in visiting mainstream advice services (Galvin et al, 2000; Middlesbrough Welfare Rights Unit, 1999).
2. The stigma of claiming is reduced because the service is legitimised, e.g. if the doctor recommends that an elderly person makes a benefits claim the resistance to claiming is reduced (Jennings & Veitch, 1993).
3. The service promotes local knowledge of advice services, e.g. many people are not aware of the range of services offered by CAB, often thinking it's just about consumer issues (Jennings & Veitch, 1993).
4. The service increases health workers knowledge of advice services and benefits, thereby enabling them to address patient needs and provide a more holistic service (Fleming & Golding, 1997; Moore, 1999). As such, the service raises the awareness of primary health care staff about the socio-economic needs of patients (Emanuel & Begum, 2000) and thereby legitimises the discussion of health related psycho-socio-economic problems (Moffat et al, 1999; Porter, 1998) rather than 'blocking' these issues, due to lack of knowledge or resources (Emanuel, 2002).
5. The presence of an advice worker in the surgery serves as a resource for health professionals when dealing with health related benefits claims such as disability living allowance, e.g. their experience and knowledge saves time for GPs completing forms and ensuring correct claims are submitted (Porter, 1998). The service therefore increases the efficiency of health related claims and appeals through proximity and team work (Fleming & Golding, 1997; Moffat et al, 1999).
6. The service provides a resource to practices working in areas of high deprivation where a large number of consultations have an underlying psycho-socio-economic basis. Advice workers are an extra resource for advice, support and referral of patients in dealing with welfare issues, thereby relieving pressure on GPs and other primary health care staff (Coppel et al, 1999; Emanuel & Begum, 2000; Scully, 1999; York CAB, 1998; Little, 1995).
7. The service may lead to an improvement in the health and quality of life of patients (Abbott & Hobby, 1999; 2000).

8. Improvement in the health and quality of life of patients may lead to a reduction in patients' use of NHS resources, e.g. consultations, prescriptions (Abbott & Hobby, 1999, 2000; Emanuel, 2002; see also Bundy, 2001, Burton & Diaz de Leon, forthcoming).

It is important, having reviewed the various projects that have been conducted to note any 'lessons learned' from their implementation within primary care services. Three particular issues are noted below:

1. It is important to provide training for members of the primary health care team about appropriate referrals to the advice worker. Referrers need to be aware of the range of assistance provided in order to avoid inappropriate referrals and ensure use of the service (e.g. Emanuel, 2002; Hoskins & Carter, 2000; Reading et al., 2000; Sherratt et al., 2000).
2. Communication & collaboration between the advice worker and the primary health care team is important in order to provide feedback about the service (referrals, actions, outcomes), resolve service issues, and ensure involvement of health staff (e.g. Coppel et al., 1999; Emanuel, 2002; Fleming & Golding, 1997; Sherratt et al, 2000; Moffat et al., 1999). Some projects report limited communication due in part to the limited time devoted to client advice sessions in the practices.
3. Advice work in primary care, compared to generic advice work, may require relatively longer sessions and longer-term involvement with patients to address complex problems and deal with follow-up work (Fleming & Golding, 1997; Reading et al., 2000).

## **9. PROSPECTIVE STUDIES**

Two major research projects are currently underway investigating the impact of advice services in primary health care settings.

The Health and Community Care Research Unit at Liverpool are conducting research into the impact of welfare benefits advice and debt-counselling services in primary health care settings (Hobby & Abbott, 1999b). The project, which is funded by the National Lotteries Charities Board, is evaluating services provided by CAB and Local Authority Welfare Rights services at 6 sites throughout the UK. Evaluation began in October 1999 and results should be reported in 2002.

The project has been designed to replicate the study by Abbott & Hobby (1999), but on a much larger scale aiming to recruit 500 patients at referral to allow for 40% being lost to follow-up at 12 months. (On the basis of previous research it is estimated that 25% of those asked will agree to participate.) The extent to which any income and expenditure of patients and their households are changed by having used advice services will be recorded along with the impact on health-related quality of life of patients (including use of the SF-36 outcome measure). Outcome measures will be administered at referral, 6 months and 12 months. Use of NHS services for 12 months before and after referral to advice services will also be examined. A comparison with non-primary care advice services will also be made, in terms of the nature of consultations, benefits applied for etc.

The Health Plus Project in Bradford has been funded for 3 years by the National Health Action Zone (HAZ) Innovations fund. It is managed through the Bradford City Primary Care Trust and evaluated in association with the School of Health Studies, University of Bradford by the two authors of this review. The overall aim of the project is to improve the health & quality of life of patients attending primary care practices by providing a network of qualified advice workers and counsellors throughout inner city GP practices (potentially 44 practices). Specific objectives of the project are to: 1) Provide access for patients to appropriate advice and counselling relating to issues such as benefits, debt, housing, immigration, personal or relationship problems; 2) Reduce the demand upon primary health care teams by addressing patients' needs for advice, support and counselling in the areas identified above.

The project has commissioned local advice agencies to employ generalist advice workers to provide practice based advice surgeries (one session per week) in GP practices throughout the inner city. Members of the primary health care team (GPs, nurses, practice managers and reception staff) are able to refer patients for advice on welfare benefits, debt, housing etc.

Specialist advice workers (welfare benefits, immigration, debt, housing and employment) have also been recruited to provide consultancy for the advice workers and take referrals on complex casework, such as appeals or court work. The project will also be recruiting a number of 'community support trainees' to assist the advice workers in helping patients, and to gain experience and training in advice work.

In addition, the project has funded 4 (2 WTE) primary care counsellors to provide practice based counselling. GPs and advice workers may refer patients experiencing 'life crises' for brief intervention counselling (6-12 sessions).

The project is being evaluated in association with the School of Health Studies, University of Bradford. Specific objectives of the evaluation are to:

1. Record the number of patients using the service, issues presented, advice given, action taken and outcomes (including income generated as a result of welfare benefits claims).
2. Assess any changes in health and quality of life for patients as a result of using the service. For those referred to advice workers, the SF-36 Health Survey Questionnaire and the Hospital Anxiety and Depression scale will be administered at referral to an advice worker, and at 6 months and 12 months follow-ups. For those referred to a counsellor, the CORE (Clinical Outcomes in Routine Evaluation) system (Core System Group, 1998) and the SF-36 outcome measures are being used.
3. Assess any changes in the use of health care services (consultations, prescriptions) as a result of using the service (data will be collected for the 6 months prior to referral and 12 months after).

Interviews will also be conducted with patients, members of the primary health care team, advice workers and counsellors to obtain their views about the service.

Advice work and counselling in GP practices began in March 2001. Results of the 12-month follow-up, with regard to patients health and well-being, and use of health services will be reported towards the end of 2002.

The study conducted by the Health and Community Care Research Unit at Liverpool is aiming to obtain more robust evidence about the efficacy of welfare benefits and debt

counselling in primary care settings. The scope of the Health Plus study at Bradford is wider, providing advice and counselling across a range of areas. Evaluation of this particular model should provide additional insights into the efficacy of welfare advice and counselling in primary care, in an inner city area where people of South Asian origin constitute the majority - 55% (Bradford City Primary Care Group, 1999).

These two studies, using similar longitudinal designs and outcome measures should complement each other, providing more reliable and in-depth evidence regarding the efficacy of providing advice services in primary care settings.

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## Appendix 1. Summary of studies

Project	Context	Method	Main Results
Abbott & Hobby (1999; 2000); Hobby & Abbott (1999).	<p>CAB welfare benefits advice in 7 GP practices in a deprived part of Liverpool (Speke and Garston). Home visits where necessary.</p> <p>Focus on the impact of income maximisation schemes on physical and mental health.</p>	<p>Longitudinal study: measures at referral, 6 months and 12 months:</p> <ul style="list-style-type: none"> <li>• Structured interviews with service users about their health and quality of life; at follow up: changes in health, role of income in health change</li> <li>• SF-36 health profile</li> <li>• Use of health services (GP consultations, prescriptions, new drugs prescribed, referrals to secondary care, visits to A&amp;E, practice nurse contacts)</li> <li>• Telephone interviews with practice personnel</li> </ul>	<p><u>Participants</u>: 68 interviewed at referral and 6 months later. 40 interviewed at 12 months.</p> <p>Mean age = 57; 56% unemployed, 31% retired; 74% arthritis; 60% physical disability.</p> <p><u>Income Advice</u> 76% (52/68) applied for new benefit. 19% (13/68) helped to re-apply for benefits withdrawn. 71% (48/68) increased income (amounts not specified).</p> <p><u>SF-36</u> Statistically significant improvements at 6 months in 3 domains: vitality, role functioning (emotional) and mental health. <i>But at 12 months improvements not statistically significant.</i> Explanation: improvements reduce over time due to levels of chronic morbidity.</p> <p><u>Use of Health Services</u> There were no statistical differences within or between the two groups. However, there was a trend towards reduction of GP consultations and new drugs prescribed for those whose income increased (compared to little change for those whose income did not increase).</p>
Abbott & Davidson (2000).	A primary care development nurse & 2 primary care support workers provide advice and support to patients referred by the Primary Health Care Team (PHCT) at 3 Health Centres (5 practices) in Liverpool.	Quantitative data on health service use before and after referral, e.g. consultations with PHCT members, prescriptions.	<p>153 Clients.</p> <p>Statistically significant reduction in GP consultations and new prescriptions for those followed up at 12 months (compared to 12 months prior to referral). N=67.</p> <p>There were no significant differences for a group who were followed up at 6 months (compared to 6 months prior to referral). N=36.</p> <p>Conclude that it may take more than 6 months before health and social problems are alleviated.</p>

<b>Project</b>	<b>Context</b>	<b>Method</b>	<b>Main Results</b>
Andalo (2001)	CAB weekly sessions at 4 Practices in Derbyshire High Peak and Dales PCG. Lottery funding will enable expansion of service to 17 surgeries.	Not formally reported, though see High Peak CAB (2000).	It is reported that, “during the past 6 months, CAB staff, working a weekly session at four practices, identified £150,000 in unclaimed welfare benefits for patients.”
Bird (1998).	Advisors for mental health service users at 7 CAB projects around the country based in Community Mental Health teams, hospitals, GP Practices and mental health day centres.	Interviews with service users, mental health professionals, & staff: 106 mental health service users 64 mental health professionals 7 CAB managers 15 CAB paid advisors 3 CAB volunteers	Main user needs: benefits (especially form filling, particularly DLA), finance & debt (especially household bills) and housing.  Critical periods for advice: hospital admission (disrupts benefits claims and may lead to non payment of household bills and rent) and hospital discharge. Also life events such as bereavement or divorce which can result in financial or housing problems.
Blackford (1980).	Brent mobile CAB at two hospitals in London area. ‘Bedside service’ for patients who would not otherwise access CAB.	Not formally evaluated.	Reports that in the first 4 months there were 664 inquiries, including those from Hospital staff.
Blackpool PCG (2001)	CAB advice in 9 Practices (17 sessions)	Information on number of referrals, issues reported for 1 <sup>st</sup> year only.  See Roberts (1999) for earlier evaluation.	Year 1 (1998): 215 clients seen; 1,233 issues. Income generated: £106,000. Year 2 (1999): Income generated: £59,215. Year 3 (2000): Income generated: £76,153  Report that 50% of issues are benefit related – principally incapacity and disability benefits. 20% relate to debt issues; they note that very few come as presenting issues but “tend to come out in the course of one or a series of interviews with clients” (p.14).  Initial low take-up of service increased dramatically over time. Suggest timing sessions to coincide with relevant patient groups, e.g. baby clinic – advice to new parents - or when community psychiatric nurse is on duty. Very little ‘one-off’ advice – mostly in-depth ongoing casework. ‘A large number of clients have mental health, long term physical poor health or disability problems” (p.14). Emphasise importance of Practice staff in making the service a success through referrals.

Project	Context	Method	Main Results
Bundy (2001)	Salford District CAB & Salford City Council Welfare Rights & Debt Advice Service. 2 advice workers in 2 health centres and GP Practice.	Service details: Weekly appointment based sessions & home visits Monthly mailshots offering benefit checks to patients 75+ Training for primary health care professionals to identify entitlements.	Total referrals for 1999-2000: 350; 1,200 issues. 43% advice only, 32% form completion, 25% appeals, reviews or negotiation. 93% benefit related (40% DLA/AA; 17% IS.). Income generated: £129,000 lump-sum payments; £482,000 additional annual income. 75% of patients said that they sought advice only because it was available at the health centre. 91% of health staff had referred patients; 84% received positive feedback from those referred; 44% "felt there had been a noticeable reduction in the number of subsequent visits from those patients referred."
Burton & Diaz de Leon (forthcoming)	6 HAZ funded projects in Camden & Islington aimed at improving health by increasing income through welfare advice.	Evaluation of 6 projects:	<p>South Islington: Welfare rights advice in 9 practices. Jan-Dec 2000: 1,400 patients seen.</p> <p>North Islington: Welfare rights advice in 5 Practices. Started August 2000; 6 months: 465 patients seen or telephone enquires made regarding their knowledge of welfare rights.</p> <p>South Camden: Focus on benefits advice to families with young children who have significant health deficits in one Medical Centre since Jan 2001. Letters to 135 patients explaining the service; 96 interviewed; 69 (72%) taken onto register of benefits advisors (64% Bangladeshi).</p> <p>Camden: Promoting benefits uptake for older people. Outreach to patients 65+ at local community centre and other organisations. Data for 1 year: 325 offered benefits advice; 20% received extra benefits: £114,000.</p> <p>Islington: Whittington Hospital identifies and refers older patients needing income support advice. Social workers refer to advice worker who then visits in hospital or at home. Started July 2000. 30 patients seen at home – all resulted in benefit claims.</p> <p>Kilburn: "Income maximisation advice" at a variety of community locations. From 259 clients contacted, 115 income increases identified.</p> <p><u>Evaluation notes</u> Note problems establishing service in single handed practices with limited staff, capacity and space for hosting advice service. Also note some GPs concerned about increase in workload and attracting the 'wrong patients.' Practices reported that the number of consultations increased initially but that as the projects developed, the number of inappropriate consultations decreased enabling them to concentrate on medical problems. Client interviews found reduction in worry/stress due to additional benefits. Conclude that for every £10,000 invested in benefits advice service, this will raise £100,000 in patient incomes</p>

Project	Context	Method	Main Results
Butcher & Lazell (2000).	GPs at St Budeaux and Cumberland Practices in Plymouth refer patients to advice worker who runs a weekly clinic at each surgery. Checks benefit entitlement, helps to complete claims forms.	No formal evaluation reported.	The scheme has helped patients claim £13,000 in the first 3 months.  Advice worker said: “many patients had said their financial difficulties were a major contributor to chronic health problems.”
Coppel et al. (1999).	Two Welfare Rights Advisors (10hrs/week) based at one inner city health centre (4 GPs) in Nottingham.	Retrospective study of enquiries by 270 patients over 11 months (social characteristics of clients, problems presented, benefits uptake).  Prospective study: 34 interviewed at time of attendance and over 3 months.  Interviews with 11 Primary Care Staff.	<u>Enquiries</u> 305 new enquiries. 84% related to welfare benefits (27% disability benefits, 23% income support, 17% housing). 40/270 owed money (15%) because they had been assessed incorrectly or changed circumstance. 24 received one-off payments totalling £16,000; 16 obtained regular payments totalling £539/week.  <u>Practice workload</u> 2/4 GPs said they did not mind the extra work if it resulted in an increase in benefit uptake (p.133); 2 GPs felt their workload reduced. GPs felt that the service was advantageous to them in that it allowed them to refine their medical skills, rather than become involved with more technical welfare rights issues (p.134).  <u>Conclusions</u> “The welfare rights service was considered by the primary health care team to be a very useful contribution in a highly deprived area” (p.131). 59% of clients had a disability (59%); of these 50% had disability based welfare rights enquiries. The health centre was accessible for these clients.
Cornwallis & O’Neil (1998). (Details from Hoskins & Carter, 2000.)	Money advice worker in 2 practices in Glasgow.	Details not provided.	42 patients seen in one year. £66,785 raised.

Project	Context	Method	Main Results
Emanuel & Begum, (2000).	CAB advisor attached to primary health care team 2.5 days/week. Location: Tipton, Sandwell, West Midlands.	<p>Longitudinal study: measures at referral and 9 month follow-up:</p> <ul style="list-style-type: none"> <li>• Measure Yourself Medical Outcome Profile (MYMOP)</li> <li>• HAD Scale</li> <li>• Patient Questionnaires</li> <li>• Use of NHS services (visits to GP, prescriptions, referrals to secondary services, visits to A&amp;E, and practice nurse contacts)</li> <li>• CAB classifications of problems.</li> <li>• Semi-structured interviews with 10 users and 10 staff.</li> </ul>	<p><u>Participants</u> 55 completed 1<sup>st</sup> questionnaires. 40/55 returned 2<sup>nd</sup> questionnaires after 9 months.</p> <p><u>Outcome measures</u> HADS: Slight reduction of anxiety and depression but not statistically significant. MYMOP: (N=31 valid). Improvements for symptoms 1 &amp; 2, Activity, &amp; Wellbeing, but not statistically significant.</p> <p>Further analysis was conducted differentiating between those patients whose income did and did not increase, but these involved very small sample sizes from which it is difficult to draw any valid conclusions. There were no significant differences on the HADS for 12 patients. On the MYMOP, for those who reported an increase in income (11 patients) there was a significant improvement in ‘activity’; but for those whose income did not increase (21 patients) there was a significant improvement in ‘symptom 2’ and the profile score. Emanuel &amp; Begum note that higher levels of morbidity were found in the group who reported an increase in income: 67% (8) reported 3 conditions or more, compared to 25% (7) of the group whose income did not increase. (Note: the numbers/percentages provided represent the whole group (40), irrespective of completed MYMOP questionnaires (32).) Thus, the lower level of morbidity in the group whose income did not change may account for the improvements, i.e. the higher the levels of morbidity the less likelihood of an improvement in health</p> <p><u>Use of NHS services (9 months before and after advice)</u> At referral, patients receiving advice had more GP consultations and prescriptions than ‘control group’ (next person on register same age and sex). GP consultations decreased; prescriptions rose, but not statistically significant.</p>

Project	Context	Method	Main Results
Fleming & Golding (1997).	4 Health Units incorporating 21 General Practices, each with 2 hour CAB session per week in South Birmingham, Ladywood and Small Heath, plus 5 sessions per week in 4 venues in Castle Dale.	Recorded CAB statistics: issues raised by clients etc. Interviews with 5 case workers, 17 Practice staff, 27 clients	<p>CAB statistics for 1995-6 8000 enquiries/year: 54% benefits. 60% clients had disabilities. Referrals: GP (49%); 37% self-referrals.</p> <p>Benefits of CAB in general practice: local access, appointment system, caseworker continuity, increase health workers awareness of CAB and range of advice offered; endorsement of CAB by health professionals; saves GPs time, e.g. form filling.</p> <p>Key factors of the service identified by clients (p.16):</p> <ul style="list-style-type: none"> <li>• Reduced uncertainty leading to reduced stress</li> <li>• Increased subjective well-being and self-esteem</li> <li>• Increased self determination and empowerment</li> </ul>
Galvin, Sharples, & Jackson (2000).	Health Authority funded 2 year pilot providing CAB services in 7 general practices in Bournemouth.	<p>Interviews with: a) Service users (5 from urban practice; 5 from rural practice); b) 2 CAB Advisors (nature of referral, outcomes, views about location of service); c) Referrers: focus group with 6 GPs (why referred patient, outcomes and views about service).</p> <p>Questionnaire: 50 current service users; mailed to 25 urban and 25 rural; 25 returned.</p>	<p>The results are discussed in terms of the following themes arising from interviews and questionnaires: Awareness of CAB; Access to service; Impact at surgery; Types of advice; Feelings about service.</p> <p>Conclusions: "Locating CAB advisors in GP surgeries facilitates access for people who would otherwise be effectively excluded by reason of age, poor health, poverty or lack of transport ... CAB in GP surgeries are a viable adjunct to primary health care teams in terms of information-giving, social support, up-take of benefits and co-ordination of services."</p>
Glendining & Clarke (2001)	<p>WellFamily service, run by Family Welfare Association, bases Family Support Coordinators (FSCs) in GP Practices, health centres and community hospitals.</p> <p>5 sites: Hackney Practice, Croydon, Newham, Luton, Norfolk.</p>	Evaluation of service over 30 months.	<p>1,300 referrals to the 5 FSCs over 30 month period for counselling, information, advice and practical help, e.g. housing, welfare rights. Clients mainly lone parents and carers (for long-term illness or disability).</p> <p>Report that GP appreciated prompt support to help patients with psych-social problems beyond their own expertise and time. FSCs filled the gap between the work of GPs, health visitor, counsellors and social workers.</p> <p>Patients felt that the service prevented problems from escalating, reduced their contact with the GP, and provided an alternative to dependence on anti-depressants.</p>

<b>Project</b>	<b>Context</b>	<b>Method</b>	<b>Main Results</b>
Griffiths (1992) (Details from Hoskins & Carter, 2000.)	Welfare benefits advice worker and money advice training for primary care staff in a health centre in Islington.	Details not provided.	157 patients advised over 6-month period. £323,000 of unclaimed benefits raised. Average weekly gain per patient: £39.59. 23% of referrals from GPs, 8% health visitors, 6% district nurse.
High Peak CAB (2000)	Advice in 4 General Practices. Advice sessions half-day/week in each practice (appointments and open door; also home visits).	Recorded information on clients, enquiries, income generated for 1 year (1999/2000) in the 4 practices.	Clients seen: 317; Enquiries: 845. Main categories: benefits (46%); legal (19%); housing (10%). Age range: highest category: 41-59yrs. Number of benefits, appeals etc. identified = 91 (91/317=29%). Total annual income identified: £90,000. 2 case studies provided.
Hobby & Abbott (1999b)	Multi-centre research project evaluating impact of benefits advice in primary care.	Longitudinal study using measures at referral, 6 & 12 months: questionnaires interviews; SF-36; use of NHS services (matched with 'control patients' - same age and gender). All clients receiving advice on welfare benefits or debt counselling at each of the six research sites will be asked to participate in the research. Aiming for a sample group of 300.	Project end date: March, 2002.
Jennings & Veitch (1993)	Birmingham CAB in 6 surgeries, 11 health centres and 2 local authority social services department (mental health) sites, as well as offering a specialist service to clients living with HIV/AIDS.	Casework evidence – 3 examples provided.	Anecdotal evidence that GPs welcomed the service which alleviated immediate social need, reduced stress and improved health of patients – especially elderly. Total income generated during 1992-3 for 5,500 inquiries: £331,000 benefits take up; average per inquiry: £60. They note that, “Significantly more people mentioning mental health problems, rather than any other, were found to have unclaimed benefits” (p.31). Concludes following advantages of situating service in health premises: 1) Service is legitimised, e.g. if the doctor recommends that an elderly person makes a benefits claim the resistance to claiming is reduced; 2) Local & accessible compared to High Street Bureaux (and no queues); home visits can be arranged; 3) Promotes local knowledge of advice service: many people are not aware of range of services offered, e.g. think it's just consumer issues.

Project	Context	Method	Main Results
Lancashire County Council Welfare Rights Service (2001)	Benefits check to pensioners at 3 GP practices in Clitheroe Health Centre.	<p>Practice Managers from 3 GP practices based at Clitheroe Health Centre contacted all listed pensioners by telephone or questionnaire asking them to request a benefits check. Welfare Rights Officers then contacted the pensioners (by telephone or questionnaires) to identify unclaimed benefits, obtain claim forms and advise on completion (some at home).</p> <p>Project 1: Contacted all 80yrs+. Project 2: Contacted all 75-80yrs.</p>	<p><u>Project 1: Contacted all 80yrs+</u> 769 letters sent; 199 (26%) responded; 188 benefit checks conducted; 83 (44%) potential claims identified. Total 128 claims made. Total unclaimed benefits obtained: £3,856/week or £200,512/year. Range: 65p - £150/week. Main unclaimed benefits: attendance allowance (48%); income Support (23%); council tax benefit (20%).</p> <p><u>Project 2: Contacted all 75-80yrs</u> 775 letters sent; 182 (23%) responses; 174 benefits checks conducted; 109 (63%) potential claims identified. Total 196 claims made. Total raised: £5,839/week or £303,628/year. Range: 70p to £172/week. Main unclaimed benefits: attendance allowance (47%); council tax benefit (23%); income support (18%). Note: Higher income from Project 2 due to more couples (two claims) and home visits.</p>
Little (1995)	GP Practice in London funded welfare benefits expert.	No formal evaluation reported.	51 patients seen in 2 months. Range of problems, but mainly housing and benefits. "One patient received £2,860 in backdated disability premium after advice."
Middlesbrough Welfare Rights Unit (1999)	2 Welfare rights officers provide benefits advice in 13 GP practices (for 1 year).	<p>Recorded types of problems and income generated,</p> <p>Training and information for Practice staff provided by Social Services relating to key benefits likely to be claimed by the client group. Leaflet produced for staff providing details of advice surgeries and the cases likely to be most appropriate for referral.</p>	<p>527 patients interviewed (67 at home). 161 advice only. 359 = further action; 231 claim forms completed: 47% DLA claim, review or appeal. 19% attendance allowance claim, review or appeal; 9% incapacity benefit claim, review or appeal. 46 clients assisted with appeals or had appeals outstanding.</p> <p>Income generation: £1,448,714 raised in unclaimed benefit or increase to existing levels of benefit. Note: A proportion of this amount relates to benefit awards calculated for the length of the award, e.g. for DLA or AA this could be the total amount in benefit for 3 to 7 years.</p> <p>Practice staff increased knowledge of social security system and role health staff can play in assisting patients through benefits maze. GPs gained insight into importance of medical evidence in respect of benefit applications and need for more claimant specific medical information.</p>

<b>Project</b>	<b>Context</b>	<b>Method</b>	<b>Main Results</b>
Middleton et al. (1993) (Details from Hoskins & Carter, p.393.)	Welfare Rights Advisor conducting two 30 minute sessions per week for 6 months in one Health Centre in Sandwell.	Details not provided.	Phase 1. 52 patients seen (total 325 appointments). 18 patients received £24,751 (£10,393 single payments, £14,358 recurrent for the year 1992-3).
Moffat et al (1999)	CAB welfare advice worker providing weekly sessions in two practices (12 months and 15 months) in 2 large group general practices in Teeside.	Interviews with advice worker, patients (11), and primary care staff (2 GPs, 2 district nurses, 1 practice manager).	Advantages of siting CAB in primary care:  For patients: reduced stigma of seeking benefits, gave confidence to re-apply having had claims erroneously rejected, assisted those with access problems. Also legitimised discussion of socioeconomic problems in the context of health.  For advice worker: increased efficiency of health related claims and appeals through close working with health care team; reduced GPs workload in terms of form filling and ensuring correct claims are submitted; raising awareness of health care team about changes in welfare system relevant to their patients.  For Health Care Team: extra work, but too infrequent to significantly impact on workload; wanted more advice sessions.
Moore (1999)	3 GP Practices in York (Clifton Health Centre) can refer to advisor from City of York Council.	No formal evaluation reported.  Staff provided with basic training.	10 patients/month referred. 70% entitled to more benefits than claiming.  Health care staff positive about project: useful for people in and out of work whose circumstances change (Health Visitor); help with finances and form filling especially for elderly (District Nurse); reduces stigmatisation of claiming benefits, provides additional resource for GPs and enables a more holistic approach to care (GP).  Benefits information advisor: reaches people who would not otherwise access benefits advice (elderly or housebound) who come into contact with GP, practice nurse or health visitor.

Project	Context	Method	Main Results
North Derbyshire RDA Project (1998)	One welfare rights worker in 2 Practices (12 GPs in total) in Derbyshire.	Service included: <ul style="list-style-type: none"> <li>Welfare rights surgeries: 4.5 hours each practice</li> <li>Targeted mailings to pensioners in year 1</li> <li>Training for practice staff</li> <li>Year 2: Survey of 130 patients.</li> </ul>	<p><b>Claims:</b>  Year 1: 491 claims; 59% won.  Annualised payments + arrears: £600,996 (30% adjudicated - potentially realise further £177,484).  50% DLA; 33% AA; 14% income support.  Year 2: 480 claims; 320 successful (61% DLA or AA).  Total for years 1+2: £1,292,406 annualised benefits and arrears.</p> <p><b>Mailshots</b>  Year 1: 105 (22%) of above claims from targeted mailings to pensioners (£135,659 - 23% of total).  Year 2: 22% of claims and payments = £154,580.</p>
North Tyneside Coastal CAB Health Centre service (1997) (Details from Hoskins & Carter, p.393.)	3 CAB workers provide 43 hours of benefits advice per week for 12 health centres.	Details not provided.	Income raised between 1992-7: £1,334,142 in unclaimed benefits (£404,800 raised between 1996-7).
Pacitti & Dimmick (1996)	MIND welfare benefits service at a local mental health resource centre.	Not formally reported.	<p>51% of people attending a local mental health resource centre were not receiving the welfare benefits to which they were entitled.</p> <p>Argue that the only way to guarantee people receive their full benefit entitlement is to ensure that welfare benefits advisers are readily accessible to all people who use mental health services.</p>
Paris & Player (1993)	CAB advisors in 10 Practices throughout South Birmingham.	Prospective study of 150 consecutive referrals. Recorded: social characteristics of clients; CAB codes for problems presented and actions taken by advisor; medical details.	<p>314 problems presented (39% benefits &amp; allowances).</p> <p>39/150 (26%) owed money, due benefit or community charge rebate; 50 claims made on their behalf totalling £58,300, for 1 year, of which £55,000 was recurring.</p>
Porter (1998)	One CAB worker in 3 GP surgeries in North Powys.	No formal evaluation specified.	<p><b>Conclusions:</b></p> <ul style="list-style-type: none"> <li>Clients appreciate help with forms, particularly disability benefits</li> <li>Advisor helps with immediate problems but also provides resources for client to cope with problems longer term.</li> <li>Resource for clients who would not otherwise attend High Street Advice Centres, e.g. elderly, young mothers.</li> <li>Promotes ethos of care in which clients can feel that it is legitimate to discuss psychosocial problems</li> <li>Resource for GPs in dealing with requests from Benefits Agency.</li> </ul>

<b>Project</b>	<b>Context</b>	<b>Method</b>	<b>Main Results</b>
<p>Reading et al. (2000)</p> <p>Further details provided in Reynolds &amp; Mclean (1998), Steel (2000), Reading &amp; Steel (in prep).</p>	<p>CAB services for families with infants in 3 primary care centres.</p>	<p>Recorded referrals, types of problems, income generated. Interviews with users of service.</p>	<p>Of the 106 families recruited to the study, 23 used the service for advice on 49 different problems. Families benefited from advice for 32 of these problems.</p> <p>Most common problems: welfare benefits, debt management, and housing.</p> <p>Income generated: One-off benefits, including debt rescheduling = £17,857. Annual recurring payments = £6,480.</p> <p>Conclude: Advice service in primary care addresses health inequalities. Active promotion of the service by the primary health care team is essential for adequate uptake of the service.</p>
<p>Richards (1990)</p>	<p>Bristol inner city. One advice worker (30 hours/week) for 2 health centres. Funded by Bristol &amp; Weston Health Authority &amp; Avon Social Services.</p>	<p>Not formally evaluated.</p>	<p>Between 1988-9 received 1,300 queries. Raised “tens of thousands of pounds of unclaimed or refused benefits.”</p> <p>Pilot schemes found that health staff were spending time trying to answer welfare rights questions for which they were not trained. Health centre seemed perfect access point for welfare rights advice, especially for sickness, disability or maternity benefits. “Welfare benefits advice had a direct effect on improving the health of the health centre’s users.”</p> <p>Two case studies discussed.</p>
<p>Roberts (1999)</p> <p>Also see Blackpool PCG (2001)</p>	<p>CAB advice service provided to 5 Health Centres in Blackpool.</p> <p>10 months pilot: January - October 1998.</p>	<p>Recorded consultations &amp; enquiries. Patient Questionnaire: 11 returned. Interviews with CAB workers, GPs and health centre managers.</p>	<p>151 clients referred. Total enquires: 728. Main categories of advice sought: sickness benefit (17%); consumer debt (15%); disability benefits (14%); income support (11%). Patient questionnaire (11 returned) found general satisfaction with the service. Interviews with GPs and health centre managers found that service was valued in terms of help and knowledge with forms (e.g. disability claims) allowing them to focus on health related matters.</p>

Project	Context	Method	Main Results
Scully (1999)	<p>Sheffield Advice Centres Group (SACG) Primary Health Care Project</p> <p>2 year project. Aim to increase take-up of benefits through the development of an infrastructure linking primary health care services with existing advice centres.</p> <p>Includes 9 primary health care based advice sessions (2 hours/week).</p>	<p><u>Interventions:</u></p> <p>1) Awareness raising/signposting to promote links and raise awareness of welfare rights in primary care (e.g. leaflet to GPs providing information on advice centres; visits to practices and advice centres.</p> <p>2) Training sessions on the benefits system and advice services.</p> <p>3) Established telephone contact/helplines for health workers; advice workers with special responsibility for linking with primary care; referral procedures between primary practices and advice services.</p> <p>4) Weekly advice sessions at 9 primary health care settings.</p>	<p>Increased income for patients using the service (average £50/week).</p> <p>Survey of 119 primary health care workers from 9 practices found that 40% were asked for help, information or advice about benefits or their money more than once a week. 61% would like training (especially relating to sickness and incapacity benefit, and attendance allowance).</p>
Sherratt & Jones (2000)	<p>CAB Welfare Officer in 7 general practices in Gateshead.</p> <p>Model 1: Fortnightly sessions in each surgery.</p> <p>Model 2: Dedicated telephone line to enable direct access to CAB worker.</p> <p>Model 3: Dedicated telephone line service targeted at housebound patients.</p>	<p>Recorded:</p> <p>Quantitative: referrals, health problems, benefits obtained.</p> <p>Qualitative: interviews with 13 patients, 2 CAB workers; focus groups with 26 primary health care team members from 10 practices.</p>	<p>Total patients seen (March 1995 – March 1998): 683.</p> <p>Sources of referral: GP (53%); nurses (16%); self-referral (10%).</p> <p>Income generated (actually gained) during 3 year study period: £1,641,865. Main categories: DLA, Income Support, AA. 32% of all referrals received additional benefit.</p> <p>Benefits for primary health care team: value help, knowledge and experience in completing forms to obtain allowances.</p> <p>Benefits for patients: accessible location for advice; being referred enhanced feeling of legitimate needs.</p> <p>Note importance of training staff about appropriate referrals and range of assistance provided (concern about inappropriate referrals).</p> <p>Note advantage of Model 2 (telephone referrals) not requiring space at the surgery and avoided unused appointment sessions; referrals were also more relevant. Recommend Model 3 as most effective use of limited resources - telephone referrals limited to patients unable to access central bureau (e.g. housebound, mental health problems): increased relevance of referrals and reduced imposition on practices. Using this model “one worker could cover the patients of the average primary care group on a continuing basis” (p.145).</p>

Project	Context	Method	Main Results
Veitch & Terry (1993)	CAB worker in 10 practices in Birmingham.	Recorded number of inquiries, amount of benefits.	<p>Results over three years:            Total enquiries: 775.            Total benefits raised: £447,865.            Average per inquiry: £57.79.            Total cost of funding scheme: £81,400.            Average cost per inquiry: £10.50</p> <p>They also report on a further project set up in August 1991 using the same model. By the end of March 1993 this project, with a caseworker in post for 12 hours a week, had secured £180,077 in extra benefits for 3042 inquirers.</p>
Veitch (1995)	Birmingham District CAB: 21 practice based projects.	<p>Data collection period 1 month.            Longitudinal study using measures at referral and 6 months follow-up:</p> <ul style="list-style-type: none"> <li>• Nottingham Health Profile (NHP) at referral and 6 months later</li> <li>• Questionnaires (demographic information and satisfaction with service)</li> <li>• Caseworker analysis</li> <li>• Medical details (illness and treatments) from GP</li> </ul>	<p><u>NHP health status questionnaire</u>            131 questionnaires sent at referral.            52 valid questionnaires returned at 6 months.            No significant differences on the NHP after 6 months, although there was a trend towards improvement in health status.</p> <p><u>Casework analysis for 118 clients</u>            Total enquiries: 378 (average 3 per client).            Main categories: 45% social security benefits; 15% consumer &amp; debt; 10% housing.</p> <p><u>Money raised for 37 clients over period of research (p.22)</u>            Total lump sum = £29,000 (range £5.70 - £8,500).            Total weekly sum = £1,400 (range £2.95 - £117.11).</p>

## **APPENDIX 2: DISABILITY LIVING ALLOWANCE AND ATTENDANCE ALLOWANCE**

Based on information provided by Nick Hodgkinson, Welfare Rights and Debt Advice Development Worker, Heartsmart, Bradford District Health Promotion Service.

### **1. Disability Living Allowance**

Disability Living Allowance (DLA) is a benefit for people aged under 65 with physical or mental impairment/s. It can be claimed by children and adults. It does not matter whether the client has paid national insurance and it does not matter whether they have savings or other income. It is paid on top of other social security benefits.

DLA is made up of two components: a care component for people who have personal care needs and a mobility component for people who have mobility problems. Each component has its own conditions of entitlement as well as some common conditions for both components. The rate paid depends on the extent of care needs/mobility problems. The same person can claim one or both components on the same claim form at the same time.

#### **Basic conditions of entitlement – common conditions for both Care and Mobility Components:**

- aged at least 3 months and under 65 years for Care Component (except ‘cooking test’ – see below) *or* at least 3 years and under 65 years for Mobility Component
- must have needed personal care or had mobility problems for at least 3 months (unless ‘terminally ill’) and these must be likely to continue for at least 6 months
- must not be ‘subject to immigration control’ (mainly affects non-British and non-EU citizens and covers people with restrictions on their right to enter or remain in the UK, including almost all asylum seekers)
- must normally live in Britain and have been here for 26 out of previous 52 weeks (unless ‘terminally ill’)

#### **Care Component (3 rates) Basic Conditions of entitlement**

Client must be aged at least 3 months and under 65 years and suffer from physical and/or mental impairment/s causing them to:

A) For the low rate:

- require attention in connection with bodily functions for a significant portion of the day (either in one period *or* a number of periods) *or*
- be unable to prepare a cooked main meal for themselves if given the ingredients (this condition only applies to people aged 16 or over)

B) For the middle rate:

- require frequent attention in connection with bodily functions from another person throughout the day *or*
- require prolonged or repeated attention in connection with bodily functions from another person during the night *or*
- require continual supervision from another person to reduce the risk of substantial danger to self/others during the day *or*
- require supervision from another person who is awake and watching over them for a prolonged period or at frequent intervals during night to reduce the risk of substantial danger to self/others *or*
- require the attendance or supervision of another person (other than NHS staff) when undergoing renal dialysis on a kidney machine at least twice a week

3) For the high rate:

- must meet the daytime attention and/or supervision condition (above) *as well as* the night-time attention and/or supervision condition (above) *or*
- be terminally ill: suffering from a progressive disease and death can reasonably be expected as a result within the next six months

#### Notes

Many of the words and phrases used in the Care Component conditions of entitlement have been defined more precisely by the courts. It is important to understand the meaning of the terms used. Refer to the 'Meaning of Terms' section following the section on Attendance Allowance for a summary of those definitions.

For young people under 16 years old there is an extra test for 'attention' and 'supervision'. A child's needs for 'attention in connection with bodily functions' or for 'supervision to reduce the risk of danger' must meet the above conditions. In addition, their care needs must be substantially in excess of the 'normal' requirements of another child of the same age who does not suffer from a physical/mental impairment.

#### **Mobility Component (2 rates): Basic conditions of entitlement**

The client must meet at least one of the following:

For the high rate:

- be aged at least 3 years old and under 65 years old
- suffer from a *physical* impairment which makes them:
  - unable to walk at all *or*
  - virtually unable to walk (see below) *or*
  - both deaf and blind *or*
  - have no legs or feet *or*
  - be severely *mentally* impaired and exhibit severe behavioural problems and receive highest rate care component

For the low rate:

- be aged at least 16 and under 65 years and suffer from a *physical or mental* impairment and, although able to walk, cannot make use of the ability to walk without supervision or guidance from another person for most of the time when walking on unfamiliar routes outdoors

#### Notes

*Low rate mobility: Extra test for under 16 years old*

A child's need for supervision or guidance when walking outdoors must meet the above test and also be substantially in excess of the 'normal' requirements of another child of the same age who does not suffer from a physical/mental impairment.

*Low rate mobility: Meaning of reassurance and guidance*

The reassurance that a disabled person (e.g. someone suffering from epilepsy) may need due to suffering anxiety when walking outdoors can count as 'supervision'. If a hearing-impaired person needs help to seek directions to avoid getting lost when walking outdoors, this may count as 'guidance'.

*High rate mobility: 'Virtually unable to walk'*

This test ignores the place where a client lives or works but considers whether their ability to walk outdoors is so limited, due to a physical impairment, with regard to:

- the *distance* over which and
- the *speed* at which and
- the *length of time* for which and
- the *manner* in which

they can make progress on foot, *without severe discomfort*, that they are virtually unable to walk or whether the exertion required to walk would constitute a danger to life or would be likely to lead to a serious deterioration in health

Note: people commonly have difficulties providing details about time, distance, etc. A checklist of questions for clients about whether they are 'virtually unable to walk' is included after the section on Attendance Allowance.

## **2. Attendance Allowance**

Attendance Allowance (AA) is a benefit for people aged 65 or over with a physical or mental impairment. It does not matter whether the client has paid national insurance and it does not matter whether they have savings or other income. It is paid on top of other social security benefits. It is paid to people who have personal care needs but there is no provision for help with mobility problems. The rate paid depends on the extent of care needs.

### **Basic conditions of entitlement**

- at least 65 years old
- must have needed personal care for at least 6 months (unless 'terminally ill') and must be likely to continue for at least 6 months
- must not be 'subject to immigration control' (mainly affects non-British and non-EU citizens and covers people with restrictions on their right to enter or remain in the UK, including almost all asylum seekers)
- must normally live in Britain and have been here for 26 out of previous 52 weeks (unless 'terminally ill')

There are 2 rates. The client must suffer from physical and/or mental impairments causing them to:

For the low rate:

- require frequent attention in connection with bodily functions from another person throughout the day *or*
- require prolonged or repeated attention in connection with bodily functions from another person during the night *or*
- require continual supervision from another person to reduce the risk of substantial danger to self/others during the day *or*
- require supervision from another person who is awake and watching over them for a prolonged period or at frequent intervals during night to reduce the risk of substantial danger to self/others *or*
- require the attendance or supervision of another person (other than NHS staff) when undergoing renal dialysis on a kidney machine at least twice a week

For the high rate:

- must meet the daytime attention and/or supervision condition (above) *as well as* the night-time attention and/or supervision condition (above) *or*
- be terminally ill: suffering from a progressive disease and death can reasonably be expected as a result within the next six months

### **Note**

Many of these words have been defined more precisely. It is important to understand their meaning. Refer to '*Meaning of Terms*' below.

#### *Terminal Illness: 'Special rules' and procedures*

Terminal illness is defined as someone suffering from a progressive disease from which death can reasonably be expected as a result within the next six months. Terminally ill clients are automatically entitled to the highest rate of DLA care component or Attendance Allowance. However, they have to claim DLA Mobility Component in the normal way.

### 3. Meaning of terms used in the DLA Care Component and Attendance Allowance

**Require** - reasonably, not medically, required and can include care needed to carry out a reasonable level of social activities.

**Attention** - active intervention of a personal kind. The disabled person must be present to receive attention (shopping for someone will not count). The spoken word can amount to attention, e.g. encouraging someone to get dressed.

**Bodily functions** - eating, drinking, breathing, walking, using toilet/bath, seeing, hearing, un/dressing, reading, walking, sitting, getting in/out of bed etc.

**Significant** - about an hour, either in one period or in shorter periods. Note: if care is needed for several shorter periods at different points in the day (over 24 hours), this may amount to 'frequent attention' (see below) and therefore a higher rate of benefit.

**Cooked main meal** - theoretical test and includes all aspects, physical and mental, of preparing a traditional (*not* microwaved, deep frozen or ready made) cooked main meal for one person using an ordinary cooker. Safety, pain and tiredness may all be relevant considerations.

**Frequent** - several times.

**Throughout** - at various points, not all in one section of the day.

**Continual** - more than occasional but may be less than continuous or non-stop.

**Supervision** - keeping an eye on someone to reduce the risk of harm.

**Substantial danger** - this need not have actually occurred but it must be considered reasonably possible to occur (i.e. not too 'remote') and the danger must be substantial.

**Prolonged** - minimum 20 minutes.

**Repeated** - twice or more.

**Night** - period of inactivity when household 'closes down for the night' – may be somewhere between 11pm and 7am.

#### Further definitions from the Courts and Social Security Commissioners

*Reasonably requires – to lead a full life:*

'The test...is whether the attention is reasonably required to enable the severely disabled person as far as is reasonably possible to live a normal life...What is reasonable will depend on the age, sex, interests of the applicant and other circumstances...'

*Domestic activities – doing something for someone:*

Performing activities such as laundry *for* a disabled person, removed from their presence, does *not* count as attention because the activity is too *remote* from the disabled person. That is, taking the laundry away and doing it *for* someone, removed from the physical presence of the disabled person, is *not* close enough to be considered attention in connection with bodily functions.

*Domestic activities – helping someone to do something for themselves:*

'If a claimant reasonably requires assistance to be able to cook for himself and can do so if he has assistance with, for example, seeing or lifting, that seems to show a requirement for attention in connection with his bodily functions'

That is, if the attention given enables the disabled person to perform the domestic activity *for him/herself* it should count as attention if it is reasonable for that disabled person to perform those activities for him/herself.

*Seeing as a bodily function – acting as someone’s eyes:*

The fact that someone is totally blind and cannot see at all, no matter how much attention is given, does not prevent attention in connection with vision from counting for the personal care test. ‘The attention is in connection with the bodily function if it provides a substitute method of providing what the bodily function would provide if it were not totally (or partially) impaired’.