Reducing health inequities in London by improving access to social welfare advice through greater collaboration between the healthcare, local authority and advice sectors

Good practice case studies

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Transformation Partners in Health and Care

SUPPORTED BY
MAYOR OF LONDON

Bromley by Bow Insights

Strengthening access to social welfare advice in London through collaboration between the healthcare, local authority and advice sectors

Good practice case studies

About the report these case studies taken from

These case studies are drawn from a study on **Strengthening the relationship between healthcare, social prescribing and social welfare legal advice in London**, which builds on years of work in this field by the Greater London Authority, Bromley by Bow Insights, the work of UCL's Health Justice Partnerships' team, Transformation Partners in Health and Care, and studies by the Low Commission, the Institute for Health Equity and others.

In 2023 Bromley by Bow insights undertook an independent study, grant funded by the Mayor of London, on initiatives to strengthen the relationships, partnerships and referral arrangements between healthcare settings, social prescribing and social welfare advice across London, and improve access to advice for social prescribing and those who are socially prescribed.

What is Social Prescribing? Social Prescribing is when healthcare professionals refer patients to support in the community, in order to improve their health and wellbeing. The concept and practice was adopted by NHS England in 2018. Social Prescribing Link Workers are employed in every Primary Care Network in England to receive the referrals from the clinicians and meet with patients to support them in whatever matters most to the patient. Currently in London there are 450 Social Prescribing Link Workers working in the Capital's 200 Primary Care Networks. London's Social Prescribing Link Workers report that around 50% of the patients they see need social welfare advice.

What is Social Welfare Legal Advice? Social Welfare Legal Advice is the information, advice and support given to a client by a Social Welfare Advisor which is based on their legal rights and entitlements. The areas of law that Londoners' most frequently require support with are, housing (including repairs and allocation), welfare benefits claims, and unmanageable dent. Other areas of law that people also frequently need support with include Immigration, Employment Rights (such as discrimination, unfair dismissal), family law, consumer law etc. Most Social Welfare Legal Advice providers hold a quality mark and are inspected and quality assured every two years.

The findings of the study contribute to the London Health Board's Cost of Living task and finish group's report which in turn inform the London Health Board's recommendation, that all Londoners should have access to free, accessible, professional social welfare legal advice. The London Health Board's recommendations call on London's ICSs to commit to action on strengthening the relationship between healthcare and social welfare legal advice, increasing access to advice and providing a viable referral pathway for social prescribing.

This initiative will contribute to reducing health inequalities through improving people's wider determinants of health in the most fundamental aspects of Maslow's hierarchy of needs.

The case for greater collaboration between healthcare, local authorities and advice sectors

Are we heading in the right direction?

The opening lines to the Health Gap, written in 2017 by Michael Marmot and the Institute for Health Equity are:

> ***"Why treat people and send them back to the conditions that make them sick?"***

Of course, they could have been written at the time Michael Marmot and Richard Wilkinson wrote The Solid Facts on the role of the social determinants of health for the World Health Organisation, in 1997, and sadly they are equally relevant today. We continue to treat people and send them back to the conditions that made them sick, and will continue to make them sick.

The impact of austerity, the falling value of salaries and welfare benefits, inflation and the rising cost of fuel, food and other essentials on low-income households is leading to poorer living standards, increased poverty and widening inequalities in health.

The life expectancy gap between the most and least deprived in London almost doubled between 2002 and 2019 [1], to 19 years for women and 17 years for men, with life expectancy actually declining for the most disadvantaged Londoners. Since 2019, the effect of the first two Covid years was to increase the gap by a further year, and it may grow by the same again, or more, due to the cost of living crisis.

Responding to ever widening health inequalities

Evidently the *'do more of the same'* option will perpetuate the conditions that are widening health inequalities. It therefore isn't an option, and Integrated Care Systems have been established with the task of reducing health inequalities.

Whilst some of the systemic social determinants of health are beyond the capacity of the members of the Integrated Care Partnership to significantly address, there are others that are within the partnerships' ability to influence and change.

This study is about one such area, which offers a tested, relatively inexpensive approach to significantly improving the social determinants of health of those who are the most deprived and disadvantaged, who suffer the worst health outcomes and the greatest health inequalities i.e. those whose outcomes we should be doing the most to improve if we are serious about reducing inequity.

For information about the study, the report and taking its recommendations forward, please contact:

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[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10105258/

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Case study examples

The following case studies provide examples of a range of partnership initiatives to improve access to advice services through collaboration with health providers

Case studies

- **Tower Hamlets Advice in GP practices,**
  a 20 year long programme providing outreach welfare advice sessions in 18 GP practices with referral arrangements for the remaining practices
- **Bromley by Bow Centre and Bromley by Bow Health.**
  a 30 year Health Justice Partnership as part of the Bromley by Bow Healthy Living Centre model
- **Patient Welfare Advice Service – Citizens Advice Wandsworth.**
  A dedicated team of welfare advisors funded to meet the needs of those being referred from GP practices and social prescribing
- **Tower Hamlets Community Advice Network and referral system.**
  A network of advice providers whose referral platform is extensively used by social prescribing link workers
- **Back on Track, Financial Shield project in Lambeth and Southwark.**
  A debt advice and social prescribing project that uses clinical data and other data to reach those working-age patients with, long-term health conditions most likely to be in debt
- **The hybrid advice-social prescribing link worker.**
  The development of the hybrid advice-link worker role
- **Royal Free Charity Welfare Rights Advice Service.**
  A welfare advice programme in the Royal London Hospital that support's patients' welfare advice needs.

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Case study

Tower Hamlets Advice in GP practices

Tower Hamlets Advice in GP practices has been running since 2004, commissioned initially by the Primary Care Trust and then by the Clinical Commissioning Group. With the transfer of Public Health into the local authority, the service is now commissioned as part of the Tower Hamlets Connect initiative through the Adult Social Care Team.

The service, which is delivered by three local advice agencies (Island Advice, Bromley by Bow Centre, Limehouse Project) and coordinated by Age UK East London, provides social welfare advice to the patients of 20 of the 36 GP practices in the borough. The remaining 16 GP practices can refer patients to see the advisors at one of the 20 practices where they give advice. The service has a presence in every Primary Care Network in the borough and provides advice on welfare benefits, housing, and debt. The service provides advice appointments for four hours per week per practice and assists an average of four clients per session. Ongoing casework and follow-up support and advocacy is provided by the dedicated advisor. In a survey of patients' feedback, the accessibility of the advisor at their health practice, the ease of making appointments, and the continuity provided by seeing the same person, particularly when coping with stressful situations such as appeals on eligibility to benefits was mentioned.

How it works

The service pre-dates the introduction of social prescribing and so originally worked in such a way that GPs and other healthcare professionals and practice staff could directly book patients into appointment slots with an advisor. This has continued to be an option for staff, though now many of the referrals go first to social prescribing link workers and then on to the welfare advisor.

Relationships have been key, with consistency in the staff team helping to build trust and rapport. The advisor team regularly refer back to social prescribing for wider needs and make themselves available to link workers for an hour each week to discuss cases and support them to help with straightforward issues e.g. Blue Badge applications, themselves. Advisors have access to EMIS patient records in some practices (with the clients' permission), to obtain supporting evidence for benefit applications and appeals. Access to patient records also allows advisors to draft evidence letters on behalf of GPs, for them to sign off, ensuring information provided is relevant to benefit assessment criteria, and saving GPs' time. However, where this is not feasible, advisors encourage the patients to obtain copies of the relevant information from reception staff to assist with evidence for benefit applications and appeals.

Providing advice within GP practices has been found to improve the accessibility of advice, particularly for vulnerable patients and to prevent the drop off from referral to attendance. During the pandemic, trusted referrals have been found to help ensure patients access support remotely. Post-pandemic, some GP practices requested a return of the outreach advice services in their practices, whilst other practices have opted for the initial referral to be for a telephone/online welfare advice appointment. If a face-to-face welfare advice appointment is then required, it is booked with the advice agency to take place outside of the healthcare setting.

Impact

The service has demonstrated in its 20 years of operation that the advice partnership arrangements with their local GP surgeries have significant benefits for advisors, practice staff, and most importantly for patients themselves. In a recent evaluation, almost three quarters (73%) of patients who accessed the advice in GP practices service reported a reduction in stress relating to finances and four fifths (81%) said that their visits to their GP had reduced. Two thirds (66%) stated that if the service wasn't available, they would have sought advice on the issue from other practice staff (clinical or administrative) rather than elsewhere (e.g. an advice agency), suggesting that the service is reducing strain on the system and addressing need which may otherwise have gone unmet.

In 2022-23, the outreach advice service supported over 2,500 patients achieving financial gains averaging £865 per patient.

Bromley by Bow Centre and Bromley by Bow Health, a 25+ year Health Justice Partnership

In 1997 Bromley by Bow Centre in partnership with Bromley by Bow Health created the first Healthy Living Centre in the UK, bringing together a community anchor organisation with a wide range of services with a General Practice. Social Prescribing was at the heart of the Healthy Living Centre model and although not called that at the time, this in effect established one the country's longest running Health Justice Partnerships. Today the Bromley by Bow model includes four GP practices with 50,000 registered patients, a team of eight social prescribing link workers and a wide range of community services, including a social welfare advice team with generalist and specialist advice services and a financial capability and fuel poverty team. In the last 12 months the Bromley by Bow advice team have secured additional income, grants and debt write off of almost £2.5 million for clients, including many who are social prescribed and supported 200 households to stay in their own home and avoid becoming homeless.

The welfare advice and financial capability teams work closely with General Practice teams, including social prescribers, and the population health teams, to consider how best to reach those likely to benefit from welfare advice. For example, by having welfare advisors at flu vaccination clinics to encourage older people and those with long term health conditions to book a welfare benefits check to ensure they are receiving their full entitlement to benefits.

For more information

For further information about the project please contact insights@bbbc.og.uk

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Case study

Patient Welfare Advice Service – Citizens Advice Wandsworth

The aim of the service is to provide GPs and other practice staff including social prescribers in the localities with the means to 'prescribe' welfare rights advice to patients. This service is delivered across three health locality areas in Wandsworth and enables GPs and healthcare staff to directly refer patients to Citizens Advice Wandsworth (CAW). The project was initiated in 2014 and is commissioned by the Clinical Commissioning Group on a three-year contract. There are 3.2 full time equivalent social welfare advisor posts and each advisor is assigned to one of the locality areas to cover the GP practices in that area.

"The key benefits of the service are that patients get the welfare advice they need quickly and that the number of repeat visits to their GPs is reduced." Citizens Advice Wandsworth

The service is targeted at patients with particularly complex advice issues, and/ or those who are vulnerable due to language, literacy, cultural, or mental or physical health issues.

How it works

Where a GP or Social Prescribing Link Worker (SPLW) identifies a patient in need of social welfare advice (e.g. benefits, debt, housing, employment, family, immigration, or consumer issues) or other support, they submit a referral to CAW. The project accepts up to 83 referrals a month from the GP practices. Most referrals now come from social prescribers, but GPs can also refer directly. The advisor contacts the patient by telephone within three working days of receiving the referral. The advisor will try to contact the patient on three separate occasions and if contact is not made, they inform the referrer. The engagement rate of patients referred to the service is 85 per cent. Thought to be significantly higher than it would be if they were simply signposted, i.e. informed of a high street service or given a leaflet.

"It is essentially a social prescribing service with attached social welfare legal advice provision. Given that central funding for social prescribing itself is now secured for at least the imminent future, we hope that the service can continue to be sustained." Project Manager

Patients are assessed during this initial telephone contact. The patient is given information, advice and signposting via telephone, and when appropriate, a follow-up appointment is made.

Face-to-face appointments are offered, where clients feel more comfortable talking face-to-face, or where their issue is more complex, or the advisor needs to see or prepare paperwork. Appointments are provided at a location convenient to the patient, and this includes home visits if required.

"The service has significantly helped my mental health... I would not have made it through [the PIP application process] without (advisor)… she has made an incredible difference in my life."
Client

Ongoing casework and follow-up support and advocacy is provided by the dedicated advisor, with supplementary advice for complex cases provided by internal housing, employment, debt and benefits specialists. The project worked with around 1,000 patients in the year from April 2022 to March 2023. Many of the cases require protracted casework around complex social welfare issues with welfare benefits, housing, debt, health and community care, being the most common, often interlinked issues that patients needed assistance with.

Managing demand

The majority of referrals to the service come from the Enable and Surrey SPLW managers and the team works closely with them to ensure referrals are made for patients who are in greatest need of social welfare advice intervention. Direct referrals from GPs accounted for 10% of referrals.

The service is funded for 3.2 full-time equivalent advisors and when demand exceeds capacity the advice service seeks to slow the rate of referrals by asking SPLW in a particular locality to cease making non-emergency referrals.

Case example

Mr X lives with his wife and dependent children and suffers from mental health issues. He was in receipt of DLA and when this was due for renewal, the DWP asked him to claim for Personal Independence Payment (PIP) but his claim was refused as was his mandatory reconsideration request. The link worker referred him to CAW for assistance to challenge the decision, who appealed to the Tribunal on the client's behalf. The appeal was allowed and the client was awarded the enhanced rate of PIP for both Disability Living and Mobility. He got backdated arrears of more than £4,000 and he is now getting £608 PIP every 4 weeks. This makes a major difference to the quality of his life and to the financial and emotional wellbeing of the patient and his family.

Outcomes

The project gained £515,000 for patients in a 12-month period, an average of £515 per patient. These financial gains include new benefit awards, benefits being increased or awarded following an appeal, benefits reinstated, debts reduced or written off, as well as health charges reduced or eliminated. It also progressed to resolution a great many homelessness and housing transfer cases to resolution.

For more information

For further information about the project please visit https://cawandsworth.org

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Case study

Tower Hamlets Community Advice Network and referral system

Tower Hamlets Community Advice Network (THCAN) comprises over a dozen social welfare legal advice providers in the borough. It was established over a decade ago with the intention of creating a coherent approach to providing for the advice needs of the borough's residents, who are some of the most deprived in the UK. The network consists of advice providers who deliver advice at Generalist and Specialist levels.

THCAN's Referral system

In 2021, Tower Hamlets Community Advice Network (THCAN) launched a borough-wide digital referral system which links residents to a wide variety of local advice and support services across the statutory, voluntary and community sector. An increase in signposting and email referrals from front line workers in food banks, schools, and social prescribing teams into the various advice agencies during the pandemic, highlighted the lack of coordination within Tower Hamlets and the need to ensure referrals are effective.

How it works

A key purpose of the new digital referral system is to facilitate a move from signposting to a referrals mindset. Referrals are more effective than signposting, particularly when supporting residents who may lack confidence, knowledge and/ or tools to access help themselves. Referrals also assist agencies with managing demand. By bringing referrals across agencies into one space, it not only increases awareness of the breadth of services available, increasing access, but also makes the process of tracking progress more streamlined for the referring party. Between March 2021 and March 2023 over 2,700 referrals were made via the system with over 60% of the referrals coming from social prescribing teams. `It is notable that over 75% of referrals related to housing problems come through social prescribers suggesting a strong connection between housing and health issues.

"THCAN referral network has helped us so much. We refer patients to services in the community for support which can be very time consuming. Having this easy-to-access referral system saves us time, the patients are contacted quickly, and we receive feedback once they are contacted."

Social Prescribing Link Worker

The principal objective of the network is to improve the accessibility and quality of advice services by improving the coordination and integration of borough-wide and locality-based advice services, and specific community provision. The network shares good practice and helps sustain effective communication across the diverse range of advice providers in the borough. It facilitates a quarterly Welfare Rights Forum and produces regular briefings and updates to share with wider health and social care partner agencies, food banks etc.

"The THCAN referral system has provided a platform for organisations in the advice sector to come together and cross-refer. As a result, residents receive a seamless journey through their advice needs and the system is very easy to navigate. The council's outreach team have been proactively using the tool since it launched and have found it very helpful."

Tower Hamlets Council Tackling Poverty team member

The network also regularly reviews the operation of the digital referral system to ensure it facilitates improved communication and access to advice services for those in need. The referral network improves joint working across VCS, Health Sector and Local Authority and enhances quality and access to the borough's services for residents.

The network, which is co-ordinated by Island Advice Centre, has been in operation for ten years with funding and support from the local authority and trust funds. However, there is currently no funding guaranteed for the next financial year despite the recognition of the value of the network and the online referral tool in supporting local communities impacted by the cost-of-living crisis.

For more information

Further details on the network and the referral system are available at www.thcan.org.uk

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Case study

Back on Track. The Financial Shield project in Lambeth and Southwark

The Financial Shield project is led by the Centre for Responsible Credit Ltd[2] with funding from Impact on Urban Health. It was commissioned by Impact on Urban Health in October 2020 and service delivery began to residents in early 2021. It is aiming to create a sustainable funding model for advice linked to primary care, by evaluating the impact of benefits advice and low-level debt advice for health outcomes and rent and Council Tax payment rates.

The project provides advice and assistance to patients of GP practices in some of the most deprived wards in Southwark and Lambeth. It employs four Financial Support Link Workers in Age UK Lambeth and Citizens Advice Southwark to take referrals from primary care, including social prescribing teams, and is testing how financial health can improve physical and mental health. It has so far engaged with over 1,000 residents and aims to reach a further 2,000 people by September 2027. [3]

How it works

The project is proactively marketed to residents with a 'Back on Track' branding by GP practices and social prescribers. These identify working-age patients with, or at risk of, long-term health conditions and text message to offer support. Leaflets and posters are also made available in GP practices, and patients can also self-refer by requesting an appointment with the Financial Support Link Workers via the project's website or by sending in a request slip from the leaflet via freepost.

The Financial Support Link Workers help people access benefits, grants, and discretionary payments and provide advice on debt problems, and work alongside health support. Complex debt problems are referred to specialist debt advice.

The project has also developed an innovative 'local breathing space' scheme with the two local authorities and four housing associations. Residents in rent or Council Tax arrears can have enforcement actions suspended, whilst the project seeks to maximise their incomes, for up to 60 days. It speeds up access to relief from enforcement activity and can be used by people who have low level arrears and who are not in multiple debt with other creditors.

The Financial Support Link Worker role involves

- Taking referrals from local GPs surgeries and other services and providing 1:1 support and assistance to maximise incomes.
- Assessing whether there is a need for the Council, local housing associations and other creditors to suspend any debt recovery action and liaising directly with these organisations to achieve this.
- Helping residents facing financial crisis to access emergency grants and other forms of assistance.

[2] https://www.responsible-credit.org.uk
[3] https://www.financial-shield.uk/healthcare-pathways

- Reporting back on the outcomes achieved to social prescribing and health colleagues and to the participating local authorities and housing associations.

Outcomes

An initial evaluation indicates that the project completed its work with 330 patients last year, securing just over £350,000 of additional income for these patients an average of £1,060 per patient. Support ranged from securing access to emergency funds for gas and electricity, to much larger amounts of previously unclaimed benefit entitlements: for example, Personal Independence Payment, worth around £8,500 per year. Around 100 people also benefitted from the project's local breathing space last year.

Data from Lambeth indicates that 56 residents have reduced Council Tax debts by more than £40,000: an average of £720. [4] However, due to rising costs of living, and a reduction in social security support in real terms, many residents were unable to make offers of repayment even after all efforts had been made to maximise their incomes and reduce expenditure. This has prompted the councils to use their discretionary funds to write down arrears in some cases.

The project has also looked at the impact on GP appointments pre and post intervention, finding that there has been a reduction in these. However, further work is being undertaken to evaluate health outcomes more robustly.

Below are some quotes from Financial Support Link Workers [5]

"There is always a trigger (for people falling into debt) like a relationship breakdown or a bereavement where life gets on top of people. We've seen how people get depressed and lose the ability to function, ignore priorities and not think about outcomes. The pandemic certainly didn't help when people lost benefits due to missed assessments and were stuck at home suffering from anxiety and depression in some cases. Their debts are not in the hundreds, always in the thousands accumulated over months and years with people burying their head because they can't see a way out or they turn to alcohol and drugs to cope. Back on Track has been very good at sorting these situations out and getting people back into the community again after a difficult time."

"Face to face is the only way to unpick the complexities behind peoples' financial problems. Sometimes you have to work alongside social prescribing and GPs to get them back into the community. We can help with the financial side, but we are not clinical experts and where there are mental and other health problems, we can't help directly but we'll collaborate and sort things out together with colleagues. Problems are usually more complex than just debts and once they feel better in themselves, they can make positive changes in their life."

'I'd like more space to be made available at GPs surgeries too, for the team to see patients when they are there anyway seeing their GPs. Home visits are difficult to arrange, and some patients might prefer surgeries – they're a safe haven. It was difficult to use them in the pandemic, but I hope we can use them now."

For more information

For further information about the project please visit https://www.financial-shield.uk

[4] The comparison is the level of Council Tax debt averaged over 3 months prior to and post intervention.
[5] https://www.financial-shield.uk/blog/reports-from-our-back-on-track-team

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Case study

The hybrid advice-social prescribing link worker

The hybrid social welfare advice–social prescribing link worker has been developed in a number of areas in England, including several London boroughs as a response to the need to provide social welfare advice to social prescribing clients in the face of a severe shortage of welfare advice on the high street. Beyond being a pragmatic response to unmet need, it is also seen by some as a more holistic and effective model, as it means that social prescribing patients with less complex welfare rights issues can be seen by one person, who provides both the normal link worker role support and generic social welfare advice on basic social welfare issues.

How it works

There have been two ways of approaching the creation of the hybrid advice link worker role, one being training social welfare advisors to become social prescribing link workers, or conversely to take social prescribing link workers and train them to become social welfare advisors.

"Housing and benefit issues are the two most important issues people are dealing with right now, if people are struggling with these issues, then asking them to think about the other side of social prescribing (increased activity, community programmes, reducing isolation, etc.) is like trying to run before you can sit up" Social Prescribing Link Worker

The intention of the role, particularly when it sits within a team of social prescribing link workers is that clients with welfare advice needs are triaged to the hybrid role. Less complex cases are dealt with by the hybrid advice link worker whilst more complex cases continue to be referred to more specialist advice provision.

Benefits of the advice link worker role

Benefits identified by link workers and their managers, in the interviews for this study, included the ability to offer a more holistic approach, to be proactive on straightforward simple queries and address some of the welfare issues directly without the need for onward referral and follow-up. This can include completing PIP forms where there is straightforward evidence of eligibility and only referring the more complex cases to advice agencies.

"Having strong links with the GP surgeries means that we can provide relevant medical information and evidence when submitting PIP claim forms and mandatory reconsiderations. Claims are more likely to be successful if the evidence of the impact of the person's condition is detailed and consistent and this reduces the likelihood that the patient will have to go through the stress of an appeal." Welfare benefits advisor

Perceived benefits also included having stronger relationships with local advice agencies and ensuring that referrals were appropriate by developing a greater understanding of the benefits and housing allocation systems so that patients were not being referred inappropriately. The hybrid/ enhanced role was seen as bringing some degree of greater efficiency to the service and to patients despite the additional workload, as patients could resolve issues earlier and not have to repeat their stories. The reduced likelihood of delays created by additional steps and drop-off during an onward referral process were also seen as a significant benefit of the hybrid role.

"I have a background in social welfare advice before becoming a Social Prescribing Advice Link Worker and I am still attached to and supervised by the social welfare advice team. This means I can give generalist welfare advice and support to patients, rather than signposting or referring patients to an advice service who often have a three-week waiting time for appointments (unless the matter is urgent). Because I am supervised by the advice team, I can triage clients to identify advice needs and provide generalist advice where appropriate or refer to a specialist advice service if the matter is more complex and requires representation. I think that due to the demand and pressures on social welfare advice services, roles like mine are needed as we are able to work across social welfare and health and wellbeing, providing clients with holistic, one-to-one personalised care which takes into account the client's need for benefit, housing or debt advice."

Advice Link Worker, Bromley by Bow Centre

Challenges of the hybrid advice link worker role

Potential challenges for the hybrid link worker role include ensuring that there is adequate supervision of their advice work, regular file reviews and access to ongoing training and information resources to keep up to date with changes in social welfare law, policies, and procedures. Another challenge identified by managers was ensuring that the postholders can meet the full intentions of the link worker role, i.e. taking a genuinely holistic social prescribing approach, including use of motivational interviewing, coaching techniques and referral for a wide range of issues, and not simply focussing on the social welfare advice issue.

"Social prescribers can be part of the journey, but qualified advice workers are needed to ensure that people are supported to access their rights and resolve the social welfare problems that are affecting their health and well-being."

Social Prescribing team leader

For more information

For further information about the project please contact insights@bbbc.og.uk

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Case study

Royal Free Charity Welfare Rights Advice Service

In 2018 the Royal Free Charity, in conjunction with the Royal Free London Trust established a patient support hub with a part-time welfare rights advisor, in recognition of the fact that for many patients; money, housing and benefits worries are major barriers to improved health outcomes and recovery.

However, such was the level of need for advice and the positive outcomes for patients, that over the past five years the number of advisors has increased to three full time equivalent social welfare advisors and a welfare rights supervisor.

"These medical conditions can be life changing for the individual and their families. For them, the help we provide is a lifeline, accessing much needed support that they would not get elsewhere".
Welfare advisor

How it works

Currently more than 400 patients a year with long-term health conditions are helped by the support hub's welfare rights advice service, who are based at the Royal Free Hospital. They have strong links with the clinical teams, who share relevant medical history, with the patient's consent, to better support claims for disability and health related benefits. They support patients who have a wide range of long-term health issues including kidney failure, liver transplant, HIV, chronic pain, stroke and vascular disease.

The welfare rights advisors support patients with:

Listening and empathising with people's individual situations – to build trust and establish how they can help them with the practical aspects of life.

Finances – assessing individual benefit entitlement; helping with applications; when decisions may need to be questioned; helping people with the process of mandatory reconsiderations and appeals.

Housing issues – advocating on behalf of patients to local authorities; helping to secure appropriate housing for people; often supporting people who are homeless or threatened with homelessness (and in many cases preventing that from happening).

Debt issues – referring people into specialist advice organisations to get the support they need.

"The hub is an invaluable service. I come across at least one patient a week who needs benefit or housing support who I refer. It allows me to spend time doing other things. I don't have the time or expertise to be able to give advice." Clinical nurse specialist, Royal Free Hospital

As well as the mainstream work of supporting patients, the team ran a three-month pilot supporting Royal Free London staff with social welfare advice, with one advisor spending one day a week rotating across the three biggest hospital sites (Barnet, Chase Farm and the Royal Free hospitals). The team supported 68 members of staff. The service is being re-started on a long term basis from October 2023 onwards.

"Your help has been invaluable and it's brilliant you exist within a hospital because benefits and the NHS are both inextricably linked when it comes to patient outcomes of recovery. The benefit system can have a hugely adverse effect to a person's mental and physical health – sometimes

the best therapy or treatment for a patient is knowing they have financial support or stability, while managing a health crisis." (Patient feedback)

Impact

In 2022-23, the support hub welfare rights service supported 429 people, achieving estimated finical gains of £700,000-£800,00, an average of £1,750 per patient. They also supported 62 people who were homeless or at risk of homelessness including those rehoused from unsuitable accommodation. They successfully referred people to housing and immigration solicitors, and for specialist debt support, as well as for psychological support. They also facilitated blue badges, freedom passes, warm home discounts and successful external charity grants for individuals.

78% of patients in a recent survey said they felt the support hub help had improved their general wellbeing, and the same percentage felt it had reduced their stress about finances.

81% of staff surveyed agreed or strongly agreed that "having the expertise of a welfare rights service onsite helps me in my role"; over 80% also agreed "the support hub has a positive impact on patient experience."

For more information

For further information about the project please visit https://royalfreecharity.org

For copies of the report, subsidiary documents and further information

The full report and subsidiary documents, listed below are available, from Bromley by Bow Insights:
https://www.bbbc.org.uk/insights/

Report

- **Reducing health inequities in London by improving access to social welfare advice through greater collaboration between the healthcare, local authority and advice sectors**
  - Full report
  - Executive summary report

Subsidiary summary documents

- **Making the case for why Integrated Care Systems should include the provision of social welfare advice**
- **Recommendations for how Integrated Care Systems, Places and Neighbourhoods can increase access to social welfare advice, particularly for the most deprived communities**
- **Good practice, replicable, case studies from London** (This document)
- **Poster/infographic**

For information about the study and taking its recommendations forward, please contact:
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