Establishing a welfare advice service in family practices: views of advice workers and primary care staff

Peter Greasley and Neil Small


**Background.** The placement of welfare advice services in family practice to assist patients with health-related social and economic issues (e.g. disability benefits) has gathered momentum over the last decade in the UK. This expansion of primary care raises a number of issues for practices hosting these services.

**Objectives.** To gain the views of advice workers and primary care staff about the issues raised in hosting a welfare advice service across 30 practices in inner city Bradford.

**Methods.** Views were obtained through focus groups with six advice workers, and primary care staff in 14 practices. A questionnaire was also posted to all practice managers asking their opinions about the service.

**Results.** The focus groups highlighted a number of advantages for patients, including improvements in health and quality of life through increased income and reduced stress from social and economic issues. For practice staff, the service provided a resource to refer patients for welfare advice, reducing the time spent dealing with welfare issues, thereby reducing workload. This was confirmed in the questionnaire to practice managers where 72% said the service had saved time for GPs and reception/office staff. The advice workers raised concerns about the perceived level of commitment to the service from some staff at some practices. Practice staff were particularly concerned about the need for feedback about referrals.

**Conclusion.** Providing welfare advice in family practice can act as a valuable resource for primary care staff helping to address their patients health-related social and economic needs.

**Keywords.** Family practice, primary care, social welfare, socio-economic factors.

**Introduction**

During the past ten years the placement of welfare advice workers in family practice to address patients’ social and economic issues (e.g. disability benefits, housing) has been gaining momentum in the UK. 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. More recently, a survey of 69 Primary Care Trusts (PCTs) found that 21 (30%) had allocated some funding to welfare advice services.

Studies have shown that these services facilitate access to welfare advice for patients and are particularly effective in identifying health related welfare benefits (e.g. disability benefits) which often go unclaimed due to lack of awareness of eligibility. For example, it is estimated that only 40–60% of people eligible for attendance allowance (a disability benefit for people over 65) actually claim it. As such, welfare advice services function to address inequalities in health relating to poverty and deprivation, providing a means by which primary care organisations can address the social, economic and environmental influences on the health of their population. These were priorities outlined in *The NHS Plan.* Furthermore, there is evidence to suggest that welfare advice can improve patients’ health and quality of life by reducing anxiety and stress caused by adverse socioeconomic circumstances.

Despite these benefits for patients, some members of the medical community have not welcomed the introduction of advice workers into practices. Chaggar, for example, felt that this constituted a violation of general practice, transgressing the boundaries of medical...
care, heralding a time when “general practitioners should be responsible for, and indeed expert on, every welfare, social and medical issue that affects their patients.” It is, he argued, “a burden we can do without”. Indeed, evaluation of a CAB advice service involving seven practices in Liverpool found that GPs did not approve of the service; only one of the nine GPs was in favour of the scheme, and seven complained about extra paperwork. (GPs supply diagnostic and functional information to the Benefits Agency for attendance allowance, disability allowance or incapacity benefit claims. They are also required to submit a letter of support if patients appeal against a decision.) Other projects have, however, found that welfare advice services are regarded as a valued addition to the practice in so far as they help to address their patients’ socioeconmic needs and relieve the pressure on GPs and other primary health care staff in dealing with these issues. In this article we discuss the advantages and problems encountered in establishing the ‘Health Plus’ welfare advice service across 30 practices from the perspectives of advice workers and primary care staff.

The Bradford Health Plus Project
The Health Plus Project, funded by the Health Action Zone Innovations Fund for three years, and hosted by Bradford City Teaching Primary Care Trust (tPCT), funded six local advice agencies to provide a welfare advice service in practices throughout the Trust area. Each advice agency employed a qualified welfare advice worker who was then allocated to provide weekly 3-hour advice sessions in five practices. The six advice workers were thus able to provide a service across thirty practices (out of a tPCT total of 44), taking referrals from all members of the primary health care team.

The project was evaluated over two years. Statistical records showed that the advice workers had provided advice for 2484 patients, dealing with over 4000 welfare advice issues, and raised over £2 million in benefits for patients. However, the number of patients referred for advice varied widely across the practices, ranging from 16 to 234 (average 80). Although there was a strong positive correlation between practice list size and number of referrals (r = 0.75, P < 0.000), monthly meetings with the advice workers suggested that level of uptake was also related to the attitude of practice staff towards the service. Focus groups with the advice workers and primary care staff enabled us to investigate these issues more thoroughly.

Methods
Focus groups with advice workers and primary care staff
Since we wished to gain qualitative insight into the issues raised by placing a welfare advice service into family practices, we decided to conduct focus groups with the advice workers and primary care staff. A focus group typically consists of 5 to 10 people who are brought together to discuss a particular topic or issue. They are particularly useful for gaining insight into the collective/shared attitudes and experiences of participants.

A focus group with the six advice workers was conducted eight months into the project. This was arranged and conducted by the first author who generated discussion around two central topic areas: a) What are the advantages of providing welfare advice in practices (for patients, practices and advice workers); b) What problems have there been in establishing and conducting the service in practices? The focus group was conducted in an advice agency and lasted one and a half hours.

Focus groups were also conducted at fourteen practices twelve months into the project. We aimed to gain the views of primary care staff from a cross-section of practices representing high and low referrers to the service. Whilst this was achieved, the final sample was to some extent ‘opportunist’ depending on the availability of practice staff for interview. Accordingly, focus groups were conducted at two practices from the lower third of referrers, five practices from the middle third and seven practices from the upper third of referrers. The views represented may therefore reflect some bias towards those practices where the service was most well received.

Where possible, it was requested that each focus group consist of a practice manager, GP, reception and nursing staff. However, this cross-section of staff was rarely attainable due to work pressures in busy surgeries. In total, the sample of interviewees consisted of eleven GPs, thirteen practice managers, five nursing staff, and eight reception staff.

Focus groups were arranged and conducted by the first author who generated discussion around two central topic areas: a) What are the advantages of hosting the advice service (for patients and practice staff); b) What problems have been encountered in hosting the advice service (and how these might be overcome and the service improved)? The focus groups were conducted in the host practices and lasted about one hour.

All focus groups were tape-recorded and transcribed, and the text analysed using a coding framework based upon the two focus group topic areas, i.e. advantages and problems encountered. Particular themes and specific issues raised within each topic area were identified and coded using a hierarchical coding frame. A report of the focus groups was provided to participants for comment and to corroborate that their views were accurately reflected.

Questionnaire to practices
In order to complement the qualitative data from focus groups with a sample of the practices, a questionnaire was posted to practice managers at all participating practices.
practices (28) 16 months into the project. (Two of the original thirty practices had ceased since inception of the service.) A reminder letter along with an additional copy of the questionnaire was sent to those who had not returned the questionnaire after two weeks. 25 (89%) questionnaires were returned. The questionnaire asked practice managers whether the service had benefited patients and saved time for practice staff, whether they wished the service to continue, and if there were any improvements that could be made to the service.

Results

Views of the advice workers: advantages of providing welfare advice in practices

Access to welfare advice. The advice workers felt that the service is providing access to advice for people who may not otherwise seek it from mainstream services, such as the city centre agencies. Whilst this applies to the patient population generally, the benefits for two groups of patients in particular were noted: people with mental health problems, and some members of the south Asian female population [the majority of people living within inner city Bradford are of south Asian origin (55%), primarily Pakistani].

Research has found high levels of unclaimed benefits amongst people with mental health problems; one study found that 51% of people attending a MIND welfare benefits service at a local mental health resource centre were not receiving the welfare benefits to which they were entitled. This group may find it difficult to access advice for a variety of reasons, e.g. the anxiety of visiting unfamiliar places, coping with public transport, waiting for attention in busy agencies. The advice worker located in a GP surgery is by contrast local, familiar and accessible through appointments:

“Another group we’re reaching are people with mental health problems—who say ‘I can’t go into town because I can’t get on a bus—can’t cope with it—can’t cope with sitting in a waiting room’—but they can cope with coming to the doctors. It’s familiar and they don’t have to wait.” [Advice Worker (AW) 1]

It was also felt that the service is ‘reaching out’ to many south Asian women who would not otherwise seek advice because they are not familiar with the range of services that exist in the community. This lack of knowledge may be due to language issues and social isolation, particularly for older south Asian women:

“I have a lot of…women coming to me and opening up about their problems—whereas they don’t even go out of the house to the supermarket. But because it’s the GP surgery they’re more than willing to come here—see their doctor and see me as well and tell me about their problems. Some people don’t get out of their house and they don’t know what’s available—y’know for years and years...so we’re reaching out to them.” (AW2)

There may also be a cultural deterrent in the south Asian community to discussing problems and seeking support outside the family because this may be perceived as bringing shame or dishonour (‘izzat’) on the family. This may be exacerbated by what are often strong ‘community grapevines’:

“I’m getting Asian women clients using the service because they can come to see me without making it obvious to somebody else that they’re coming to seek advice—so I’ve had women with domestic violence issues or matrimonial issues—they’re more reluctant to go to an advice centre.” (AW2)

Two further advantages relating to access were noted. Firstly, compared to central advice agencies, there is continuity from the same advisor, which enables the building up of a relationship of trust. Secondly, the ability to provide home visits for those patients who warrant it was also identified as a ‘big plus’ of the project.

Interagency working. One of the benefits of being located within the practices was that the relationship between advice worker and health professionals facilitated the processing of patients’ benefit claims. For example, where supporting information from the patient’s GP is required this is more easily acquired:

“Patients benefit—because when we’re based in a practice—if we need information, they’re willing to give it to us. For example, completing disability living allowance forms: if we’re based at the CAB and have to write to practices they’re not very willing, but here they’re helpful to us—very beneficial. Practice staff say ‘leave the form with us and we’ll ask the GP and they will fill it in for us’.” (AW3)

The service therefore increases the efficiency of health-related claims and appeals through proximity and teamwork.

Improvements in health and quality of life. The advice workers felt that they were improving the health and quality of life of patients by helping them to deal with social and economic problems, thereby reducing stress and anxiety, and improving their social and economic circumstances:

“Most clients have got some health related problem—so the GP or the nurse—they can deal with health side and you can try to take pressure off them by dealing with the housing problem. Because if they’re not well—a carer for example—they haven’t got the time to deal with anything else—they’re just overwhelmed, overburdened with the responsibility of caring for somebody—or if they’ve...
got a health problem themselves—so it's just taking that pressure off them.” (AW5)

Improving a patient’s economic status by ensuring that they are getting the benefits to which they are entitled was also seen as helping to improve health and quality of life, and for some helping to avoid health problems:

“For some people with mental health problems—problems with money are either starting the problems off in the first place or making it a lot worse—and by having someone to deal with that—it’s helping the depression or the emotional anxiety that they’re experiencing.” (AW6)

Other studies have reported improvements in health and well-being (especially reductions in stress/anxiety) as a result of increased income, resources obtained and problems addressed with the assistance of advice workers.3,8

Views of the advice workers: problems experienced in providing welfare advice in general practices

The advice workers noted two particular problems. Firstly, there had been a number of inappropriate referrals. It was suggested that this was partly due to a lack of knowledge amongst some members of the primary health care team about the role of the advisors and the type of advice they could offer. Secondly, there was felt to be a lack of commitment to the service at some practices. One advice worker (AW2) gave the following example of a positive and negative experience in practices:

Positive Experience: they took time to get to know me personally, and my role; they ring me to check if the referral is appropriate.

Negative Experience: they put me in a room; reluctantly make appointments; there’s no interaction with staff; they’re not interested in my role and how it might benefit patients.

These issues highlighted the need to provide sufficient training about the service offered. The following strategies to increase engagement with the service were suggested:

provide feedback to practice staff about clients referred—so they can see the outcomes of advice and whether or not it was helpful for them to refer the patient;

have a named person to whom advice workers can discuss issues concerning the service;

offer half-day promotion/training sessions about the role of advice workers.

Views of primary care staff

Benefits of the advice service. There was a great deal of enthusiasm for the project, especially from those practices where the number of referrals was high. The advice workers serve as a resource to refer patients for welfare advice thus providing a further means of addressing their patients needs. This also relieves the burden upon the primary health care team in dealing with welfare issues, thereby reducing workload. This is illustrated in the following comment and in Box 1:

GP1: “If patients come in and say they’ve got a problem with their benefits or they’ve got a form they want help with filling in you can just say, ‘well make an appointment to see the advice worker’. It saves us time and the advice worker can do it far better than us.” (Referrals ranking 21/30. This figure provides the rank order of practices from highest (1) to lowest (30), in terms of the number of referrals made, to indicate ‘popularity’ of the service in the practice from which the quote is taken)

The following comment illustrates the extent to which advice workers relieve the workload for practice staff by helping patients whose first language is not English to complete benefit forms (particularly relevant in inner city Bradford):

Practice Manager 2: “Quite often I would be asked to complete forms that really weren’t appropriate for me to do—disability allowance or attendance allowance forms. And because you know patients, and you know they don’t have anybody else in their family that could read or write you tended to do it for them and it could take an hour out of my day . . . So
yes I have benefited. Also I was happier with them seeing the benefits advisor because I wasn’t always sure that the information I was giving out was right. So it benefited me greatly. I probably saved three hours a week.” (Referrals ranking 1/30)

**Problems encountered in hosting the advice service.** At some practices there was concern about the level of communication and feedback about patients seen and outcomes. Whilst it was appreciated that advice issues were confidential, some form of feedback was felt to be important—to see if the advice worker had actually helped the patient. It was suggested that some form of paper feedback would be useful providing basic information on the number attending for advice (because staff did not know whether or not patients referred actually took-up the offer of advice). One practice manager suggested that details might be entered onto computer records. However, at one practice there was some debate about the extent to which feedback was warranted—that advice issues were not only confidential but might be best kept separate from medical issues. One GP expressed a reluctance to become involved in “everything that goes on in people’s lives”. This led on to an exchange about the role of advice work in general practice presented in Box 2.

Later in the discussion the theme returned to social issues being dealt with in practices, as presented in Box 3.

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**Box 2** Dialogue excerpt considering the role of advice work in general practice. Referrals ranking 5/30

| Interviewer: | “So it sounds like you’re happy with the service as it is?” |
| GP1: | “Yes, the one problem I had was I was wondering whether a General Practice has to be the place [for advice work]. Because I read an article before this [project] was set up and I thought why couldn’t resources be put up into services like CAB? Rather than the medical side, to medicalise it and bring it into Practice, so that suddenly we become the answer to everything and if you’ve got any problem like if your neighbour’s making too much noise, go to your GP. For me that just medicalised the whole situation . . . I just wonder if it’s the wrong place.” |
| GP2: | “It could be actually if you looked at it another way, you could say it’s helping patients to see that General Practices are much more than seeing a doctor. But they are not actually medicalising the problem, it’s just that they can come here, sometimes they might see a nurse and sometimes they might see us and sometimes they might see a health plus advisor.” |
| GP3: | “Yeh and they don’t have to medicalise it. It just means that it’s all part of a healthy living centre that’s all.” |
| GP4: | “A community service.” |
| GP1: | “Yeh, you could be right. That’s not general medical thought.” |

There was some concern about the extra work involved in administering the advice service, i.e. making appointments, directing patients to see advice workers. However, this was quite localised. Indeed, most reception staff felt that this was not an issue, and that the cost of any additional tasks was outweighed by the benefits of helping patients with their problems. One practice manager commented thus:

Practice Manager 2: “The feeling I get is that everybody is positive about [the advice service] because it has helped patients and it has reduced everybody’s work. The only extra work receptionists had would be to put a name in a book. Well I don’t think that is overload. We can live with that.” (Referrals ranking 1/30)

To sum up then, whilst there was some concern about extending the responsibilities of family practice to deal with patients socioeconomic issues, primary care staff generally welcomed the welfare advice service as a resource to address their patients socioeconomic needs, which actually reduced the amount of time spent dealing with welfare advice issues. These conclusions were supported in the questionnaire to practices.

**Questionnaire to practices**

Table 1 summarises the results of the questionnaire posted to practice managers. From the table we can see that practice managers felt that the service benefited patients at all practices, with 60% responding ‘quite a lot’ and 20% ‘to a great extent’.

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**Box 3** Dialogue excerpt concerning social issues being dealt with in practices. Referrals ranking 5/30

| Interviewer: | “It sounds like you’re a bit wary of becoming a social service?” |
| GP1: | “I’m gradually becoming converted to it. There’s always been a bit of a divide. I know in theory it’s good to bring it all under one thing, but I think it’s possible to medicalise it and to make it the doctor’s job . . . but I’m reassured that has not happened in this case. I’ve had certainly no extra work by [the advice worker] being here. I’d probably consider it less.” |
| GP2: | “I’ve had probably not more than two or three forms to fill in where [the advice worker’s] obviously helped somebody to make their application. And I always feel better because I know that she’d done it properly and she’ll have talked to the patient properly and I feel more confident filling in, even though you’re not responsible for what goes on before, you know it’s a proper application.” |
| GP3: | “It is particularly helpful for patients, for those that are illiterate or it will take you a long time to explain to them about CABs and what they have to do, whereas you can say make an appointment at the desk to see [the advice worker] on Thursdays.” |
Nine practice managers commented, praising the easy access to the service (e.g. “advice in a familiar setting”) and the expert advice provided to patients. The availability of south Asian speaking advisors for practices with high proportions of south Asian patients was particularly valued. Two practice managers commented on the low number of referrals made to the advice worker, one of whom felt that this was due to inadequate promotion of the service (“not enough patients are made aware of the service”).

From the table we can also see that the majority of practice managers felt that the advice workers had saved time dealing with welfare advice issues, thus confirming the views gained through the focus groups with practice staff:

- 72% felt the service had saved a large amount of time (i.e. ‘quite a lot’ or ‘to a great extent’) for reception/office staff.
- 60% felt the service saved a large amount of time for nursing staff.
- 72% felt the service saved a large amount of time for GPs.

Ten practice managers commented, referring to time saved directing patients to advice services and assisting them to complete forms; the satisfaction from providing “a good service” for patients was also noted:

Practice Manager 8: “Staff are happy to refer to [the advice worker] and feel we are giving patients a good service.” (Referrals ranking 3/30)

Practice Manager 25: “Patients, staff and doctor are very happy with Health Plus. Patients now see the advisor for benefit form filling rather than members of the primary care team. We have had no patients asking for help with benefit appeals since Health Plus was introduced to the practice.” (Referrals ranking 18/30)

Practice managers were also asked to indicate if they would like the service to continue at the practice, and if ‘yes’, would they like more, less or the same amount of sessions. 24 practices said they wanted the service to continue. 17 practices felt that the current number of sessions was adequate (3 hours/week). Two practices felt they could manage with fewer sessions. However, 6 practices wanted more sessions.

One practice was ‘not sure’ if they wanted the service to continue due to a perceived lack of demand. This was the only practice to report that the service had not saved time for any staff: receptionist/office staff, nursing staff or GPs (Table 1). It was interesting to note, however, that the number of referrals at this practice was higher than many other practices (referrals ranking 21/30). One factor that might have influenced the perceived level of demand was the relatively high proportion of referrals that did not come from within the primary health care team: 62% were ‘self-referrals’ following recommendations from family or friends, or having seen written publicity. Indeed, this practice manager had commented that it was “difficult to know” whether the service had benefited patients “due to lack of feedback to the practice about patients referred”. This further supports the need to ensure that advice workers feedback to practices about patients seen for advice.

A final question asked if any improvements could be made to the service. 11 practice managers responded. Comments focused on two particular areas: 1) the need for communication and feedback about the service; 2) the need for more information promoting the service to patients. For example:

Practice Manager 5: “It would be useful if we have feedback. Let us know if there is a lot of DNAs [‘did not attend’].” (Referrals ranking 17/30)

Practice Manager 20: “I am fully satisfied with the present practice. It needs a booklet (information) for patients enabling them to know the areas covered by Health Plus service in English as well as Asian languages.” (Referrals ranking 25/30)

To sum up, the questionnaire to practices provided more objective, quantitative support for the views expressed in the focus groups, showing that the service is perceived as a valuable resource to address patients socio-economic needs, reducing the amount of time spent by primary care staff in dealing with welfare advice issues. Further comments also confirmed the importance of...
maintaining feedback to practices about patients seen for welfare advice to ensure that practices are aware of the service they are providing for patients.

Conclusion

There has been an increasing presence in health policy of a recognition that the tasks of primary care include the promotion of health as well as the treatment of sickness and that a seamless service should be the target as health and social care work more closely together. In part these changes reflect a recognition of the potential of primary care to tackle health inequalities including those relating to socioeconomic status. The experience of primary care groups, and then trusts, is one of some expansion of the primary care team and some developments in collaborative working with other, none NHS, organizations. The provision of welfare advice, as we have described, is a part of that.

While it may be a legitimate concern to question the expansion of the remit of health services and the ‘clinical gaze’ into income and welfare rights, the argument raised by Chaggar that these additional services may be a burden to GPs is not substantiated. On the contrary, as we have seen in this study, the advice worker actually serves as a resource to relieve the burden upon the primary health team of dealing with patients social and economic welfare rights issues.

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