How Social Welfare Legal Advice and Social Prescribing can work collaboratively in healthcare settings

Bromley by Bow Insights

SUPPORTED BY
MAYOR OF LONDON

The Legal Education Foundation

Contents

Introduction ... 3
Acknowledgements ... 4
Executive Summary ... 5
Recommendations ... 6
Methodology ... 9
A note on terminology ... 9
The Case for Change ... 11
The Impact of COVID-19 ... 12
Models of operation ... 14
Findings ... 17
  Funding ... 17
  Management ... 21
  Referral pathways ... 22
  Onward referrals ... 30
  Location ... 30
  Working protocols and data sharing ... 31
  Delivery methods ... 36
  Relationships ... 37
  Training ... 42
  Scaling up ... 45
Conclusions ... 46
Appendices ... 47
    Appendix A: Interview guide ... 47
    Appendix B: Participating organisations ... 48

2020
Bromley by Bow Insights
Bromley by Bow Centre
www.bbbc.org.uk
insights@bbbc.org.uk

The Bromley by Bow Centre is a charity, registered in England and Wales no. 1041653 and Company Limited by Guarantee no. 2942840

Introduction

Over the past 15 years, social prescribing has steadily established itself as a crucial component of primary and social care settings, initially as very much a bottom-up, locally developed movement, and more recently being adopted as national policy and rolled out. This mainstreaming has been cemented by NHS England's decision to fund link workers as part of its commitment to widening the range of skills and specialisms within each Primary Care Network (PCN), with a commitment to 1,000 in post by March 2021, rising to 5,500 over the following three years[1]. Whilst models of social prescribing schemes and its adoption within PCNs varies, the vast majority had at least one link worker in post by July 2020, and in August NHS England launched a scheme to incentivise the rapid recruitment of the next 500 link workers.

However, alongside this, there is concern that this commitment to universal access to social prescribing as part of the NHS model, with funding for social prescribing schemes and link worker roles, but without consideration of the capacity of and connection with the crucial services that they refer into risks jeopardising the endeavour. Social welfare legal advice is one of the most prominent amongst the types of services that social prescribing services refer onto meaning that the interconnection between the two services is critical to the effective operation of social prescribing and the achievement of its intentions.

Social welfare legal advice services predate social prescribing and have a well-established sense of identity, with a growing number of these services offered within a healthcare setting in recent years and a growing evidence base of the benefits of this kind of working. Citizens Advice reports that its local services operate within 600 primary care settings. Benefits are considered to include reaching people earlier, addressing the social determinants of health for the most vulnerable who inevitably tend to access more healthcare and capitalising on referrals from trusted intermediaries.

Despite this, the presence and operations of social welfare legal advice within healthcare settings varies significantly and there remains an absence of a defined model of best practice for how this can function and crucially, how it can interact and intersect with social prescribing services, ensuring a smooth journey for those being referred.

In addition, whilst commitment to social prescribing, with resources to match, is increasingly becoming reality, funding levels for social welfare legal advice have seen no corresponding rise, despite external factors such as welfare reform, increasing online migration of welfare systems and now hardship caused by the COVID-19 pandemic point to continuing rises in the level and urgency of need. While there are no reliable figures available, it is estimated that only approximately 10 - 15 per cent of GP practices currently host social welfare legal advice sessions. This sits a long way below the universal access to social prescribing which is now part of the NHS model of care and funding settlement for link workers within Primary Care Networks. More broadly, the Advice Services Alliance (ASA) estimate a funding gap of at least £13 million per year in the sector in London with more than half of advice providers experiencing a reduction in funding levels over the past three years[2].

There is emerging evidence that where social prescribing schemes and social welfare legal advice do coexist within healthcare settings (most often in primary care) there is ample potential for collaboration, increased efficiency and improved health and wider life outcomes for those accessing services. However, there is also a risk that without sustained efforts to connect these services up at both a strategic policy level and an operational one, they risk operating separately, having a mismatch in capacity levels and even competing for referrals meaning that this potential can go unfulfilled. With

[1] https://www.england.nhs.uk/personalisedcare/social-prescribing/

[2] Advice Services Alliance (2020) Advising Londoners: An evaluation of the provision of social welfare advice across London. Available at: https://asauk.org.uk/projects/

the onset of COVID-19, even greater challenges have emerged in relation to how joined up working can be effective when much of it is conducted remotely.

This report, commissioned by the Mayor of London and The Legal Education Foundation, aims to explore the ways in which well-integrated social prescribing and social welfare legal advice service provision can be supported at all levels, with consideration of the roles of all stakeholders across London to make this happen. In order to understand this, interviews have been conducted with stakeholders in London and across the country, including clinicians, link workers, welfare advisers, project managers, commissioners and representative bodies, as well as utilising the Bromley by Bow Centre's experience as a pioneer of social prescribing services as well as a long-time social welfare legal advice agency.

Acknowledgements

This study was undertaken in 2019 and 2020 by Jo Goodman, Sara Thomas and Ellie Pointing of Bromley by Bow Insights at the Bromley by Bow Centre. We would like to express our heartfelt thanks to the Mayor of London and The Legal Education Foundation for their support which made this report possible.

We'd also like to thank all those organisations and individuals who gave their time to contribute by being interviewed or providing thoughts and ideas which have contributed to this report.

- The Advice Services Alliance
- Advice UK
- Our colleagues from advice and social prescribing at the Bromley by Bow Centre and our clinical colleagues at the Bromley by Bow Health Partnership
- National Citizens Advice, as well as Citizens Advice Bexley, Tower Hamlets, Waltham Forest and Wandsworth
- Dundee City Council
- Greater Manchester Health and Social Care Partnership
- NHS Health Scotland
- NHS Scotland Improvement
- Scottish Public Health Network
- UCL Centre for Access to Justice

Executive Summary

With social prescribing link workers now firmly in position as part of multi-disciplinary teams at primary care level as well as in some secondary and tertiary care settings, the lack of clarity on the role of social welfare legal advice and where provision of timely, high quality advice fits into the bigger picture is thrown into stark relief. As one of the primary onward referral destination routes for social prescribing, and one that is critical to addressing the social determinants of health, it is vital that provision of social welfare legal advice has sufficient capacity and is well-integrated into both a broadened out understanding of care and clinical care pathways. The ongoing risks to health and economic uncertainty brought about by the COVID-19 pandemic makes this work more urgent than ever.

This report aims to address the relationship between social welfare legal advice and social prescribing and how the two services can work together to address the needs of patients in London. By interviewing 17 professionals from across the advice and health policy and delivery landscape, we have built a picture of current delivery and areas for development.

Currently, the provision of social welfare legal advice in healthcare settings across London is patchy and due to uncertainty around funding and the separation in set-up arrangements between the services, collaboration and joined-up working between advice and social prescribing services can be fairly limited even where they operate in the same space, meaning some of the benefits of joined-up working fail to be realised. There is much that could be done to address the current situation in terms of both policy improvements and practical support to encourage greater interconnection of services and a more joined-up experience for patients.

At a policy level, consideration should be given to how the funding and status of social welfare legal advice can be elevated and integrated into wider health and wellbeing agendas. This could involve broadening the definition of care and working with partners at multiple levels including Health and Wellbeing Boards and Integrated Care Systems. Sustainable funding must be a high priority and ambitious aspirations around universal access to social welfare legal advice could form a core pillar of London's recovery from the COVID-19 pandemic. This consideration is particularly important at this juncture if we are to reduce the deepening of inequality and health inequality that is likely to happen over the next months and years.

On a practical level, there are a number of things that could be provided to support joined-up delivery on the ground including guidance and templates to support data sharing, training packages to improve mutual understanding between services and clinicians and support to develop appropriate referral pathways. These should balance the need to maintain a high level of quality in services but allow for local differentiation according to need and preferred ways of working.

It is our aspiration that this report sets out a clear path for how the Mayor of London and partners could lead the way in taking further important steps in developing a population health approach that addresses the needs of Londoners, and particularly creates a safety net for those who are most disadvantaged. By ensuring that high-quality, well-integrated support is available to address the social determinants of health and utilising existing health pathways and community assets, universal access to the services which help to secure a decent standard of living will be within reach for Londoners.

Recommendations

The position of social welfare legal advice and its role in London's recovery

- The Mayor of London and partners should position social welfare legal advice as a core pillar of London's recovery from the COVID-19 pandemic, with a core focus on ensuring adequate funding and practical support for advice agencies to ensure ongoing viability. This should be integrated into the work of the London Recovery Board around ensuring access to rights and entitlements and minimising hardship.
- An urgent review should take place looking at the risks of exclusion from services for the most vulnerable including support needed by local and BAME-specific advice agencies and tools needed to make remote services more accessible for those who are digitally excluded or speak English as a second language. This should also incorporate the role of healthcare agencies and social prescribing in ensuring the most vulnerable can be identified and referred as needed during times of limited in person engagement.

Funding

- Available funding should be targeted with due consideration of varying levels of deprivation and existing provision across the capital.
- Consideration should be given as to how funding can be drawn in to supplement NHS England funding for link workers and enable an adequate level of social welfare legal advice services to meet onward referral demand. This may involve roundtable events bringing in a range of funding stakeholders.
- The role of Health and Wellbeing Boards in ensuring adequate social welfare legal advice provision should be considered, including how this can be encouraged and potentially turned into a statutory duty.
- If funders are forthcoming, it may be wise to consider piloting multiple models of operation in the initial period as this is still a relatively new area of delivery.

Management

- A toolkit of guidance for managers should be produced to set out the core components of management of social welfare legal advice in a healthcare setting, along with guidance for social prescribing managers on effective service integration with social welfare legal advice.
- Consider incorporating an 'embedding phase' with possible additional management support in plans for new programmes.

Referrals

- Partners should consider exploring ways of establishing automatic referral reminders within patient data management systems to trigger clinician referrals to social welfare legal advice and social prescribing. This could initially be trialled with a small number of conditions to assess its effectiveness and the time implications for both clinicians and auxiliary services.
- Alongside this, broader routine screening questions for patients aimed at triggering social welfare legal advice referrals could be piloted to assess the impact on referral numbers and patient health and wellbeing.

- A referral pathway quality framework should be established which provides key components which should be present in any approach, while allowing for flexibility of approach. The framework should incorporate expectations for:
    - How clinicians and other practice staff should identify need and refer onwards.
    - The journey for the client including where signposting is appropriate and where a full referral is needed, and differentiation in pathways for different types of issue to minimise risk of client dropout.
    - How appointments should be booked, with encouragement to use the same system as the practice for full integration.
    - Turnaround of referrals, particularly for urgent social welfare legal advice demand
    - How social welfare legal advisers and link workers should identify need for the other service and refer onwards.
    - Mapping of onward referral partners, particularly for specialist areas of advice.

Location

- The management toolkit should incorporate guidance on how to maximise the benefits of co-location including through promotional activities and visibility in the practice, while also maintaining discretion for clients attending social welfare legal advice appointments to reduce stigma.
- Guidance should be provided to health practices on what facilities are needed for social prescribing and social welfare legal advice to be effectively delivered within the practice premises.
- Consider engaging with NHS Property Services to negotiate for charges to be waived for advice services operating in practices.

Working protocols and data sharing

- Provide model working protocols and data sharing policies and templates for adaptation by services.
- Incorporate data protection issues into training for all parties.
- Undertake research with patients to understand their feelings around data sharing and how this should be approached.
- Ensure guidance encourages regular review and service improvement feedback loops so that learning can be acted upon to refine processes.
- Consider piloting a single case management system approach (with appropriate data protection measures in place) to assess whether this is beneficial to the work of all parties.

Delivery methods

- Work collaboratively with health stakeholders and patients to assess the range of apps which already exist to provide guidance to those on particular health pathways and consider gaps both in content of existing apps and in the range of apps available.
- Provide a range of good practice case studies of alternative delivery methods e.g. volunteer-led, remote online delivery and digital sessions.

Relationships

- Incorporate the building of relationships into training for link workers and social welfare legal advisers who will be working in healthcare settings as well as guidance for scheme managers, with separate focus on how to build relationships with different stakeholders e.g. practice managers, clinicians, reception and administration staff.
- In collaboration with the Practice Managers' Association, consider how best to reach this important group of staff members in order to raise the level of understanding of the value social prescribing and social welfare legal advice to their practice and its operations.
- In guidance to schemes encourage actions which are likely to foster good working relationships including:
    - Information on how to initiate positive relationships with key staff members.
    - Encouragement for frontline staff to attend practice meetings.
    - Encouragement for consistency in staffing within practices.
    - Where possible ensuring that social welfare advisers and link workers are on site at the same time and /have regular opportunities to check in with one another.

Training

- Develop a standard package of training in conjunction with partners such as Advice UK, the Advice Services Alliance, NHS England, the Royal College of GPs and Health Education England with separate modules for:
    - Link workers, to incorporate basic knowledge of social welfare legal advice, how to spot issues, role boundaries and how to prepare a client for an advice appointment.
    - Social welfare legal advisers, to include understanding primary care, patient data management systems and the role of link workers.
    - Clinical staff, covering the role of link workers and social welfare legal advisers, the issues they can support patients with and how they can support their role, as well as how to work with clinical pathway referral systems and act as 'problem noticers'. This could also be incorporated into medical student training.
    - Practice managers, reception/telephony and administrative staff, to increase understanding of the value of auxiliary services and how they can support their practice and its operations, as well as the support they need to function well.
- Provide support for this training to be delivered locally including through Health Education England Training Hubs and incorporating involvement of local partners including the RCGP's local faculties, to enable training to also play a role in building effective local partnership working.

Scaling up

- Ensure that frontline workers, service managers and service users are engaged in plans for scaling up and that multiple stakeholders are brought together to share learning with decision-makers.
- Balance the need for standard levels of service with allowances for local flexibility based on what works best for those on the ground.
- Consideration should be given as to whether a new definition of care should be developed, which incorporates the right to support to ensure that a threshold of living conditions is met. As a first step, this could encompass universal access to social welfare legal advice, including where necessary specialist legal advice. This would need to be delivered and overseen at borough and Integrated Care System levels.

Methodology

This research utilised snowball sampling to undertake interviews with commissioners, social welfare legal advice services (individual providers and provider networks), healthcare managers and professionals (in both primary and secondary care), social prescribing scheme managers and link workers. As largely social prescribing and social welfare legal advice services co-exist in primary rather than secondary or tertiary care, there is a greater focus on this within the report, though relevant secondary care examples are referenced where possible.

In total 17 interviews were conducted, transcribed and coded, and thematic analysis was employed to understand key themes emerging from the interviews. The interview guide can be found in the Appendices along with a table of organisations from whom representatives were interviewed.

In addition, there has been some secondary analysis of research reports and evaluations of schemes, as well as policy papers to generate a deeper understanding of the challenges and opportunities in this area. The Bromley by Bow Centre team involved in the creation of this report have also drawn on the organisation's long history of delivering both social prescribing and social welfare legal advice services in Tower Hamlets, East London.

Research was primarily conducted prior to the onset of the COVID-19 pandemic which necessarily influences the focus of the report. A limited number of additional interviews were conducted a few months into the pandemic to gain as much understanding as possible as to how this was affecting service delivery and any anticipation of ongoing changes in operations. As this was conducted after an initial draft of the report was completed, the consideration of this impact has been somewhat limited.

A note on terminology

Who is using and delivering the service?

While clinicians and those in primary care tend to use 'patient' to refer to the individual they are supporting, link workers and welfare advisers often use the term 'client'. In addition, there is also variation in whether social prescribing professionals are referred to as 'social prescribers' or 'link workers'. For the purposes of this report, we will be using the term link worker for social prescribing staff members, while client will be used in relation to people accessing social prescribing and social welfare legal advice services and patient for those accessing health services.

What do we mean by social prescribing and social welfare legal advice?

Social Prescribing

The National Social Prescribing Network states that social prescribing *"involves empowering individuals to improve their health and wellbeing and social welfare by connecting them to non-medical and community support services".*

It is a way for healthcare services (at present usually primary care) to refer people to a link worker who is trained to use a holistic approach to support people's health and wellbeing (in its broadest sense), by giving people time to focus on 'what matters to me'. They then connect people to community groups and statutory services for practical and emotional support.

There is growing evidence that this:

- Improves individuals' wellbeing and health outcomes, by tackling the wider determinants of health, both immediate presenting issues and those of a longer-term nature (Institute for Health and Human Development, 2017)[3].
- Increases people's levels of understanding of the issues they face and how to resolve them and can increase levels of activation and self-efficacy (Elston et al., 2019)[4].
- Supports community development and local partnership working (Dayson & Bashir, 2014)[5]
- Provides a cost saving to the NHS by reducing demand in primary care and A&E services (Polley & Pilkington, 2017)[6]

Social Welfare Legal Advice

Social welfare legal advice refers to the provision of advice predominantly relating to welfare benefits, debt and housing, though which may extend to energy advice, family, employment, education, immigration and consumer law. Individual services may provide advice in relation to clients' rights in a range of these areas as well as onward referrals to services providing specialist support for different areas or more complex cases. Within this report, when referring to social welfare legal advice services, it is in relation to organisations which have achieved independent accreditation (in either England[7] or Scotland[8]) that have demonstrated that they are easily accessible, effectively managed and employ qualified staff with the skills and knowledge to meet the needs of their clients. Advice may also extend to legal representation, for example at tribunals, and may incorporate pro bono work by legal firms.

---

[3] Institute for Health and Human Development (2017) The Social Prescribing service in the London Borough of Waltham Forest final evaluation report. Available at: https://www.researchgate.net/publication/320280866_The_Social_Prescribing_service_in_the_London_Borough_of_Waltham_Forest_final_evaluation_report

[4] Elston et al. (2019) Does a social prescribing 'holistic' link-worker for older people with complex, multimorbidity improve well-being and frailty and reduce health and social care use and costs? A 12-month before-and-after evaluation. Available at: https://pubmed.ncbi.nlm.nih.gov/31547895/

[5] https://www4.shu.ac.uk/research/cresr/sites/shu.ac.uk/files/social-economic-impact-rotherham.pdf

[6] https://westminsterresearch.westminster.ac.uk/item/q1455/a-review-of-the-evidence-assessing-impact-of-social-prescribing-on-healthcare-demand-and-cost-implications

[7] http://advicequalitystandard.org.uk/about-the-aqs/

[8] https://www.slab.org.uk/advice-agencies/scottish-national-standards-for-information-and-advice-partners/

The Case for Change

Over the past 15 years, there has been growing recognition of the benefits of social welfare legal advice being co-located in healthcare settings, utilising the value of healthcare workers as trusted intermediaries[9] to ensure legal matters across a wide range of areas of law are advised on and addressed, and that clients are able to access their full benefit entitlement. This advice helps to improve people's social determinants of health (e.g. income, housing, employment etc) leading to relatively immediate improvements in short-term mental health and well-being, reducing financial strain and generating considerable financial returns (Woodhead, Khondoker, Lomas & Raine, 2017)[10]. Resolution of issues can involve navigating complex statutory systems and entitlements (including around health and disability related support, housing, employment and family law) to advocate for rights which are not always clear to those without access to information and so access to advice helps to level the playing field for the most vulnerable.

Example from practice: With seed funding from St George's Hospital Charity, Citizens Advice Wandsworth established a social welfare legal advice service for patients who have experienced major trauma and their families in 2015. The service has been found to be highly effective in enabling faster discharge of patients (more than 50 per cent of beneficiaries reported this), as well as freeing up clinicians to focus on the core elements of their role (80 per cent of staff reported this). The advisers are based on-site and offer support with a focus on benefits and housing issues (particularly relating to homelessness and domestic violence). As well as making a practical difference, more than 90 per cent of advice recipients said that the service had reduced their stress levels and improved their wellbeing.

In recent years, as social prescribing has increased its presence in healthcare settings, the two services have begun to work together where they co-exist, however to date there has been little consideration of the relationship between the two and the potential this has to revolutionise the approach to personalised care. By creating a wraparound service which responds to the needs of the individual, these models aim to effectively address social determinants of health in conjunction with physical and mental health needs. This clearly has system level benefits; by integrating services, avoiding duplication and maximising sharing of intelligence and data on patient needs, the entire system is likely to become more efficient and needs are likely to be met more promptly and cohesively.

An integrated approach can also enable proactive identification of issues and challenges, potentially before the patient themselves is aware of them and they become something which could become detrimental to health and wellbeing. While currently referrals to social welfare legal advice consist predominantly of those clearly presenting a need (often acute), there is increasing interest in how referrals or information resources can be effectively targeted at those within certain clinical pathways which are likely to trigger a social welfare legal advice need (in the present or the future), even without the patient raising this as an issue e.g. new diagnosis (such as cancer or dementia), pregnancy and maternity, caring responsibilities. This form of early action could not only result in less complex cases for advice services and reduced detriment to health and wellbeing for individuals, but reduced costs to the state if issues are resolved promptly as identified by the Low Commission[11].

---

[9] Ipsos MORI (2018) Ipsos MORI Veracity Index; Trust in Professions Survey.
Available at: https://www.ipsos.com/ipsos-mori/en-uk/advertising-execs-rank-below-politicians-britains-least-trusted-profession

[10] Woodhead, C., Khondoker, M., Lomas, R., & Raine, R. (2017). Impact of co-located welfare advice in healthcare settings: Prospective quasi-experimental controlled study. *British Journal of* Psychiatry, 211 (6), 388-395. Doi: 10.1192/bjp.bp.117.202713

[11] The Low Commission (2014) Tackling the Advice Deficit; A strategy for access to advice and legal support on

The Impact of COVID-19

The onset of the COVID-19 pandemic has rapidly and drastically altered the landscape for service delivery and continues to lead to much uncertainty both in relation to the levels of demand likely to be seen and how services will need to be delivered over a prolonged period. A limited number of additional interviews were conducted to understand the impact of the pandemic on services and those using them.

In the initial phase of the pandemic, participants reported that there was an increase in need for social welfare legal advice combined with a simultaneous challenge for usually face-to-face services which needed to pivot to remote delivery. This was perhaps more straightforward for national organisations whose case management systems and so on were already well set up for home working, whereas some smaller local agencies initially struggled. As time goes on, it appears that most have found a way to deliver advice remotely, albeit with ongoing challenges, while face-to-face services are now resuming for some client groups with appropriate health and safety measures in place.

Going forward there are a number of key areas for consideration. Firstly, it is likely that the need for advice will continue to rise, particularly as much of the government's COVID-related protections come to an end i.e. the furlough scheme and self-employment support, moratoriums on evictions and debt collection, mortgage holidays and additional maternity protections[12]. This will inevitably unleash a significant amount of pent up demand which is likely to be ongoing as the economy and families continue to struggle.

Secondly, this is likely to lead to a change in profile of clients and the kinds of cases which inevitably necessitate a shift in service delivery. Services report an increase in domestic violence and housing issues, and it is likely that these will continue alongside increasing numbers of new benefit claims for those newly out of work. Those we have spoken to also report an increased number of younger clients and those who had been in steady employment until very recently. While this may mean that a higher proportion of clients are more able to self-manage their situation with a more basic level of assisted information rather than full casework support, there are also important considerations as to what the entry of this cohort into advice services means for other client groups. As services reach and exceed capacity, there is a risk that those clients who are best able to navigate through services (including advice services), and advocate for their own needs will come to the fore, with those who are digitally excluded or who speak English as a second language may struggle more to access services. Consideration must be given to ensure that the pandemic does not lead to further entrenchment of existing inequalities.

It is also important to recognise the impact of remote services on clients, particularly those who are digitally excluded and from BAME communities. These groups are particularly likely to be dependent on smaller, local advice agencies and are also more likely to find it difficult to engage remotely e.g. needing to email documents, build a rapport with an adviser over the phone. Marie Burton recently argued that it is crucial that the role of place in social welfare legal advice is not neglected and that regardless of whether advice is provided over the phone or in person it is particularly important for disadvantaged clients that their advisers are well-connected with wider service delivery within their

---

social welfare law in England and Wales.
Available at: https://www.lag.org.uk/about-us/policy/the-low-commission-200551

[12] More information on the changing profile of advice enquiries to Citizens Advice in the first three months of the pandemic is available here: https://www.citizensadvice.org.uk/Global/CitizensAdvice/Covd-19%20Data%20trends/Citizens%20Advice%20data%20report%20-%203%20months%20of%20a%20pandemic.pdf

locality[13]. Furthermore, there is a risk that the reduction in attendance at general practice through the COVID-19 pandemic to date (and likely going forward) and the increase in appointments given by phone may limit the potential for holistic conversations triggering referral to social prescribing and/or social welfare legal advice. In some areas this has been balanced by proactive calls by social prescribing schemes to those identified as vulnerable, though practice has varied considerably in relation to who was contacted and which needs were addressed.

All of these factors when taken together show how critical it is that there is a considered and focused approach to the provision and delivery of social welfare legal advice in the months and years to come. Proper thought must go into how advice fits into London and the country's recovery from the pandemic including how it is to be effectively funded ensuring adequate access to those who need it and how it can be made accessible to all including the most vulnerable. This is likely to necessitate an approach which focuses on supporting clients to access remote services as well as ensuring the ongoing viability of local independent advice services, particularly those whose services are specifically targeted at or disproportionately accessed by BAME communities and those who are digitally excluded.

Effective integration with social prescribing and primary care in particular is likely to be key to ensuring straightforward access pathways, particularly as many other community 'problem noticers' such as community groups and faith communities have had much more limited contact with participants. However, it should also be noted that distancing requirements have presented critical challenges to general practice, social prescribing and social welfare legal advice, including with regard to collaborative practice and working relationships (which have historically often been at least in part dependant on co-location), data sharing and staff welfare. While swift innovations in practice have helped to tackle some of these challenges, it is undeniable that they are likely to have an impact on how services are able to operate for the foreseeable future.

Recommendations:

- The Mayor of London and partners should position social welfare legal advice as a core pillar of London's recovery from the COVID-19 pandemic, with a core focus on ensuring adequate funding and practical support for advice agencies to ensure ongoing viability. This should be integrated into the work of the London Recovery Board around ensuring access to rights and entitlements and minimising hardship.
- An urgent review should take place looking at the risks of exclusion from services for the most vulnerable including support needed by local and BAME-specific advice agencies and tools needed to make remote services more accessible for those who are digitally excluded or speak English as a second language. This should also incorporate the role of healthcare agencies and social prescribing in ensuring the most vulnerable can be identified and referred as needed during times of limited in person engagement.

[13] Burton, M. (2020) Lost in Space? The role of place in the delivery of social welfare law advice over the telephone and face to face, *Journal of Social Welfare and Family Law*
Available at: https://www.tandfonline.com/doi/abs/10.1080/09649069.2020.1796217?journalCode=rjsf20

Models of operation

It is perhaps important before looking at interview findings to consider what some of the models of operation of social prescribing and social welfare legal advice we encountered were. It is important to note that these are not definitive fixed models and others may well exist which we are not aware of. The 2018 UCL Centre for Access to Justice study which mapped models of social welfare legal advice in healthcare settings (with or without social prescribing provision alongside) is a useful resource to understand how these services have been established in healthcare settings[14].

Separate service models

Without any integration of social welfare legal advice with social prescribing services, the default model is for GPs and other healthcare staff to refer to link workers, who would then make an onward referral or signpost to external social welfare legal advice services delivered outside of a healthcare setting. As we estimate 85 to 90 per cent of primary care settings and most secondary care settings do not have embedded social welfare legal advice, this is likely to be the model in most settings where social prescribing is now present.

This means the client will have contact first with the link worker and then with the welfare adviser and depending on the demand on each service and the model i.e. whether a fast track referral is triggered without a link worker consultation or not, they may have to wait for both services. This may cause a delay in accessing social welfare legal advice which may be critical, particularly for those whose income has stopped or who are experiencing threat of imminent action or high levels of stress in relation to their situation. There is also no guarantee that external services (such as social welfare legal advice), will have sufficient capacity to take on the volume of referrals coming from social prescribing and it may only be possible for link workers to signpost to generic drop-in sessions which are generally oversubscribed and likely to lead to a high level of dropout. Once clients access social welfare legal advice, they will often be required to return to their GP for medical evidence e.g. for benefit applications or appeals, or to demonstrate priority need for housing. This can be challenging and, in some cases, there may be charges for this. The effectiveness of this model is likely to be dependent on the relationship between the services and whether they have found an efficient way of working together.

Example from practice: Ways to Wellness delivers social prescribing support for adults with long-term conditions in the west of Newcastle. While they work within primary care settings, they work closely with a range of advice agencies to refer clients on for support as needed, with clients being fast-tracked as needed. Link workers are given training so have a basic working knowledge of the benefits system and the holistic assessment used incorporates financial issues to ensure these are picked up.

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

Co-located service models

Where social welfare legal advice exists alongside social prescribing, co-location of services is perhaps the most common model we came across in our research. In this model, both services exist within the same space, but are likely to be delivered by different organisations and supported through different funding streams with separate management. The actual model of delivery within these services can vary significantly and is often dependent on the relationships between the services and the relationship they have with GPs and other healthcare professionals. In some models, all referrals pass through the link worker initially and are then passed onto the social welfare adviser, but with increased efficiency due to the services being co-located and perhaps having a closer relationship. In other models, GPs and other health professionals can refer straight to a social welfare adviser where this is the immediate presenting issue or make simultaneous referrals to the social welfare adviser and link worker. There may also be a facility for patients registered at a GP practice to book an appointment directly for the social welfare legal advice service e.g. through reception staff. Social welfare advisers may also benefit from access to medical records (with client consent) and direct contact with GPs in order to attain relevant evidence for benefit claims, particularly where the health of the client is relevant to the claim, and so on, streamlining this process. As above, there may still remain a mismatch in supply and demand for social welfare legal advice depending on the funding level provided.

Example from practice: In Wandsworth, Citizens Advice advisers available to all GP surgeries, including some where they offer advice sessions directly. Advisers work alongside link workers who are employed by Enable. Citizens Advice train link workers in 'Advice First Aid' to ensure they know who to refer and why and a referral platform is used to enable cross-referrals. Almost all referrals come first through link workers and then to Citizens Advice, with a small proportion (around five per cent) coming direct from primary care staff.

Co-funded service models

In a very small number of cases currently, there are social prescribing and social welfare legal advice services delivered through the same funding stream. This can mean that in addition to the benefits noted above, the services are likely to have been established in parallel using the same data systems enabling more integrated working, as well as providing opportunities to promote the services as a single package to inward referrers in healthcare settings. This model may also be more likely to ensure parity of service capacity, with consideration given to the volume of onward referrals likely to come from link worker engagements. It is also likely to mean that services are working towards collective KPIs and are able to firmly focus on the client journey, reducing any sense of competition between services for client numbers.

Example from practice: Voluntary Action Rotherham provide social prescribing services for adults with long term health conditions in Rotherham. Alongside the funding for the social prescribing service, there is a pot of money that is used to commission services according to client need, including social welfare legal advice. This ensures that there is sufficient capacity within onward referral services to accept those clients who are identified through social prescribing.

Fully integrated single service models

Some organisations which are perhaps further down the social prescribing road have begun to experiment with having more specialised link worker roles where there may be multiple link workers with individual specialisms, with social welfare legal advice being a crucial one. In this model, the client would see a single worker who was trained and appropriately qualified as both a social welfare adviser and link worker, or in some cases a social welfare adviser may receive more light touch training to enable a holistic assessment of client need which can be undertaken alongside delivery of advice. This is likely to have the benefit of reducing lag time between services, as well as eliminating the need for the client to form two new service relationships and repeat their story. Additionally, the adviser would be able to use their own judgment as to when to move from social welfare legal advice issues onto other matters.

However, there may also be a risk that the purpose of one or both services is somewhat neglected, potentially depending on the background of the adviser or primary focus of the service or that the capacity of the service is significantly reduced due to the double workload. It should also be noted that as well as different qualifications and training, there are distinct skillsets for each role, with link workers needing high levels of interpersonal skills and the ability to motivate clients, while social welfare advisers need a high level of attention to detail and up-to-date legal knowledge.

Example from practice: The Bromley by Bow Centre delivered the Getting on with Money project from 2017 to 2020 which, although not offering pure social prescribing or social welfare legal advice, was an example of a single service model. The project combined support with financial capability and advice issues with holistic assessment and motivational interviewing approaches which are common to social prescribing. The evaluation[15] found that clients valued the balance of 'doing with' and 'doing for' with more focus on what they could do for themselves than traditional advice models. Taking a more holistic view enabled social welfare issues to be viewed in the context of clients' wider lives, connecting the issues together and enabling onward referral to a broader range of services.

[15] https://www.bbbc.org.uk/wp-content/uploads/2019/04/Almost_Any_How_BBBC_GOWM_Booklet.pdf

Findings

This section will look at the common themes emerging through the interviews conducted with stakeholders from a range of organisations working in different ways and examines what is needed for successful collaboration between social prescribing and social welfare legal advice services, with examples taken from practice used as illustrations. It is important to note that, given the range of delivery partners working within this space, particularly within the social welfare legal advice sector, there is unlikely to be a one-size-fits-all model. Despite this, there are still a number of areas that can be considered at a local, pan-London and national level to establish what good practice looks like and how the approach could move to scale.

Funding

Funding level

Funding is a key area to look at to consider how to ensure integration at the frontline. With social prescribing having secured a long-term funding commitment, social welfare legal advice funding remains fragmented, a postcode lottery from one borough to the next and precarious, and, as discussed in the recent ASA report, demand in London significantly outstrips supply[16]. This high and increasing level of demand is attributed to a range of factors including:

- Stagnating incomes and an increase in the numbers of Londoners earning below the living wage and living in poverty.
- A consequent increase in Londoners claiming benefits.
- Welfare reforms including increasing digitisation of the benefits system, the roll-out of Universal Credit, changes to disability benefit processes etc.
- Decreased generosity of welfare payments, delays in payments and increased rate of sanctions/benefits being stopped causing increased levels of hardship and having a knock-on effect e.g. on bills, rent payments, arrears and debt and mental health.
- Increased migration (until the more recent Brexit-related slowdown) and changes to funding eligibility for migrants leading to large numbers having no recourse to public funds.
- Increased complexity of cases and demand causing increased strain on services and staff leading to higher sickness absence rates and staff turnover.

Alongside this rising tide of demand (which did not include that linked to COVID-19 due to the timing of the research), ASA found that more than half of advice services in London had experienced a reduction in funding over the past three years and a similar proportion expected a reduction in the coming three years. This was also reflected in those interviewed from the advice sector, some of whom reported reductions in services in healthcare settings in recent years for these reasons. With local authorities being the main funder of locally based advice services and the only statutory agency that has a duty to fund them, many services have experienced funding cuts occurring in parallel with those that local authorities have experienced themselves. Cuts to eligibility for legal aid have also been a factor in further restricting access to advice, particularly at specialist levels, for members of the public.

As well as a general oversubscription of advice services which, for those being referred via social prescribing, is likely to lead to long waiting times or difficulty in accessing services, 75 per cent of

[16] Advice Services Alliance (2020) Advising Londoners: An evaluation of the provision of social welfare advice across London. Available at: https://asauk.org.uk/projects/

respondents to the ASA survey reported gaps in service in their areas, whether this was a particular specialist area of advice or tailored services for certain communities. This undersupply of services and instability of funding can make it difficult for advice services to plan for the future or invest time in innovative approaches to the provision of advice.

Alongside this clear imbalance in supply and demand, it is also important to recognise that current estimates of demand do not include latent need. In the 2016/17 financial year, entitledto estimated that over £21 billion in means-tested benefits went unclaimed by eligible households[17], even before non-means-tested benefits are considered. This category may be particularly important in a health context as a large proportion are health and disability related. This is likely to be due to a combination of a lack of awareness of both entitlement and support available, and a reluctance to access support, possibly due to advice services being stigmatised. Both of these factors are likely to be somewhat addressed through locating advice services in healthcare settings, potentially increasing opportunities to draw out latent need.

> *"The drawback for us will be that if, as I suspect, many of these people will be new and we wouldn't have seen them, certainly at this point in their journey and maybe… we would never see them at all; then that is putting more demand on our service. And at the moment, money hasn't followed the destination organisations, it's only followed the link workers."*

Advice policy professional

Additionally, if a core rationale for integrating social welfare legal advice into healthcare settings is to be proactive and preventative to reduce health detriment by creating pathways for those who may be eligible for support e.g. post-diagnosis of long-term conditions, on reaching pension age or starting a family, it is important to recognise that this work cannot simply entail relocating existing services, but necessitates expanding capacity particularly in the short to medium term. While a more preventative proactive approach may eventually lead to a reduction in demand for complex issues where timely advice has not been accessed, in the initial phase of promoting early referrals there will always be a double caseload i.e. those who are accessing advice early and those who missed the opportunity before such early referrals were so available:

> *"Let's say for example you were to put advice and support firmly at point x of a cancer care pathway globally across the NHS. There would be a potential capacity impact on our services initially so it would have to be a wide conversation about how that's best managed. And that could be a national approach to some funding at the beginning until we understand what it means, but then things might start evening themselves out because we see people at an earlier stage."*

Advice policy professional

[17] entitledto, 2018, *Over £20 billion still unclaimed in means tested benefits.* Available at: https://www.entitledto.co.uk/blog/2018/december/over-20-billion-still-unclaimed-in-means-tested-benefits/

Further to this, there is a risk that with funding flowing into social prescribing services but currently not into social welfare legal advice services to the same extent, this can cause not only an imbalance in capacity, but a sense of being undervalued and being seen as 'the poor relation' which can cause issues in terms of staff motivation:

> *"It's all very well having a social prescribing scheme but it's not writing out the prescription that makes a person better. It's getting the medicine or intervention that makes a difference. And so, a lot of the resource so far seems to have gone into the mechanisms for writing out the prescription."*

Advice policy professional

> *"I think social prescribing's kind of taken some of the kudos here. And I suppose we're kind of sitting alongside them."*

Advice manager

Some referred to a sense that now social prescribing was becoming firmly embedded within primary care settings, there was a sense that some felt that other auxiliary services weren't needed as social prescribing is seen as a 'catch-all' and this has caused some funding streams to end or be reduced despite the increased demand for such services where social prescribing is embedded.

Funding models

Although there are clearly huge challenges in relation to the current underfunding of social welfare legal advice services, there are also opportunities for more innovative models of funding. The Bromley by Bow Centre's recent report on co-commissioning approaches to social prescribing (which was published before the NHS England announcement on social prescribing funding) explored ways in which local authorities and clinical commissioning groups could collectively commission social prescribing services. Although the landscape has now changed with the funding announcement from NHS England, this does not mean that there isn't scope for collaborative funding models to support more cohesive and integrated services.

The Bromley by Bow Centre report concluded that there were many advantages to co-commissioning, including:

- Reducing siloed working and overlap
- Increasing cohesion and cooperation between services.
- Ensuring a range of perspectives are considered within service design and outcome measurement, as well as bringing local authority expertise on areas such as prevention and working in community spaces.
- Broadening the scope of social prescribing e.g. to consider a broader range of outcomes and focuses.
- Increasing available funding levels through pooling of budgets.

These advantages could certainly apply to social prescribing with attached social welfare legal advice services, particularly given that central funding for social prescribing itself is now secured for at least the imminent future. Local authorities as current funders of social welfare legal advice may be interested in working with health partners and advice delivery organisations to look at reshaping delivery models in order to maximise impact through the apparent increased efficiency of advice delivered in healthcare settings. There may also be the possibility of regional funding e.g. the Mayor of London providing some funding to match local authority contributions. Non-statutory funders could

also be approached to support the scaling up of this approach – this additional external funding may be particularly useful in the early stages of the approach being used locally in order to demonstrate impact e.g. reduced demand on services, earlier action preventing worsening of health/financial detriment, which could justify ongoing local investment. In some cases, universities with law schools have also supported social welfare legal advice services which incorporate an element of student volunteering and training.

Example from practice: In Greater Manchester, many local authorities and CCGs have now combined multiple functions and undertake joint commissioning of key services to ensure services are joined up, avoid duplication and provide value for money. This helps to connect the focus of all stakeholders and look holistically at the needs of communities and individuals within them and naturally leads to increased focus on early intervention and cross-system efficiencies.

It should however be noted that along with the benefits of increased security for social prescribing, there is a risk that NHS England funding could have a detrimental impact on services' ability to engage CCGs and other health partners to fund social prescribing and associated services such as social welfare legal advice. Engaging local health partners in funding broader services necessitates encouraging a broader understanding of the factors which affect health and wellbeing beyond the clinical as discussed in the Bromley by Bow Centre report. It is important that progress that has been made isn't lost with the perception that funding for social prescribing is now secure, meaning that all work relating to the social determinants of health is somehow resolved.

If multiple stakeholders can be brought together to increase the funding available to 'social prescribing plus' i.e. social prescribing alongside onward referral services such as social welfare legal advice, there may be an opportunity to build on the learning from models such as those used in Rotherham and parts of Greater Manchester. In these areas, there is a pot of funding which sits alongside social prescribing to either commission or spot purchase onward referral services such as social welfare legal advice. These integrated models help to address the mismatch in capacity between social prescribing and the services it refers onto.

More broadly, concern around funding security for social welfare legal advice in particular may be addressed by engaging multiple funders, enabling greater long-term planning and embedding of services. There may be a role for Health and Wellbeing Boards to integrate considerations on the coverage of social welfare legal advice within their areas as part of a more holistic view of health and for the Mayor of London to encourage this to happen organically as well as lobbying for this to be made a statutory duty.

Another area for potential exploration is the idea that with the recent confirmation of funding being expanded to cover a number of link worker roles per network, PCNs may be able to use this to consider developing hybrid roles for social welfare legal advice specialist link workers to increase capacity further. By taking an approach whereby roles undertake generalist social prescribing activities alongside individual specialisms there may be an opportunity to prevent duplication as described in the models of operation section.

Recommendations:

- A thorough assessment of the funding required to meet demand for social welfare legal advice should be conducted, incorporating the findings of the ASA's report and consideration of varying levels of deprivation and existing provision across the capital.

- Consideration should be given as to how funding can be drawn in to supplement NHS England funding for link workers and enable an adequate level of social welfare legal advice services to meet onward referral demand. This may involve roundtable events bringing in a range of funding stakeholders.
- The role of Health and Wellbeing Boards in ensuring adequate social welfare legal advice provision should be considered, including how this can be encouraged and potentially turned into a statutory duty.
- If funders are forthcoming, it may be wise to consider piloting multiple models of operation in the initial period as this is still a relatively new area of delivery.

Management

In most instances, those we spoke to had separate management for social prescribing and social welfare legal advice services, as often the two were delivered by separate organisations. However, it was clear that in spite of this, there is an important role for managers to play in facilitating effective joined up working on the ground. This includes the role of management in establishing working protocols as well as service level and data sharing agreements, but also of setting clear expectations of staff in relation to how they work with other services based within the same practice. Some interviewees reported significant variation on an individual staff member level in relation to the extent to which they prioritised working with other services and so ensuring that this is clearly laid out in job descriptions, training and performance review will be key.

Single management models may also be possible going forward if more integrated funding approaches are explored. This may help to ensure a 'single team' approach, though thought should also be put into ensuring that specialist management support is available, particularly for social welfare legal advisers who require appropriate supervision and file review processes to ensure quality and adhere to accreditation standards. This supervision may be available from a different part of the same organisation or by collaborating with another organisation who can provide this support.

Regardless of the management model, a number of interviewees expressed the importance of allowing for an embedding phase, with some suggesting that having a skilled development manager with knowledge of NHS working practices in place for this phase could be helpful.

Recommendations:

- A toolkit of guidance for managers should be produced to set out the core components of management of social welfare legal advice in a healthcare setting, along with guidance for social prescribing managers on effective service integration with social welfare legal advice.
- Consider incorporating an 'embedding phase' with possible additional management support in plans for new programmes.

Referral pathways

One of the most crucial elements of an effective and integrated service experience for clients is the referral process and this was corroborated by the experience of many of the interviewees. This is also crucial to ensure continued buy-in on the part of the referrer (i.e. practice staff) as negative experiences either for their patient or themselves may lead them to write the services off as ‘a waste of time’ and not to refer further patients who are in need of support. The need for a well-considered referral pathway or multiple pathways was emphasised by a number of interviewees:

> *“Where there's been a conversation about what a referral pathway looks like, the role of everybody in it and that clarity of expectation about what you can expect from our services, that obviously works really well because then you're giving the client some realism about what's going to happen when. That's a benefit for anybody in the system including patients.”*

Advice policy professional

Identifying appropriate referrals

Who to refer?

One of the key challenges for those referring to social prescribing and social welfare legal advice services, is knowing when a referral is appropriate. In some cases, this may be clear, with patients expressing a defined need e.g. no money for food, an issue with a landlord or perhaps a looser expression of need which requires further exploration. However, there may also be opportunities to proactively identify those who are in need, particularly of social welfare legal advice, based on their circumstances. For example, those witha recent diagnosis or worsening of ill health may be newly eligible to access welfare benefits, but may not raise this themselves, or those who are pregnant may be unaware of financial support available or changes to housing eligibility. There may also be some who would benefit from social prescribing services but may not actively express a particular need e.g. recent bereavement leading to isolation, loss of job leading to dual need for benefit advice and employment and skills support. For some, the issues may be long-term and something they have become so habituated to that they are not consciously aware of it constituting a ‘need’:

> *“I think often people don't actually realise that one of the reasons why their health and wellbeing might be suffering which is why they end up at the GP is all of the other stuff that is going on in their lives. So, if you struggle day to day to feed your family that's going to impact your health. But if you think that is “life” then you're not seeing it as a problem.”*

Advice policy professional

One element of being able to identify patients for whom advice would be beneficial in these circumstances is clearly training for inward referrers, which will be discussed later in this report. However, alongside this there is scope to explore technological solutions to automatically trigger a suggestion of a referral for patients in certain situations or ways of incorporating trigger questions into patient assessments. This could be built into clinical pathways for certain patients and, depending on level of need and capacity to take action themselves may result in either provision of light touch information (e.g. a leaflet, signposting to an app) or a referral to social prescribing and/or social welfare legal advice. These kinds of approaches may help to maximise the preventative or anticipatory benefits of advice services to reduce risk of poor health and social outcomes. One potential upcoming example where this could be trialled is the introduction of the right to ‘breathing space’ for people experiencing a mental health crisis which will entitle them to a moratorium on any debts enabling

them to access advice and focus on their recovery without the added stress of debt collection proceedings[18]. A similarly focussed scheme has also been piloted in Lambeth and Southwark around debt caused by hardship during the COVID-19 pandemic[19].

Example from practice: Citizens Advice have a partnership with Macmillan Cancer Support whereby 58 local Citizens Advice offices are funded to deliver welfare benefits advice to cancer patients. The way this works is negotiated on a local basis, but largely works to a model of referral on diagnosis, particularly as this often triggers an almost total rethink about everything from work to relationships and housing. By reaching people at an early stage, the scheme aims to prevent financial and other issues from developing and having a detrimental impact on patients' health and wellbeing. Advisers have access to Macmillan's training packages to ensure a strong understanding of the issues affecting those with cancer.

Macmillan Cancer Support also funded the Bromley by Bow Centre to deliver a social prescribing service for cancer patients in East London from 2015 to 2019. Referral pathways and outreach activities ran across both primary and secondary care, with 75 per cent of clients coming through referrals or outreach within secondary care due to the close working relationships that developed between specialist teams. The service was connected to tailored social welfare legal advice for cancer patients commissioned by Macmillan and delivered by Toynbee Hall in hospital settings. Additionally, employment law queries were referred to the Legal Advice Centre. Due to a combination of the presenting needs of clients and the close working relationship with a tailored advice service, social welfare legal advice was the primary onward referral from the service.

At the Spinal Injuries Unit in Southern General Hospital in Glasgow, referrals for social welfare legal advice are built into care pathways in order to ensure that benefits are in place to enable discharge.

How to refer?

There was a strong consensus among those interviewed that a true referral process between healthcare professionals and auxiliary services is preferable to signposting – with a suggestion from one interviewee that signposting tended to lead to just a 20 – 25 per cent conversation rate. In practice the referral process looks very different depending on the local context, but importantly means that the responsibility of booking the client onto the non-clinical service is not the responsibility of the client. Depending on the model, the actual booking of an appointment may be done by the clinician making the referral, the reception staff at the practice, or the responsibility of the link worker or advice worker who receives the referral. Many practitioners discussed utilising the same system that is used by patients to book appointments with their GP, instead of creating a new booking system.

> *"Use the same appointment system that the practice uses. So for example in the homeless practice or in an area of multiple deprivation appointment systems might not work because people have got other things going on in their lives and they might just have quite chaotic lifestyles… so if the practice offers drop in appointments then the advice workers usually just mirror that and they offer drop in appointments."*
>
> Public health professional

Some also allowed clients to book themselves in directly through reception without a referral.

[18] https://www.gov.uk/government/news/breathing-space-to-help-millions-in-debt
[19] https://www.gsttcharity.org.uk/get-involved/news-and-opinion/views/how-covid-19-financial-shield-can-protect-health-those-low

Where to refer?

Once the need for a referral has been identified, the next challenge is knowing where the patient should be referred. Many of those interviewed worked in settings where both services were present, but largely separate, meaning that the referrer may have to make a decision on where to refer their patient:

> *"One of the challenges for it is making the referral pathways for the GPs intelligible. So, it's like, does this person go to a social prescriber, does this person go to welfare rights?"*
>
> Welfare and health professional

Some interviewees who had been running services prior to the introduction of the other service reported that there had been some difficulty when the other service initially came in to ensure there was clarity on the different roles of each service and where patients should be referred.

It is therefore important that regardless of funding arrangements, social prescribing and advice staff work together to establish a clear and easy to comprehend process for all those referring in regardless of whether the pathways once the referral is received may be somewhat more complex e.g. differing for those with more urgent welfare advice needs or those whose situations may necessitate more prolonged casework. Largely those we spoke to operated on either a social prescribing to advice referral model or an advice to social prescribing model with benefits and drawbacks to each approach.

Social prescribing as the initial destination of referral

Many primary care settings have social prescribing as the main route of referral from primary care into community services, including advice services, acting as a single point of referral for primary care staff. This referral often occurs through the data system used by the health practice (e.g. EMIS or System One) which sends a secure email referral to the social prescribing team. The social prescribing team will often have an initial assessment conversation with the patient and at that point, they will make a referral to welfare advice.

The benefit of this system is that it ensures that the patient has the opportunity to discuss any other matters that they might need support with and creates a single and simple referral process for staff in the health practice, increasing the likelihood of a referral happening in the first place. Clinicians also talk of the importance of making a referral that they trust will be picked up in a timely manner and by a professional they have developed a trusting relationship with.

> *"It's been designed to be as easy as possible so that you're not feeling, oh do you know what? I can't be bothered to do that because it just takes too long. As long as I've got a background of what their needs are, I can then write it on the social prescribing form, it takes me 30 seconds to fill out the form, email it to the right person and then there is no need to be chasing it up because I know it will be chased up. The next part of the process where it goes from the social prescribing coordinator to the Welfare Advice team has always been a bit of a mystery."*
>
> GP

Both advice workers and social prescribing workers talked about the time it takes to gain trust in a health practice, and to be seen as 'part of the practice', so streamlining this work as the role of the social prescribing team could also minimise duplication of work. However, advice workers also note the importance of a strong relationship with practice staff and particularly GPs in order to secure the best possible outcome for clients and so even if the relationship is not one of direct referral, it is still important to ensure adequate communication in other ways e.g. around evidence for benefit claims.

Social welfare advisers working in this way do however note that there can be value in the link worker making the initial contact with the client, particularly if they have an understanding of the advice process in order to ensure they are adequately prepared to make best use of their appointment.

> *"Some social prescribers are really good in identifying the type of documents a patient would need to bring to the appointment. This is really helpful for advisers because it means that the issues/matters that the patient has presented with can be resolved in the first initial appointment rather than having to book a follow up appointment for the patient to bring the necessary documents".*

Social welfare legal adviser

Conversely the main drawback is that often a welfare issue can be the most pressing amongst those facing a client, and this system creates an extra step on the journey, as they need to talk to the social prescribing team before their welfare need can be addressed. This can cause particular issues where the issue is one of extreme urgency e.g. food poverty and destitution, imminent or current homelessness etc. If in this instance it takes a few days to speak to the link worker by which point the weekly social welfare advice session has passed there may be a significant lag time which could be critical to the client.

Additionally, many of those interviewed highlighted that the clients most in need of support, are often those most at risk of dropping out during a multi-stage referral process, and this increases with every step that is introduced on their pathway.

> *"We find that there are lots of opportunities for people to drop out of a particular journey or not complete it successfully. You really need to plan in detail about how to, you know, work with the grain of how people actually behave as they take the journey."*

Advice policy professional

It's therefore important that this step of seeing a social prescribing link worker is not an unnecessary step for the client.

> *"For someone who's trying to get help, being told that you need to go somewhere else and see another person to be assessed, is, from their perspective, an unnecessary detour, a waste of limited time, energy and (sometimes) money."*

Advice policy professional

There may be adjustments that can be made to the process to prevent these pitfalls. For example, where the referral is clearly an urgent welfare advice need (perhaps indicated through a specific flag within a referral system), the link worker may be able to bypass the usual process and immediately pass the referral to the adviser or the initial contact with the client could be predominantly focused on booking the advice appointment and ensuring the client is prepared, with the social prescribing service being offered as appropriate e.g. after the advice appointment or with an initial assessment being conducted at the same time. Other solutions may include enabling direct booking of welfare advice appointments via reception staff which is easily signposted to alongside a referral to a social prescriber for broader support.

Example from practice: Dundee City Council offer social welfare legal advice in a number of primary care settings across the city. They enable booking directly through reception staff and use banners to advertise the service to patients so that they can self-refer as well as being referred by a clinician or other staff member.

Thought should also be given as to how link workers are able to effectively identify social welfare issues within their holistic assessment in order to ensure onward referrals are made even where this was not part of the rationale for the original referral and perhaps where clients themselves aren't aware of a need e.g. new diagnosis triggering eligibility for welfare support. Link workers having this capacity is found to be a useful part of the process for both link workers and advisers:

> *"I think there are standard questions, there's trigger questions you can always ask. And one of them is about money worries. So from a social prescriber's point of view if in their initial assessment they're allowing the patient the time to define their own ground, I think even asking a question like "do you have any money worries?" is a very neutral question and then that gives the patient space in order to open up about that."*

Welfare and health professional

> *"When the referral comes through the social prescribers, there's a proper assessment, a triage has been carried out. Once this is done the patient is then referred to the appropriate services. Not only is this helpful for the advisers, it is also beneficial for the patients as they are able to access other services."*

Social welfare legal adviser

Advice services as the initial destination of referral

Conversely, some argue that, when the primary issue identified is an advice-related one, the default mode of operation should be for advice services to be the first destination in the referral process. This is primarily on the basis that if you are struggling to meet your basic needs, you will not be able to focus on wellbeing and development opportunities often associated with social prescribing support. This follows the logic of Maslow's hierarchy of needs theory which suggests that basic needs must be met before higher level psychological and self-fulfilment needs can be engaged with.

> *"Usually they'll go to the advice worker first of all because also what we've recognised is that you need to get that financial crisis sorted before you can start to think about what else you might want to do to improve your health and wellbeing. So, in most instances they would see the advice worker first of all to make sure there's no money worries affecting how they're feeling and then the advice worker would support the person to go to the link worker".*

Public health professional

Once their most urgent welfare issues are dealt with, social prescribing can be the logical next step for a client:

> *"But…breaking that cycle of chaos of crisis in peoples' lives is that once you sort the immediate problems, then referring on to something like a social prescriber is the ideal model because hopefully once that person's stabilised and they start to access other services that are going to support them, then they're not going to be back at the advice service's door in 18 months' time with the same problems."*

Welfare and health professional

It should also be noted that the social welfare advice process often uncovers other household issues which could be addressed through a social prescribing intervention. For example, domestic abuse and gambling addictions may be concealed behind a debt problem, while a traumatic relationship breakdown may trigger someone to present with a housing issue.

However, this process also has potential drawbacks. As with the social prescribing first model, having additional stages in the process may lead to some clients disengaging, and this is a particular danger for those clients whose predominant initial need was around social welfare advice. In the Bromley by Bow Centre's experience, while some clients show interest in onward referral after an advice intervention, many are satisfied that they have dealt with their main or most immediately pressing problem and cease to engage at this point. This may be more straightforward where the initial referral from the practice incorporates elements beyond social welfare advice which provide a rationale for accessing the service, whereas referrals to simply explore what may be helpful may be more challenging to 'sell', particularly as they are likely to necessitate engagement with a minimum of two further services i.e. the social prescribing service itself and any further onward referrals.

Again, mutual understanding between the social prescribing and social welfare legal advice service are critical. This enables the adviser to more effectively ensure the client understands the benefits of the social prescribing service and to lay the foundations for what it can do for the client e.g. identifying interests and goals. Having social prescribing as a point of onward referral may help to alleviate some strain from the adviser who may otherwise be the one who must try to establish any onward referrals needed. If there are strong working relationships in place and the two teams view each other as colleagues (even if they work for different organisations), there is increased potential for a 'warm handover' with the client feeling supported in the transition between services.

It should also be noted that complex advice matters may necessitate engagement with an adviser over a period of months so the services must work together to establish when the referral to social prescribing would be best made i.e. after full resolution of the issue, after the first advice appointment or at some point towards resolution.

> *"The welfare adviser will start to work on your case using a case management approach. But they may well at the end of that session ask the person if they want to see the link worker. So actually, the link worker will then be engaged to see the patient. But in the meantime, the welfare adviser is going away and doing all that follow up work. We don't wait until that person has got their housing benefit reinstated or their PIP or whatever 'cause that could take several months. So, the link worker is seeing people while they're being supported by the adviser."*

Public health professional

In some cases, it may be that the adviser can be trained to undertake a light touch holistic assessment themselves to reduce the need to access both services separately. This is likely however to need ongoing support from specialist link workers to ensure that the full breadth of local services can be referred to and knowledge of the local landscape is kept up to date.

Simultaneous access to both services

In some instances, it may be helpful for clients to access both services simultaneously, although it may be the case that one service still handles the initial referral to ensure that practice staff don't have to go through two separate processes. This is likely to also necessitate close collaborative working between the services to ensure that the client doesn't feel bombarded with contact or confused by the distinction between the services. Clients with the most complex needs are likely to need ongoing engagement with both services for a more prolonged period:

> *"So, I think if you look at it down the road with advice services and social prescribing, you may be engaging with both services at the same time until you're most stabilised within the community."*

Public health professional

Example from practice: At the Bromley by Bow Health Partnership, all referrals are sent through the Social Prescribing service, however the referrer also has an option of ticking a 'welfare advice' box. This triggers referrals to both social prescribing and advice simultaneously. Both services receive the referral and often the patient has access to both services at the same time. This means that for complex benefit system cases that can take months, the client is also receiving holistic support from the social prescribing link worker at the same time.

Personalised and collaborative referral pathways

> *"The real crux of the issue is that…you need to have a sense of the journey as it looks for the person who uses that service, investing in improving those journeys, making them easier to take, particularly where you can predict the points where people get stuck or drop out."*

Advice policy professional

It was clear from interviews with practitioners that both referral routes (GP-SP-Advice versus GP-Advice-SP) have strengths but also potential weaknesses and currently there isn't enough evidence to recommend one pathway above the other. However, with an awareness of the potential weaknesses and mitigating action taken to reduce the impact of these, both pathways can provide a meaningful and coherent journey for clients. This is largely dependent on the relationship between the teams, as well as the more formalised processes e.g. referral protocols, data sharing agreements etc. which enable smoother collaborative working, for example by differentiating the approach to different types of cases within the process.

> *"It's allowing both the social prescriber and the adviser time in order to work together as well and that's really important in any partnership or collaborative working, is that you actually have time to speak to your colleagues about the work that you're doing, about the trends that are coming through for you and what are the most appropriate ways that social prescribers and welfare rights can work together."*

Welfare and health professional

In general, the different pathways or sequences can be successful, as long as they are personalised and beneficial for this individual

> *"Try to make sure that each stage of the pathway actually delivers something that's of value to the person seeking help."*

Advice policy professional

The key lesson is not about prioritising one pathway over the other, but to prioritise the need to build effective relationships between the two services and frontline staff to ensure that clients receive effective and joined-up support. It should therefore be a locally made decision, that supports the shared vision of the local stakeholders, and scale-up processes. should support this place-based decision making.

Single service pathways

The final model that some schemes are beginning to experiment with is to have a single service which integrates social prescribing and social welfare advice into one role, with the client only needing to make one relationship and access one service. As social prescribing schemes continue to grow the

number of link workers, some are starting to question whether having some degree of specialisation may help to ensure that they are as effective as possible:

> *"I think they will be much better if they were joined up and social welfare advice was part of the social prescribing portfolio… Practically I think that means that some basic welfare rights advice should be part of what link workers do and that means they need some basic social welfare training…And if social prescribing is going to scale up then I think there are some arguments about having a welfare rights service."*
>
> Social prescribing manager

This has obvious benefits in relation to maximising the opportunity for clients to access both services without needing to be passed between them with the attendant risk of dropping out at each onward referral point. However, this approach also brings challenges in relation to maintaining the capacity of a service with a double workload and ensuring that the client is able to get the same quality of support they would have done had they accessed both services individually. This is something that will largely come down to the level of training staff have and the time available to work with each client.

This integrating of services could entail recruiting qualified social welfare advisers and training them in link worker skills or vice versa. Where link workers are trained to provide some level of social welfare legal advice, proper consideration needs to be given to ensuring that the quality of advice will be maintained through proper supervision, as well as that proper accreditation and liability insurance is in place. With legal frameworks changing frequently, the risk of giving incorrect advice is high. It may be that in these types of models, unless link workers have a background in advice, the best approach is for them to undertake basic social welfare advice work such as benefit applications and mandatory reconsiderations, basic contact with local authorities and housing providers and so on, while specialist advisers support, supervise and take on complex cases such as appeals.

Recommendations:

- Partners should consider exploring ways of establishing automatic referral reminders within patient data management systems to trigger clinician referrals to social welfare legal advice and social prescribing. This could initially be trialled with a small number of conditions to assess its effectiveness and the time implications for both clinicians and auxiliary services.
- Alongside this, broader routine screening questions for patients aimed at triggering social welfare legal advice referrals could be piloted to assess the impact on referral numbers and patient health and wellbeing.
- A referral pathway quality framework should be established which provides key components which should be present in any approach, while allowing for flexibility of approach. The framework should incorporate expectations for:
    - How clinicians and other practice staff should identify need and refer onwards.
    - The journey for the client including where signposting is appropriate and where a full referral is needed, and differentiation in pathways for different types of issue to minimise risk of client dropout.
    - How appointments should be booked, with encouragement to use the same system as the practice for full integration.
    - Turnaround of referrals, particularly for urgent social welfare legal advice demand
    - How social welfare legal advisers and link workers should identify need for the other service and refer onwards.

Onward referrals

It is important to recognise that social prescribing and social welfare legal advice are not the only non-clinical services which are of value for patients and for this reason it is important that services have strong connections to other services. Even within social welfare legal advice, it is likely that individual advisers will not be able to support all types and levels of cases and so referrals either within organisations or externally may be needed e.g. for high level cases such as appeals or specialist areas such as immigration advice. Social prescribing also needs access to the full range of services it may need to refer onto. For these reasons it is important to consider how the services are integrated not only within primary care, but with the wider service landscape in the area. In some areas such as Rotherham and parts of Greater Manchester there is further service integration whereby the social prescribing scheme is able to 'purchase' or commission some of the services it refers into ensuring a good balance of capacity between social prescribing and onward referral services.

Recommendation:

- The referral quality framework should incorporate a requirement to map onward referral partners, particularly for specialist areas of advice.

Location

One question which was addressed within the interviews was the importance of location in joint working arrangements and whether it was a necessity for social prescribing and social welfare legal advice services to be co-located in order to work effectively together. Most interviews were conducted prior to the onset of COVID-19 which clearly presents some challenges in maximising the benefits of co-location with many teams operating remotely.

Advice workers who were interviewed were clear on the benefits for them of having some sessions located within a health practice. One reason for this was that a significant proportion of advice work relates to health and disability e.g. benefit eligibility, housing need etc. and requires medical evidence so siting this work in a healthcare setting makes sense to clients. It was also felt that it is a neutral location that is trusted and familiar without a fear of being stigmatised for attending, particularly if it is possible to conceal the purpose of attendance for clients. This is particularly valued by advice workers who are aware of the reluctance some feel in attending traditional advice locations:

> *"Going into a GP doesn't signal that you've got a debt problem. People understandably may not feel comfortable sharing. Going to see a GP doesn't signal that you're reliant on benefits. And we know very clearly that there's a stigma attached to both."*

Advice policy professional

> *"Patients find it a lot less stigmatising, you know, if they're going to go into the surgery rather than, say, being referred onto the advice agency where their neighbours might see them walk through the door and it's got that big sign with "I've got problems" over the door. Nobody really wants to walk in and admit it."*

Welfare and health professional

A further reason for co-location of auxiliary services is that there may be some limitations on where data can be accessed depending on the systems that are in place so being on one site can be beneficial for this, as well as for staff to be able to interact and strengthen the relationships between the services. Some advice services also reported that by advertising the service through promotional

materials within the health practice such as leaflets, banners and information on display monitors they were able to reach other patients beyond those who were referred by a member of staff.

Although largely social welfare legal advisers were very positive about delivering services onsite within health practices, those involved in social prescribing gave a slightly more mixed picture. A number noted the benefit of having at least some follow-up meetings, if not initial meetings, (depending on client preference), outside of a healthcare setting. Locations such as cafés, community centres or the option of undertaking home visits was felt to be beneficial as often these locations allow a different and less formal relationship and allow the link worker to notice elements of the person's life that could be helpful to get a picture of their needs, and importantly their own assets and strengths:

> *"So, they try and visit people in their own homes because then you pick up things…Their staff are trained in observation skills. And they can spot things around the room so you have a conversation. Oh, I see a guitar in the corner. Do you play? And then away you go then with a potential interest that gives you a hook. You know, whereas you wouldn't get that if the person came to you."*
>
> Public health professional

Assuming that, COVID-19 situation allowing, most services will incorporate at least some element of onsite working, challenges which must be addressed in order include ensuring that an appropriate room is available, along with access to necessary equipment (e.g. computer, phone, scanning/photocopying facilities), as well as the support of administrative staff to ensure clients know where they're going and any issues can be resolved swiftly. In some cases, advice services reported having been charged for the use of consulting rooms which may be a barrier to delivering a service depending on funding arrangements.

Recommendations:

- The management toolkit should incorporate guidance on how to maximise the benefits of co-location including through promotional activities and visibility in the practice, while also maintaining discretion for clients attending social welfare legal advice appointments to reduce stigma.
- Guidance should be provided to health practices on what facilities are needed for social prescribing and social welfare legal advice to be effectively delivered within the practice premises.
- Consider engaging with NHS Property Services to negotiate for charges to be waived for advice services operating in practices.

Working protocols and data sharing

While in a number of cases, services working alongside each other operate mostly separately, a number have found that they have benefited from some degree of integration of their working processes or of establishing clear protocols to ensure smoother collaboration. Ensuring data can be straightforwardly shared where appropriate and with adequate consents is also a key area of focus. These 'infrastructure' elements can be critical to ensuring that frontline staff are able to provide the best possible support in the most efficient way.

Working protocols

In some cases, guidance has developed organically as joint working has evolved with frontline staff or managers deciding to establish processes for how the services will work with each other and clients:

> *"We've agreed that we should draw up some operational guidance between the social prescribing and the welfare rights service as to how they work in conjunction on a person's case."*

Advice manager

In other cases, this may be something that is put in place at the outset and this is often viewed as preferable to ensure that all parties have confidence in each other's processes and feel more able to work together:

> *"We've got an agreement with the practice. And we share the subject access request information with* [the practice]*. We've got a template for that. And we've also got a mandate which we use. So, we give those to the practices when we start working with them, and that way all partners can see exactly how it's going to be documented. And any sort of documentation that the practice wishes us to complete for any reason, whether it's for access to systems or whatever, we go along with that. You know, whatever the practice deems to be necessary to get the project up and running, we go with it and we'll work with them."*

Advice manager

Where a service level agreement or referral pathways are put in place from the outset, it is also important to ensure that there are service improvement feedback loops built in and that there is regular review of how things are working in practice both for clients and staff. A particular area of focus for service level agreements or similar is ensuring that staff feel clear on how their roles interrelate:

> "*But that is about managers and service providers making parameters clear to their staff and what to do in certain situations. So as long as that's clear, and any service in its early days if it doesn't have clear parameters can go feral very quickly and start doing things it's not meant to be doing just because people want to help, then I think it is having that clarity of role is incredibly important from the outset, just saying "this is what the remit of your role is, this is what to do in x, y and z situation."*

Welfare and health professional

Particularly crucial is a strong understanding of the beginning and end of each other's role and the boundaries which must not be overstepped. This is particularly critical for link workers, who while they may identify social welfare advice issues, will not be qualified or equipped to advise clients on these matters:

> *"We don't advise them on any welfare benefit issues. And that's mainly because the benefit system is constantly changing and so is the legislation related to it. This is a completely different and specialist area of work. If we're not sure and give out welfare benefit advice we can potentially sabotage a benefit application so it's important we refer them to the right service and people."*

Link worker

Data sharing

One of the most critical areas of integration between link workers, social welfare legal advisers and healthcare staff is that of data sharing. Done well, participants reported that this can enable clients to avoid having to retell their story or do the work of obtaining copies of information themselves. However, these benefits must be balanced with ensuring that individuals have control of their own data and give informed consent to this being shared with multiple parties.

For social prescribing, access to EMIS (or equivalent) was highlighted by many participants as important to ensure a smooth referral and to create feedback loops for the clinicians so that they can easily understand what happens to a patient after they are referred to social prescribing through looking at notes on the system. Utilising the same system as the healthcare staff also helps to build the evidence base by being able to accurately track NHS attendance after a referral using patients' NHS numbers:

> *"We use EMIS, it is a database used by GPs. On there we record things that we've discussed in the one-to-one session, issues that we've addressed, the intervention that has been agreed, any follow up, safeguarding. Also, if a client declines, the reason for declining, and non-attendance so the GP can keep a track of what happened to the referral, and if the patient goes back and says they haven't been contacted the GP has notes there that he/she can refer to."*

Link worker

For social welfare legal advice services, access to the medical data of patients was the predominant benefit of data sharing. With access to health-related benefits amongst the most common issues within their caseload, they need to not only have a strong understanding of how health conditions and disabilities affect their clients day-to-day, but to be able to provide benefit agencies with evidence of this. In the normal advice process, things are significantly slowed down by the need for clients to request this information from their GP. This can create additional steps for both clients and advisers leading to delayed resolution and an increased risk of clients dropping out of the process entirely. Having access to the full breadth of information available rather than only what is provided was also reported to lead to more successful applications which are processed more quickly:

> "T*here was a point just after we started in 2015 where Personal Independence Payment decisions were taking somewhere in the region of about eight to nine months to come through – there was a huge backlog in decision-making – and we got a PIP decision within a matter of weeks from, you know, from a case where we had supplied the extra medical evidence. So that was a bit of an eye-opener."*

Advice manager

Where data sharing agreements are not in place it is evident that for some this was felt to cause significant inefficiencies even with co-location:

> *"We discovered late on in the day the GPs were not giving the advisers full access to medical records. Instead the advisers … were having to chat with the GPs to say what type of medical evidence would be helpful and then the GPs were then looking for that medical evidence and providing it for the adviser which to me seems the most ridiculous way of doing it."*

Public health professional

However, others found that if practice staff were able to provide information in the required timeframes this could still be an effective way of working:

> *"What they do is work with the adviser in order to produce medical evidence that the patients need. And they're happy with that and I must admit that the advice service is happy with that as well because we always get really appropriate information from them, and they always provide information and they were never charged for it."*

Welfare and health professional

Many interviewees emphasised how clinical time could be freed up as long as there is trust in how advisers will utilise evidence and information:

> *"I wish we'd been involved in the development of that because we would have been able to show them how it saves GP time; the advice workers know what evidence they're looking for."*

Public health professional

This was also echoed by GPs who could see the benefit of the adviser being the one to compile the evidence, particularly with their understanding of what is most relevant to benefit agencies to be able to conduct their assessment of eligibility:

> *"A well-trained advice worker would actually be able with the patient's consent to look through the notes and pull up the information that would relevant thus bypassing the need for a report in the first place. And if there was still this bizarre need to have a doctor's name on the bottom of it, at least if a report was put in front of me and then I could read it and have a quick glance of the notes and go, that sounds fine, it might take me three to five minutes as opposed to 25 to 30."*

GP

Those experienced in this type of service integration expressed the need for this, even going as far as to say they would walk away from delivering the service in a practice if this condition was not met. However, some primary care teams expressed some hesitation as to whether it was appropriate to ask patients to share their data and whether they could truly give informed consent:

> *"What I think of that is irrelevant because to be honest with you the general public feeling about anybody having access to their notes who is not their own personal doctors, has always been very against that… even when somebody consents they don't really understand what they're consenting to."*

GP

It is therefore important that social prescribing schemes and advice services are supported to understand and meet data management standards common in primary care, and that primary care teams' concerns are listened to and incorporated into service design. As this is still a relatively new area of joined-up working, it is also important that patient input is sought in relation to how data is shared and that the risk of unintended negative consequences of data sharing is mitigated. Alongside this, primary care should be supported to allay its fears, through understanding that social welfare advisers and social prescribing link workers are highly skilled professionals, who are used to working within defined data management policies, handling sensitive data and respecting clients' boundaries:

> *"The advice workers know what evidence they're looking for. The advice workers aren't there to be nosy. They've got, they work to professional standards and stuff like that."*

Public health professional

This research did not find any instances of an integrated case management system being used by both social welfare legal advice and social prescribing, and some questioned the appropriateness of having one. There may however be benefits, similar to those of clinical staff understanding the onward journey of those referred to social prescribing for those delivering social welfare legal advice.

It could also help to support increased understanding of the impact of integrated models as often social prescribing teams struggle to access information regarding onward referrals making it challenging to measure the cumulative impact of social prescribing support. Additionally, this may provide additional data on social determinants of health which could be of use for strategic needs analysis leading to better informed commissioning. For these reasons there is a need to explore how data could be used to support collaboration between these teams as well as helping to provide an evidence base for integrated models.

Example from practice: Dundee City Council have a welfare rights team who offer social welfare legal advice across a number of primary care settings across the city. The team recognised that 74 per cent of their caseload related to disability or sickness benefits and so felt it made sense to co-locate themselves in a medical setting. The team use mandates to gain consent to access patient data. Through this access and collaboration with GPs, the team has found that they are able to reach clients earlier, provide better evidence for benefit claims and achieve resolution of cases quicker and with less complications. It has also helped to identify clients who are unlikely to be eligible for benefits based on their medical records and avoid them building up false hope of accessing benefits and wasting their time.

The Dundee scheme was set up with the support of the Improvement Service in Scotland which supports the development of welfare advice and health partnerships in healthcare settings[20]. The service provided template agreements and protocols enabling fast and efficient set up. A 2016 evaluation conducted by the Improvement Service and NHS Lothian suggested that co-location of welfare rights advisers in healthcare settings along with access to medical records led to an estimated social return on investment of £39 for every £1 spent[21].

Recommendations:

- Provide model working protocols and data sharing policies and templates for adaptation by services.
- Incorporate data protection issues into training for all parties.
- Undertake research with patients to understand their feelings around data sharing and how this should be approached.
- Ensure guidance encourages regular review and service improvement feedback loops so that learning can be acted upon to refine processes.
- Consider piloting a single case management system approach (with appropriate data protection measures in place) to assess whether this is beneficial to the work of all parties.

[20] Improvement Service, Welfare Advice and Health Partnerships.
Information available at: https://www.improvementservice.org.uk/products-and-services/consultancy-and-support/welfare-advice-and-health-partnerships

[21] Improvement Service and NHS Lothian (2016) Forecast Social Return on Investment Analysis on the Co-location of Advice Workers with Consensual Access to Individual Medical Records in Medical Practices
Available at: https://www.improvementservice.org.uk/__data/assets/pdf_file/0023/9167/SROI-co-location-advice-workers.pdf

Delivery methods

With an increase in demand for social welfare legal advice, a number of services have adapted their approach to try to broaden their reach and this can also be considered within a healthcare setting as part of certain pathways, particularly for those who may be able to 'self-serve' with the right information. There is a suggestion that 'just in time' information could be provided through the provision of apps, web-based or printed materials targeted at specific demographics e.g. pregnant women, those diagnosed with cancer which could incorporate welfare information alongside health and practical advice. As much of the welfare system moves online, some have also experimented with providing tablets in waiting room areas or running supported online sessions where clients can use computers or tablets to try to do their own application or communication, with help on hand if needed. These approaches may help to alleviate some strain on social welfare legal advice services where clients are able to utilise information and act on it themselves.

Example from practice: The Baby Buddy app designed by the charity Better Beginnings provides information for mothers during their pregnancy and the first six months of their baby's life. This incorporates a wide variety of topics including maternity leave rights, welfare benefits and is designed to be fun and engaging. The app has been integrated into maternity care pathways in 48 sites across the country.

It should however be recognised that these services will never be able to fully replace one-to-one advice services and casework support, as their functioning is entirely dependent on the capacities of the client and the complexity of the issue they are facing. So, for example while someone who is digitally competent and reasonably literate may have little trouble filling out an online benefit application, someone with fewer digital skills may struggle, and there will be certain types of issues such as benefit appeals where individualised advice will always be crucial.

In recognition of this need, many advice services incorporate an element of volunteer-delivered provision to increase their capacity for one-to-one support, particularly for more straightforward cases such as benefit applications and mandatory reconsiderations. Although this approach can help to expand capacity, it should also be noted that there are still significant time and cost implications to this approach. These include training and supervising volunteers and providing costs for expenses. As such, involving volunteers cannot be seen as a simple 'add-on' to expand capacity with minimal effort or investment. Some services are primarily focused on delivery by volunteers, including those with volunteers drawn from law departments in universities.

Example from practice: The UCL integrated Legal Advice Clinic (iLAC) launched in January 2016 in Newham, one of England's most deprived boroughs. It was based originally within health centre premises and is now based nearby with close links. It provides advice, casework and representation across a range of legal issues, with specialisms in welfare benefits, housing, community care and education law. The UCL iLAC is staffed by UCL law students working under the supervision of experienced, qualified lawyers and advisers.

During the course of the pandemic, services have had to adapt to a very different way of delivering services including delivery by phone and over video conferencing software. Having increased capability to deliver in these ways may help to increase access to services going forward, particularly for more specialist elements of social welfare legal advice where there may not be a suitably qualified

adviser available locally or enough demand for a full session at a location. It should, however, be noted that access to services through these approaches is also dependent on clients' digital skills, access to computers etc, unless support is provided to access the service e.g. logging on to the system, support with scanning documents.

Recommendations:

- Assess the range of apps which already exist to provide guidance to those on particular health pathways and consider gaps both in content of existing apps and in the range of apps available.
- Provide a range of good practice case studies of alternative delivery methods e.g. volunteer-led, remote online delivery and digital sessions.

Relationships

One of the key themes from the interviews was the critical importance of relationships, both between social prescribing link workers and social welfare advisers and between these services and practice staff. Link workers often state that building successful working relationships is a key element of their role, with this stemming perhaps partly from the novelty of social prescribing as a service and the need to educate partners, as well as the nature of the service itself. This aligns with research conducted on the role of social prescribing in the past[22], and highlights the importance of this element being incorporated into the training and development of this role. Social welfare advisers, and particularly those who have been working within healthcare settings with no social prescribing present (at least initially) also reflected on the building of relationships being critical to the success of integrated working. Working together towards similar goals introduces a further set of important relationships and reemphasises the importance of staff being skilled in this area.

Relationships between services and practice staff

Relationships between services and practice staff are critical to the successful operation of schemes in healthcare settings and this is often a significant focus at setup stage. In particular, there is a need to get buy-in and commitment from both senior GPs and practice managers. Practice managers are particularly crucial as they are responsible for a lot of the operational systems that are often cited as being key to the success of a programme – booking clinic rooms, patient booking systems, data systems, coordinating team meetings and are often the staff member who organises and attends the key meetings associated with success of an integrated system e.g. reception staff meetings, clinician meetings, MDTs, partner meetings etc. As such, many commented that it was the practice manager that was key to the success (or failure) of a programme, with one stakeholder mentioning that if they could offer one piece of advice to somebody setting up a service it would be to create an effective working relationship with the practice manager.

> *"Sometimes it's the senior GP or the senior partner within the practice, but generally speaking the practice managers are the ones who make the decision as to which services come in and which ones don't."*

Advice manager

> *"One of the key things we always say is the practice manager should be your best friend 'cause they're your gateway into the practice."*

Public health professional

---

[22] Bertotti, Marcello & Frostick, Caroline & Hutt, Patrick & Sohanpal, Ratna & Carnes, Dawn. (2017). A realist evaluation of social prescribing: an exploration into the context and mechanisms underpinning a pathway linking primary care with the voluntary sector. Primary Health Care Research & Development. 19. 1-14.

"Practice managers do just run the show, yeah. I mean, a good practice manager, once you've convinced the practice manager, that's fine. They will do it."

Welfare and health professional

Conversely, if the practice manager doesn't support this way of working, others talked about the difficulties of establishing an effective service.

"It seemed as though there was a kind of reluctance to even offer a space or offer us… at one point [the practice manager] referred to us as a "non-health service." And she only wanted health services within her practice. And it just felt a bit of a fudge from my point of view, and I also felt that there was not the buy-in from the practice manager that you absolutely need."

Advice manager

Where this was the case, it was often found that other practice managers who had already bought into the service were able to help those who were sceptical or reluctant to reconsider and become more open to the idea of accommodating additional services within the practice:

"The practice manager at first appeared quite dismissive, saying "what is this? This is totally leftfield." And so [colleague] said "look, it's much more… I've seen the results of this in [other practice]. It would really help the GPs, it would take a lot of the work away from the GPs." And so [she] decided "yeah, okay then, we'll trial in, see whether it helps." Within about four or five weeks she absolutely loved it. She was a complete convert."

Advice manager

In terms of building relationships between frontline teams, one of the main challenges that was expressed was that of staff turnover meaning that new relationships constantly had to be rebuilt. Where possible it was considered preferable to ensure that staffing is as consistent as possible within social prescribing and social welfare legal advice services, though on the NHS side there may inevitably be locums in place at certain points.

The other issue was in terms of NHS staff capacity to engage, so it is important to look at ways of building relationships and buy-in which don't take up a huge amount of time. A number of interviewees mentioned the importance of attending practice meetings both as a way of reaching clinical staff within existing forums, and as a way of establishing link workers and social welfare legal advisers as part of a multidisciplinary team. This may be challenging if team members are required to go between a number of practices and only spend a small amount of time in each, but where possible this was found to be highly beneficial.

Finally, and of critical importance, particularly in relation to the capacity issues for clinical staff, is the need to demonstrate clearly what the impact will be for them and their workload, particularly in relation to providing a straightforward avenue for non-clinical issues to be dealt with:

"What the GPs say is that it's not like we're seeing less patients, they're far more productive in their consultations because if one of these socio-economic issues kick up, then they can just say "go to reception, make an appointment and they'll see about it next Tuesday" or whenever the next appointment is. "Now, what's your clinical issue?"

Welfare and health professional

Promoting a package of social welfare legal advice and social prescribing as a cohesive response to the social determinants of health and issues that could be considered 'non-clinical' may be particularly helpful in securing buy-in and prevent fragmentation.

Relationships between social prescribing and social welfare legal advice

Where relationships between social prescribing and social welfare legal advice are strong, there is a clear understanding of the ways in which the two services support each other and the complementary roles they play for clients accessing both services. Practitioners often refer to the ways in which the services can alleviate strain for each other where things work well:

> *"For us to make a referral to other services, it can take up quite a lot of our time. Therefore, where a social prescriber refers the patient to other services this frees up the advisers time to focus more on the presenting issues and advice."*
>
> Social welfare legal adviser

> *"[Welfare Advice Issues] might still be ongoing. But at least it's being dealt with. So, then we can broaden out that conversation a bit."*
>
> Social prescribing manager

> *"So, people are far less likely to address their medium to long-term goals until the major crisis in their life is dealt with. Now, whether that's lack of money or insecure housing or whatever, before you can actually make a plan within social prescribing which is going to engage people with activities that will address maybe the social elements of health through engaging with community organisations and through more involvement with their communities; people won't make these type of plans or these types of commitments until they're stable, you know, whatever crisis they're facing is stabilised."*
>
> Welfare and health professional

Where these relationships and mutual understanding were not as strong, it was clear this was an obstacle to the most effective joint working relationships:

> *"I think it would be useful for advisers to know the exact role of social prescribers or the social prescribing service, because most advisers think that social prescribing is a gateway service where social prescribers just conduct triage and refer/signpost patients to non-clinical services. You asked me earlier on if we make any referrals to social prescribers; very rarely do advisers make referrals to social prescribing service because we are under the assumption that the social prescriber's role is to signpost and refer clients to other services; something that the advisers would have done already in the first initial appointment with the client."*
>
> Social welfare legal adviser

This example demonstrates that without knowledge of what social prescribing does beyond making referrals i.e. holistic assessment, motivational interviewing and goal-setting, building a thorough understanding of the local patchwork of services, some may not see the need to refer on for something they believe they do themselves.

With the benefits of strong inter-service relationships clear, thought must be given as to how these can be cultivated. Firstly, where one service is being added second (e.g. social welfare legal advice after social prescribing), it is important that effort is made to ensure it is not seen as a threat to the working relationships and processes which the other service may have expended significant energy in building. For practice staff, it is also critical that there is a strong understanding of the role of both

services and how they interplay. Good management, training and working protocols are likely to be key to facilitating good working relationships from the outset while enabling frontline staff to have input into how the working relationship operates and being able to adapt this over time is also likely to be critical.

Secondly, it's important that practical arrangements are made to maximise contact between the frontline workers in each service. Often, they will each only be onsite for part of the week as their time may be split between multiple practices. Where possible, it may be preferable to have these sessions coinciding so that both are onsite at the same time. Where this isn't possible either due to scheduling or space issues and with limited on-site working due to the COVID-19 situation, there should be opportunities for the services to connect in other ways such as regular meetings. Some have found that offering staff from different services an opportunity to sit in and shadow other teams can help to maximise understanding of their role and what they can offer in a much more tangible way than simply hearing an explanation.

Relationships as a tool for culture change

> *"I think the biggest and most difficult thing is winning the hearts and minds and the cultural journey you need to take people on… They just need to see it and feel it and engage with it."*

Public health professional

Social prescribing has been noted as a change agent that can successfully extend the boundaries of traditional general practice by bridging the gap between primary health care and the voluntary sector, strengthening partnerships (South et al, 2008)[23]. The same could be said of advice services that are embedded in healthcare settings, and the difficulty of facilitating this culture change was echoed by many practitioners.

> *"I still think there's a kind of cultural issue almost in terms of how services kind of get social prescribing if it's targeted at particular conditions like long-term conditions or mental health. They still don't necessarily get the issue of the wider determinants of health and the importance of finance debts and gambling et cetera."*

Social prescribing manager

However, it was also recognised that having both services working together in the same setting had significant benefits compared to having one operating in isolation in terms of moving the understanding of staff members on:

> *"We've typically seen things working more effectively when there's a recognition that advice is part of a wider coordinated effort to improve the lives of an individual or a community. And on top of that we've seen the best results happening when the person themselves, and the community of which they're part, are put at the centre of deciding what is important, how things should be done, and what they can contribute."*

Advice policy professional

Practically, these services, when they are both serving the same General Practice often end up working together to support this culture shift in general practice, and there are many examples of the services coming together and supporting each other:

---

[23] South, J., Higgins, T. J., Woodall, J., & White, S. M. (2008). Can social prescribing provide the missing link? *Primary Health Care Research & Development*, *9*(4), 310-318.

“We actually work really well with prescribers in some of the practices they were already in...Where we get a really good social prescriber in a practice, they will advocate for welfare rights to come into that practice to work alongside them…By the way, we’ve managed to get a lot of the social prescribers into some of the practices as well…It hasn’t gone just one way”

Advice manager

“And within a lot of the practices… they already have social prescribers in there which is helpful because the GPs are used to having ancillary services working out of general practice. So, having another one coming in to complement social prescribers isn’t a problem at all or to work within the team of social prescribers isn’t really a problem.”

Welfare and health professional

While this culture shift can be difficult to achieve, it is clear that once staff in the practice can see the benefit of these services, it becomes much easier to embed the service.

“But if you’ve got them, that’s the whole thing about buy-in, buy-in from stakeholders. If you’ve got the buy-in from general practice, they’ll get that service embedded in next to no time”

Welfare and health professional

The culture change also tends to build momentum over time, and many services discussed a critical tipping point where it becomes embedded and seen as a normal part of service delivery, and even a service that is sought out by other practices.

“So we kind of felt that if we started to get a bit of critical mass in terms of numbers of GP practices coming on board, it would gain some momentum and eventually…practices might actually approach us to ask whether we would be, you know, if we could come into their practices.”

Advice manager

It is therefore important to understand the culture shift as a necessary part of the process of embedding these services, requiring the right elements to be successful. Some of the main elements of this embedding process are highlighted below.

Recommendations:

- Incorporate the building of relationships into training for link workers and social welfare legal advisers who will be working in healthcare settings as well as guidance for scheme managers, with separate focus on how to build relationships with different stakeholders e.g. practice managers, clinicians, reception and administration staff.
- In collaboration with the Practice Managers’ Association, consider how best to reach this important group of staff members in order to raise the level of understanding of the value social prescribing and social welfare legal advice to their practice and its operations.
- In guidance to schemes encourage actions which are likely to foster good working relationships including:
    - Information on how to initiate positive relationships with key staff members.
    - Encouragement for frontline staff to attend practice meetings.
    - Encouragement for consistency in staffing within practices.
    - Where possible ensuring that social welfare advisers and link workers are on site at the same time and have regular opportunities to check in with one another.

Training

Training for link workers

There were two areas of training which were seen as highest priority for link workers. The first is a basic understanding of social welfare legal advice, an ability to spot issues and identify what assistance may be needed. As examples, this may include an understanding of common welfare benefit issues and the range of benefits available, a basic understanding of debt solutions and who is recognised as having priority need for rehousing. However, there was an equally clear recognition of the need for this training not to blur the boundaries of what link workers can do, with the focus being on identification of need rather than on addressing it themselves unless they are taking on a hybrid role with comprehensive training:

> *"You know, there's so many twists and turns within the benefits system that a little bit of knowledge is a dangerous thing sometimes."*

Advice manager

The second area, which was seen as equally important, particularly where the link worker is the initial point of referral is in terms of understanding the advice process. This was valued as it enabled the link worker to ensure that clients firstly had realistic expectations of what the adviser would be able to offer them and when and secondly that they flagged the practical elements of preparation that may be needed e.g. which paperwork would be required. They may also be able to provide them with basic information on what they can do in the meantime if they will be required to wait for an appointment:

> *"And they might say 'Oh my God six weeks until I talk to somebody about my debt issues and stuff' well yes but actually because you know it's going to happen and if you're then being chased by a creditor, you can say 'I've got an appointment with* [advice agency] *in six weeks' time' or whatever it might be. So already it's part of helping to reassure."*

Advice policy professional

Training for social welfare legal advisers

Some of those we spoke to suggested that they would tend to prefer placing more experienced advisers within healthcare settings as they would be more likely to know what they're looking for within health records, as well as being more able to work independently and earn the trust of practice staff. Often as there is no set approach to working within healthcare settings, much of the training is done on the job by shadowing colleagues who have already worked within a practice or where advice is established for the first time, working with the practice to establish the best way of working. It may however be useful to have some standardised training on working within a health system.

To date it is not clear how much training has been made available to social welfare legal advisers on working effectively with clinicians or on the role of social prescribing. In some cases, it is clear that initially having a limited understanding of the breadth of the role of link workers can inhibit referrals as most social welfare legal advisers will have previously been used to making onward referrals themselves. Training should therefore cover understanding the role of link workers in broader terms including holistic assessments, motivational interviewing, goal setting and service mapping.

Training for healthcare staff

For those referring to social prescribing and social welfare legal advice such as GPs, other healthcare staff and receptionists, some of the main areas of training needs raised were understanding the services provided by link workers and social welfare legal advisers and being confident in their role as a referrer. Much of the former part of this is heavily connected to the relationships they are able to

forge with staff delivering schemes which should enable them to build trust and understanding, but there may also be some general training which is feasible to provide on understanding the benefits of social prescribing and social welfare legal advice, both in terms of patients themselves and for clinicians and practices e.g. reduction in repeat attendance, reduced isolation, reduced requests for benefit evidence etc. Making clear connections between support provided and agendas which are important within the healthcare setting can also be critical:

> *"I suppose that's the bit that we've been trying to piggyback on, is the push if for person-centred care, quality of care, continuity of care and, you know, this agenda around financial inclusion absolutely speaks to that. It's about, you know, what's your circumstances, what's going on, how can we help, and you need to look at the whole person and, you know, money issues and other social issues really need to be part and parcel of that."*
>
> Public health professional

There was some concern that the general model of social prescribing was for GPs and other clinical staff to have an understanding of the link worker's role but not that of services they refer on to, but that for advice, particularly where this is delivered onsite, it is hugely helpful for referrers to be aware of at least the basic elements of what could be provided, particularly as it may be less obvious than other services which may be more familiar to clinicians e.g. physical activity, social groups to combat isolation. In some cases, there may also be a stigma attached to perceptions of social welfare legal advice and welfare recipients which may need to be addressed.

In terms of the skills required to be able to actually make a referral, there was some discussion of clinical staff's confidence in discussing non-medical matters and undertaking holistic consultations with patients. Many felt that as well as a lack of skills in this area, this reticence was also linked to limited knowledge on how to follow this up that often led to this reticence. In this sense, the very presence of services to provide support around such issues was considered to be a significant boost:

> *"So, if a doctor asks someone with asthma if they're living in damp housing, they can't solve that problem so they may be hesitant to ask them a question about their housing and simply give them more medication. But if they know that there is a service in the same building that they can refer them to that can help with housing, they may be more prepared to discuss that with the patient."*
>
> Advice policy professional

Example from practice: In Scotland, a question on money worries was added into the Universal Pathway for Health Visiting[24] who are undertaking home visits to pregnant women and those with young children. This helps to instigate an initial conversation and trigger a referral to a money/welfare advice service. Training was provided to enable staff to understand the importance of the question and relevance to their broader work in order to prevent it from being 'skipped over' and the fact it was clearly a standard question was felt to help reduce stigma for those asked. Learning around financial inclusion and child poverty was also incorporated into the undergraduate and postgraduate curriculum for health visiting and a module on child poverty, health and wellbeing was developed for healthcare professionals[25].

[24] Scottish Government (2015) Universal Health Visiting Pathway in Scotland: pre-birth to pre-school Available at: https://www.gov.scot/publications/universal-health-visiting-pathway-scotland-pre-birth-pre-school/#:~:text=The%20programme%20consists%20of%2011,months%20and%204%2D5%20years.&text=To%20get%20to%20know%20the,to%20the%20family%20at%20home.

[25] NHS Health Scotland, Child Poverty, Health and Wellbeing Available at: http://www.healthscotland.scot/learning-resources/child-poverty-health-and-wellbeing

Advice services in particular have worked in conjunction with clinicians over a number of years to try to improve their confidence to flag issues such as money worries, and there was some concern that in passing things over to link workers this reduced the emphasis on clinicians being able to have these conversations (even if to a limited extent) themselves, thereby potentially missing opportunities to identify issues:

> *“If that's all going straight away into link work, we're could be taking away those conversations again because as soon as some GPs see the flag - somebody says, 'I'm having a really tough time at home' they'll think 'link worker, boom'. So, there's a danger actually we go almost backwards in terms of GPs looking at people as a set of diseases rather than a person in the round.”*

Advice policy professional

However, while to date much of the focus of training has been on clinical and reception staff who may make referrals, there may also be some merit in looking at training for practice managers who are viewed as being particularly critical to the success of schemes. As such, working with organisations such as the Practice Managers’ Association and other representative and training bodies may be an important step to support the scale-up of integration of health practices and community services such as social prescribing and advice services.

Recommendations:

- Develop a standard package of training in conjunction with partners such as Advice UK, the Advice Services Alliance, NHS England, the Royal College of GPs and Health Education England with separate modules for:
  - Link workers, to incorporate basic knowledge of social welfare legal advice, how to spot issues, the role boundaries and how to prepare a client for an advice appointment.
  - Social welfare legal advisers, to include understanding primary care, patient data management systems and the role of link workers.
  - Clinical staff, covering the role of link workers and social welfare legal advisers, the issues they can support patients with and how they can support their role, as well as how to work with clinical pathway referral systems and act as ‘problem noticers’. This could also be incorporated into medical student training.
  - Practice managers, reception/telephony and administrative staff, to increase understanding of the value of auxiliary services and how they can support their practice and its operations, as well as the support they need to function well.
- Provide support for this training to be delivered locally including through Health Education England Training Hubs and incorporating involvement of local partners including the RCGP’s local faculties, to enable training to also play a role in building effective local partnership working.

Scaling up

One key question this report aimed to answer was how to support a successful parallel and complementary scale-up of social prescribing and social welfare legal advice. This report has aimed to answer this question by talking to practitioners on the ground who have learnt lessons on what works and, importantly, what doesn't in order to establish recommendations of next steps. This process of engaging with both practitioners and service users has been highlighted as an essential element that should be done throughout the process of scale-up:

> *"If you're going to scale it up, speak to the people who deliver the services. Because if you come in with a massive model and it doesn't work, then you've got systemic failure built into your model from the start. If you build the service or you scale up the services using the practitioners who are going to be using it, then you will get a model that works. It's also essential to consult with service users as well. It's them that are going to use the service, so if it doesn't work for them, it's not going to work at all."*

Welfare and health professional

In conjunction with the input of frontline workers, there will also be a need to achieve buy-in across a range of stakeholders in relation to the potential this model can unlock, ensuring that there is adequate long term support from both a funding and commissioning perspective and in terms of policy and practical support to ensure that services can be effectively embedded into primary care settings. Consideration will also need to be given as to the scale at which this should be approached. At present it is largely at a practice, PCN or borough level, but there may be scope if higher levels of funding are secured to consider looking at the level of Sustainability and Transformation Plans/Integrated Care Systems or even on a city-wide basis.

Recommendations:

- Ensure that frontline workers, service managers and service users are engaged in plans for scaling up and that multiple stakeholders are brought together to share learning with decision-makers.
- Balance the need for standard levels of service with allowances for local flexibility based on what works best for those on the ground.
  Consideration should be given as to whether a new definition of care should be developed, which incorporates the right to support to ensure that a threshold of living conditions is met. As a first step, this could encompass universal access to social welfare legal advice, including where necessary specialist legal advice. This would need to be delivered and overseen at borough and Integrated Care System levels.

Conclusions

This research has uncovered ground-breaking work being done throughout the country to support the embedding of social prescribing and social welfare legal advice services within healthcare settings which both seek to broaden our understanding of what makes us ill, and importantly what keeps us healthy. These roles are fundamental in shifting the NHS focus from a biomedical understanding of health to one that is person-centred and holistic.

In practice the two services and roles are hugely complementary and can support clients to address the issues which are important to them and pertain to the social determinants of health. However, to date these roles and services have largely been working separately and in some cases in competition with each other. Over the coming years, it can only be hoped that these services come to be seen firmly as part of a package of support which is beneficial to both primary care staff and their patients and something which is an integrated part of multidisciplinary teams working to improve population health through addressing the social determinants of health alongside presenting clinical need.

This will not be something that happens overnight or without significant work at national, regional and local levels. It is clear, however, that this work is necessary and will pay dividends both for patients who are better able to access a wide range of support in a more integrated way and for professionals who are able to focus on their specialism – whether healthcare, advice or holistic support – with the confidence that other colleagues are supporting individuals' other needs.

Appendices

Appendix A: Interview guide

Question	Interviewee
1) What type of Social Welfare Legal Advice do you provide? a. Generalist b. Social welfare law c. Specialist (debt; welfare benefits; housing; employment; consumer; discrimination)	Social Welfare Advice
2) Where is the biggest need?	Social Welfare Advice
3) Describe the social welfare advice model you work with. Do you think it works well? Why? Why not? a. What setting? (primary; secondary; tertiary; social) [Prompts] -data sharing -location -referral pathway (draw this if in person)	Somebody working on a social welfare model
4) Do you know of an example of a model that works well? Why? Why not? [Prompts] -data sharing -location -referral pathway (draw this if in person)	Other e.g. advice uk, SP service, commissioners
5) Do you believe SP and SWA makes sense in primary care settings?	Healthcare professionals
6) What are the opportunities and barriers to implementation?	Healthcare professionals
7) How would you identify a need with your patients? What would make it easier to do this?	Healthcare professionals
8) What do you think the benefit of this model is? a. for patients b. for other services	Healthcare organisations, advice providers
9) What specifically about the design of your model do you think works well (over other models e.g. signposting etc).	Healthcare organisations, advice providers
10) Is there a social prescribing scheme (social welfare advice) in this area as well? If so, how does this service relate to it? Does this work well? If not why? Is there a way that it could work better? [prompts] -cross referrals	Social welfare advice, SP

-shared infrastructure -shared case- management	
11) Do you know of any examples where SWA and SP work together well?	Other e.g. Advice UK, SP service, commissioners
12) What is the scale of the service? (how many practices, clients etc)	SP and SWA
13) Would it be easy to scale this up across London? Why? Why not? [Prompts] -cost -partnerships -stakeholders, community -opportunities e.g. PCNs -technology -operations (data, HR, finance, training and supervision) -time and embedding -appropriate referrals and case-load management -evaluation -support for commissioners -support for providers	SP and SWA

Appendix B: Participating organisations

	Commissioners	Social Welfare legal advice services (individuals)	Intermediary support services (Advice & SP)	Primary care health care professionals and managers	Social prescribing scheme managers	Link Workers
Has Social Welfare Advice (no SP)		UCL Centre for Access to Justice Dundee City Council	Advice UK			
Has SP (no welfare advice)			Greater Manchester Health & Social Care Partnership		Ways to Wellness (Newcastle)	
Has both	Scottish Public Health Network	Bromley by Bow Centre Citizens Advice Wandsworth Citizens Advice Bexley Citizens Advice East End Citizens Advice Waltham Forest	NHS Scotland Improvement Service Citizens Advice NHS Health Scotland	Bromley by Bow Health Partnership	Bromley by Bow Centre	Bromley by Bow Centre