Bradford Inequalities Research Unit

Findings of a before and after evaluation of the VCS Alliance Welfare Benefits Advice intervention

Summary report for the Reducing Inequalities in Communities (RIC) programme

Authors: Sian Reece, Rachael Moss, Mohammed Hammad, Zahrah Tanveer, Kate Pickett, Josie Dickerson

Bradford Inequalities Research Unit, Born in Bradford

Version: 2.0, 11th September 2023

Approved by: Josie Dickerson, BIRU Director

BRADFORD INSTITUTE FOR HEALTH RESEARCH | MAKING RESEARCH REAL

NIHR | Applied Research Collaboration Yorkshire and Humber

Executive Summary

Project overview

Financial insecurity can precipitate and perpetuate mental health problems and has been found to be a predictor of chronic physical illness. There is evidence of unequal access to benefits in some communities in the UK, and this has been found to be particularly pronounced in some ethnic minority groups.

The VCS Alliance co-ordinate a welfare benefits advice (WBA) programme. There are six core providers delivering general welfare advice services and three providers delivering specialist welfare benefits services for those with complex needs. Each welfare advice provider is connected to a general practice and their services are accessed exclusively through GP referral. All services are registered and delivered by appropriately trained and accredited welfare advisors. These services are commissioned by the Bradford City CCG (now Bradford District and Craven Health and Care Partnership) Reducing Inequalities in Communities (RIC) programme.

Two systematic reviews have reported evidence of financial gains, and evidence of promise that these services may improve health and wellbeing for recipients.

Evaluation overview

This report shares the findings of a before and after evaluation which looked at the change in financial insecurity, depression symptoms (PHQ-9), wellbeing (SWEMWBS) and health-related quality of life (EQ-5D).

These measures were collected from clients at the start and the end of their involvement with the intervention. As there is not a matched control group for this evaluation, we cannot say whether any improvements are directly caused by receipt of the welfare advice.

The study also looked at the cost consequences and return on investment of the intervention.

These measures were not collected within usual practice, therefore, ethical approval was received from the University of York, and explicit consent was given by participants before completing these measures.

Findings

181 clients were recruited into the evaluation between March 2022 and February 2023. 125 (69%) participants completed the 3 month follow-up survey.

Clients who completed both before and after surveys had a mean age of 49 (SD 11.8) years. A greater proportion of participants were female (63%) and the majority were of Pakistani heritage (87%). The participants in this population reported high levels of financial, food and housing insecurity, alongside poor physical and mental health.

Executive Summary

Findings

65% Severe financial insecurity was high in this population. At the start of the intervention 65% of clients reported finding it difficult or very difficult to make ends meet. At the follow-up, 60% continued to report financial insecurity. This difference was too small to be confident of any real change over time.

59% PHQ-9 depression scores were high, with 59% of clients reporting clinically important (moderate-severe) symptoms at the start of the intervention. The average score reduced by one point from the start (13.0) to the end (12.0) of the intervention. This difference was too small to give us confidence of any real change over time.

Wellbeing scores improved from 17.98 (IQR 15.32-23.35) at the start to 19.25 (IQR 15.84-24.11) at follow-up appointments. This difference (1.27) was small, but was statistically significant, suggesting evidence of promise that welfare benefits advice may improve wellbeing.

The EQ-5D health state index scores also demonstrated improvements from 0.45 (SD 0.117, 0.887) at baseline to 0.59 (SD 0.100, 0.887) at 3 month follow-up. This difference (0.14) was statistically significant, suggesting evidence of promise that this intervention may improve health-related quality of life.

There was no control group for any of these measures meaning that we cannot be sure if these changes were caused by the intervention or not.

Recommendations

Welfare benefits advice co-located in GP practices reach a population with high levels of financial, food and housing insecurity, many of whom have poor physical and/or mental health.

This evaluation provides evidence of promise that this intervention may improve wellbeing and health-related quality of life in this vulnerable population.

We would recommend that this intervention is considered for continued commissioning in areas of high deprivation across the district.

To understand the causal impact of this intervention on health, wellbeing and financial security, a study with a comparator group would be required, and to understand the medium – to longer term impacts, longer term follow up would be needed, but this comes with a risk of low response rates.

Background

What is the VCS Alliance Welfare Benefits Advice?

The Voluntary and Community Sector (VCS) Alliance [1] is a voluntary community organisation that was developed to co-ordinate the voluntary and community sector in Bradford to deliver health and social care projects across the area.

The VCS Alliance co-ordinate a welfare benefits advice (WBA) programme co-located within the primary care network across inner city areas across Bradford, commissioned by the Bradford City CCG (now Bradford District and Craven Health and Care Partnership) Reducing Inequalities in Communities programme. It brings together nine distinct welfare advice providers, delivering welfare advice services across Bradford. There are six providers delivering general welfare advice services across the district and three providers delivering specialist welfare benefits services for those with complex needs: Equality Together provide a specialist service for those with disabilities; Cancer Support Yorkshire for those with cancer and long-term conditions; and AgeUK for the elderly population.

Each welfare advice provider is connected to a general practice in Bradford and their services are accessed exclusively through GP referral. All services are registered and delivered by appropriately trained and accredited welfare advisors.

What does the existing evidence tell us?

The links between financial insecurity, social deprivation and mental and physical health are well established [2]. Financial insecurity can precipitate and perpetuate mental health problems and it has been found to be a predictor of chronic physical illness [3-5]. There is evidence of unequal access to benefits in some communities in the United Kingdom (UK), and this has been found to be particularly pronounced in some ethnic minority groups [6]. Various schemes have been put in place to improve uptake of benefits by co-locating welfare rights advice services within healthcare settings.

A systematic review of welfare rights advice delivered in healthcare settings, published in 2006, found that there was evidence that this approach resulted in financial gains but at that time there was limited high quality evidence to suggest that this resulted in improved uptake or measurable health or social benefits [7]. This systematic review was updated in 2020 and demonstrated improved financial security for participants and modelled the potential wider health and welfare benefits for participants and for health services as a result of co-located services. However, the majority of the included studies were of poor scientific quality. The review highlighted the need for more high quality research, using experimental methods and larger sample sizes, to further build upon this evidence base and to measure the strength of the link between co-located welfare advice services and benefits to health and wellbeing.

Evaluation Aims

Aim of the evaluation

The main aim of this evaluation is to explore whether the VCS Alliance WBA programme improves the financial security, mental and physical health of clients accessing their services.

The objectives are to assess:

- The impact of the VCS Alliance WBA programme on the financial security of clients accessing the service.
- The impact of the service on the mental health, wellbeing and health-related quality of life of clients.
- If feasible, the return on investment for commissioners.

What will this study be able to tell us?

This evaluation will be able to tell us whether there is a measurable association between welfare benefits advice delivered through the VCS Alliance WBA programme and improvements to client financial security and health and wellbeing. The evaluation will also be able to tell us whether the service represents value for money for commissioners with respect to these outcome measures.

What will this study not be able to tell us?

As there is not a matched control group for this evaluation, we cannot say whether any measured associations are directly caused by receipt of any welfare advice through the programme. Nor can we provide any confidence in the return on investment as we do not know if any changes are caused by the intervention.

Study outcomes

The primary outcome is:

- Change in self-reported financial security of clients at the start and end of the intervention.

The secondary outcomes are:

- Change in mental health, measured using the Patient Health Questionnaire (PHQ-9) instrument, at the start and end of the intervention.
- Change in wellbeing, measured using the Shortened Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS), at the start and end of the intervention.
- Change in health-related quality of life, measured using the EuroQol EQ-5D-5L instrument, at the start and end of the intervention.

Methods

Data

An uncontrolled before-after study (a study without a matched control group) was used to evaluate the VCS Alliance WBA programme. Welfare advisors asked clients to complete the financial, health and wellbeing measures at the start and at the end of their involvement in the intervention.

These measures were not collected within usual practice, therefore, ethical approval was received from the University of York, and explicit consent was given by participants before completing these measures.

Analysis

Self-reported financial security

To explore whether there were changes in self-reported financial security, multiple logistic regression models were used to explore differences in self-reported financial security before and after the provision of welfare advice.

Mental health, wellbeing and health-related quality of life

To explore whether there were changes in mental health, wellbeing and health-related quality of life from the beginning to the end of the intervention, we calculated the mean scores and standard deviations of the measures. The EQ-5D score was converted into a utility index which ranges from 0 (a state as bad as being dead) to 1 (full health)[8]. A within person multiple linear regression analysis was then completed using the continuous scores for PHQ-9, SWEMWBS and EQ-5D-5L to look for individual level change over time.

Cost consequences

If it is possible to calculate, a return on the investment measure will be calculated. If possible, the total financial gain for all participants will be divided by the total cost of the service to commissioners over the data collection period.

Results

The Population

From 1st March 2022 to 28th February 2023, 181 clients (20.3%) were recruited into the evaluation over the one year evaluation period, with 125 (69%) participants completing the 3 month follow-up survey.

Clients who completed both before and after surveys had a mean age of 49 (SD 11.8) years. A greater proportion of participants were female (63%) than male (36%). The majority of participants were living with a partner (59%). 33 (27%) participants reported that they were single parents. The majority of participants reported that the main earner in the household was unemployed (79%).

Participants were predominantly of Pakistani heritage (n= 82, 87%), less than 5% identified as White British (n = <5) and 10 (9%) were of other ethnic groups. Table 1 at the end of this report describes the baseline characteristics of the clients who took part in the study.

Financial Security

At the time of accessing the service 81 (64%, 95% CI 56.53%, 73.68%) of clients reported being financially insecure. Three months after starting the intervention, 71 (59%, 95% CI 50.68%, 68.11%) of clients reported being financially insecure. This change was small, and the confidence intervals wide meaning that we cannot be confident that this is a meaningful change.

Mental health

Following access to the intervention, the mean PHQ-9 scores fell from 13.00 (IQR 4.00, 20.00) to 12.00 (IQR 2.50, 19.50) at 3 month follow-up. This difference was too small to give us confidence of any real change over time.

Wellbeing

Wellbeing scores improved from 17.98 (IQR 15.32, 23.35) at initial appointments to 19.25 (IQR 15.84-24.11) at follow-up appointments. This difference was statistically significant, suggesting evidence of promise that WBA may improve wellbeing.

Health-related quality of life

Mean group EQ-5D health state index scores also demonstrated improvements from 0.45 (SD 0.117, 0.887) at baseline to 0.59 (SD 0.100, 0.887) at 3 month follow-up. This difference was also statistically significant, suggesting evidence of promise that WBA may improve for health-related quality of life.

Cost consequences

Figure 1 shows the most frequent welfare advice and support provided. The total cost of VCS Alliance welfare advice programme for the 2022 to 2023 financial year was £123,573.63. This was calculated as £12,357.36 per provider of core services and £12,357.56 per provider of complex services per annum for the 2022 to 2023 financial year.

The majority of participants (55%, n = 56) were documented to still be awaiting the outcome of their claims. No detail was included on any debt managed. Therefore the return on investment for commissioners could not be calculated at this timepoint.

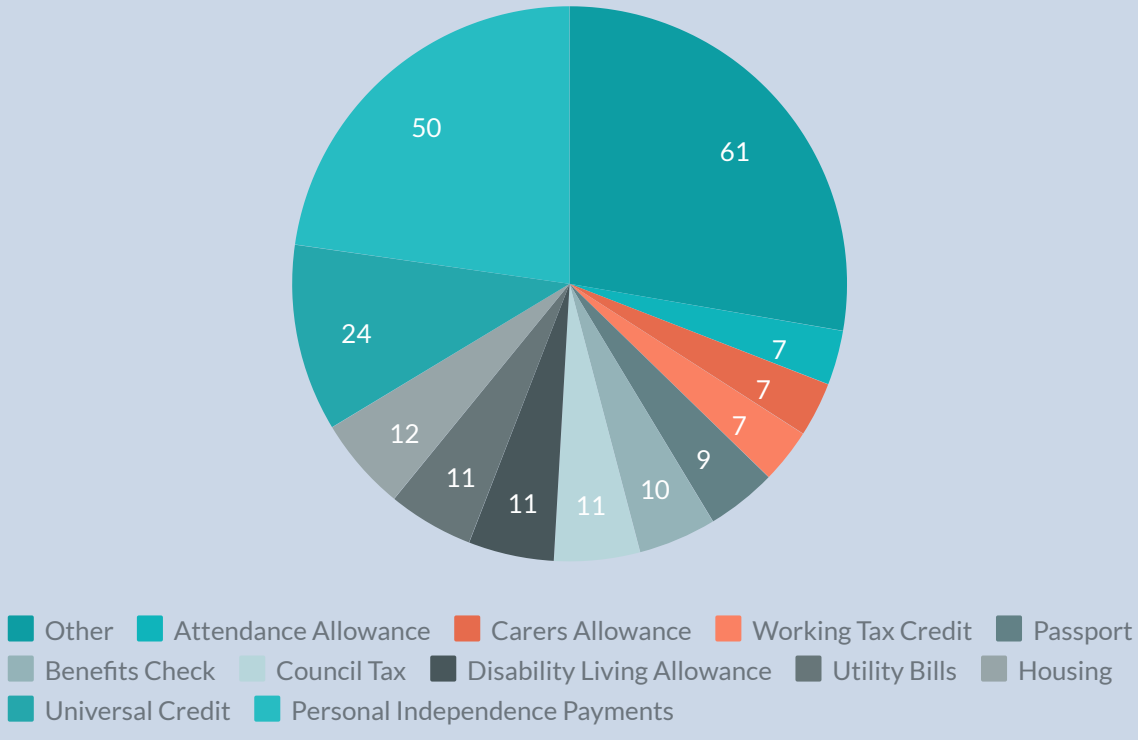

Figure 1. The most frequent types of welfare advice provided by the intervention.

Conclusions

This study offers a unique assessment of the impact of a welfare advice service co-located in a health setting in a seldom studied population, living in the most deprived centiles in the UK and more vulnerable to mental and physical health conditions. This study offers evidence of promise that welfare advice services co-located in health settings improves individuals' wellbeing and health-related quality of life.

There was little evidence to suggest that this intervention improves mental health, however this study was not powered to detect small effect sizes with respect to change in PHQ-9 scores. To provide more confidence in these findings it would be important to revisit this analysis in the longer-term, with the inclusion of a control group.

Recommendations for Practice

This service may be able to improve inequalities in health and wellbeing in the short-term for those in financially insecure circumstances. However without a control group we cannot be certain that this change is caused by the intervention. The findings were collected at the end of the intervention so we have no evidence of the medium to longer-term impacts of this study. The changes found here may reduce over time, or they may increase further. For example, changes in depression and financial insecurity may take longer to achieve.

This is an important service supporting a vulnerable population with clear financial benefits to participants, and potential health and wellbeing benefits. We would recommend that this service is considered for continued commissioning in all areas of high deprivation across the District.

Further evaluation of WBAs is needed to understand the medium to longer-term impacts. However, such an evaluation would be complex to undertake and would need funding for an evaluation partner: To understand the causal impact of this intervention on health, wellbeing and financial security, a study with a comparator group would be required, and to understand the medium – to longer-term impacts, a longer term follow up would be needed, but this comes with a risk of low response rates.

References

[1] Bradford VCS Alliance Ltd. The VCS Alliance. Bradford, 2023.

[2] Marmot M, Atkinson T, Black C, Broadfoot P, Cumberledge J, Diamond I. Fair Society, Healthy Lives: The Marmot Review. 2010; London; 2010.

[3] Georgiades A, Janszky I, Blom M, László KD, Ahnve S. Financial strain predicts recurrent events among women with coronary artery disease. *International Journal of Cardiology* 2009; **135**: 175-83.

[4] Kahn JR, Pearlin LI. Financial Strain over the Life Course and Health among Older Adults. *Journal of Health and Social Behavior* 2006; **47**: 17-31.

[5] Alliance AS. The Role of Advice Services in Health Outcomes Evidence Review and Mapping Study: The Role of Advice Services in Health. 2015; London; 2015.

[6] Prady SL, Bloor K, Bradshaw J, Tunstall H, Petherick ES, Pickett KE. Does Administrative Data Reflect Individual Experience? Comparing an Index of Poverty with Individually Collected Data on Financial Well-being in a Multi-Ethnic Community. *Social Policy and Society* 2016; **15**: 513-35.

[7] Adams J, White M, Moffatt S, Howel D, Mackintosh J. A systematic review of the health, social and financial impacts of welfare rights advice delivered in healthcare settings. *BMC Public Health* 2006; **6**: 81.

[8] Brooks RG, Rabin R, De CF. The measurement and valuation of the health status using EQ-5D: a European perspective: evidence from the EuroQol BIOMED Research Programme. Dordrchet: Kluwer Academic Pub.; 2003.

Tables

Table 1. Baseline characteristics of study participants

Table **1** Baseline characteristics of study participants

	Number	Frequency (%) (95% CI)
Gender		
Female	63	63 (55-74)
Male	36	36 (26-74)
Missing	26	
Age		
18-24	<5	<5
25-34	6	6 (3-13)
35-44	34	34 (26-44)
45-54	32	32 (24-42)
55-64	12	12 (7-20)
65 and above	15	15 (9-24)
Missing	24	
Current relationship status		
Living with partner	59	60 (50-69)
No longer living with partner	<5	<5
Single	27	27 (19-37)
Widowed	10	10 (5-18)
Missing	25	
Whether single parent		
Yes	33	27 (20-35)
No	91	73 (65-80)
Missing	<5	
Ethnicity		
Pakistani	82	87 (81-96)
White British	<5	<5
Other	10	9 (5-14)
Missing	30	
Religion		
Christian	<5	<5
Hindu	<5	<5
Muslim	89	94 (86-97)
Other	<5	<5
Missing	23	
Preferred language		

Tables

Table 1 continued

Preferred language		
English	15	15 (9-24)
Urdu	18	18 (12-27)
Punjabi	29	30 (21-39)
Mirpuri	18	18 (12-27)
Other	18	18 (12-27)
Missing	27	
Self-reported health issues		
Long term health condition	9	9 (5-17)
Physical or other disability	29	30 (21-39)
Mental health condition	31	32 (23-42)
Other	<5	<5
None	25	26 (18-35)
Missing	27	
Employment status of main earner in household		
Employed	15	15 (9-23)
Self-employed	7	7 (3-14)
Unemployed	81	79 (70-86)
Missing	22	
Worry about job security of main earner in household		
Yes	20	16 (10-24)
No	7	6 (3-24)
Don't know	97	78 (70-85)
Missing	<5	
Worry about eviction		
Never	29	23 (17-32)
Sometimes	31	25 (18-33)
Often	64	52 (43-60)
Missing	<5	
Worry about whether food will last		
Never	19	15 (10-23)
Sometimes	41	33 (25-42)
Often	65	52 (43-61)
Missing	10	

Tables

Table 2. Change in measures from the start (baseline) to the end (3 month follow up) of the intervention

	Baseline		3 month follow-up		
	Number	**Frequency (%) (95% CI)**	**Number**	**Frequency (%) (95% CI)**	**p-value**
FINANCIAL SECURITY					
Self-reported financial insecurity					
Secure	44	35.59 (27.32-44.47)	48	40.58 (32.89-49.32)	0.059
Insecure	81	64.41 (56.53-73.68)	71	59.42 (50.68-68.11)	0.059
MENTAL HEALTH					
	Median	**Interquartile range**	**Median**	**Interquartile range**	
PHQ total score	13.00	4.00-20.00	12.00	2.50-19.50	0.344
Clinical relevant symptoms	**Number**	**Frequency (%) (95% CI)**	**Number**	**Frequency (%) (95% CI)**	
No	51	40.80 (32.31-49.17)	54	43.31 (34.10-52.09)	0.414
Yes	74	59.20 (50.83-67.69)	71	56.69 (47.91-65.90)	0.414
WELLBEING					
SWEMWBS score	**Median**	**Interquartile range**	**Median**	**Interquartile range**	
Adjusted score	17.98	15.32-23.35	19.25	15.84-24.11	0.048
SWEMWBS category	**Number**	**Frequency (%) (95% CI)**	**Number**	**Frequency (%) (95% CI)**	
High wellbeing	76	60.73 (51.96-69.00)	73	58.54 (49.76-67.47)	0.027
Average wellbeing	26	20.08 (14.90-28.25)	33	26.04 (19.72-35.28)	0.027
Low wellbeing	23	23.19 (12.49-26.11)	18	14.42 (9.83-22.67)	0.027
QUALITY OF LIFE					
EQ-5D health state index score	**Number**	**Interquartile range**	**Number**	**Interquartile range**	
EQ-5D health state index score	0.4535	0.117-0.887	0.587	0.100-0.887	<0.001