Integrating money advice workers into primary care settings: an evaluation

James Egan
Oonagh Robison

Glasgow Centre for Population Health

January 2019

Glasgow Centre for Population Health

Acknowledgements

We would like to thank the people accessing money advice services for agreeing to take part in telephone interviews, and Karen Shields from the money advice agency for providing the researchers with support to undertake the interviews and for providing anonymised money advice data.

We would also like to acknowledge, in no particular order, the following colleagues who provided helpful comments on drafts of the report: Ronnie Burns; Gillian Dames; Graham Watt; Tony Quinn; Carol McGurin; Janet Tobin; Douglas O'Malley; Kate Burton; Pete Seaman; Jennie Coyle; and Joe Crossland.

Cover image: © Joe Crossland

Contact

James Egan
Public Health Programme Manager
Glasgow Centre for Population Health
Email: james.egan@glasgow.ac.uk
Tel: 0141 330 1876
Web: www.gcph.co.uk
Twitter: @theGCPH

Contents

Executive summary

Background to this study

Integrating money advice services into GP practices has been well established in other parts of the country but has only been tested on a small scale in Glasgow, which has 80 of the 100 'Deep End' GP practices which serve the 100 most deprived populations in Scotland. Following successful integration of advice services in two Deep End GP practices in northeast Glasgow, this study examined further integration across nine GP practices operating in some neighbourhoods facing the biggest losses as a result of the UK government's welfare reforms.

Headline summary

Over 12 months, GPs led the way in referring 654 people, which led to 451 (68.9%) engaging with advice services. Many people reported no past contact with advice services. This resulted in around £1.5 million in financial gains with over half for disability-related benefits. Support to manage household debts totalled £470,000. Homeless and housing issues, followed by mental health were the most frequent reasons for people being referred on to other support services.

The nine practices achieved the equivalent of more than half of the 1,264 referrals achieved under the 'locality model', over a similar 12 month period. The established locality model allows healthcare professionals to refer people to advice services based in seven health centres across northeast Glasgow. There were 71 locality referrals from 35 GP practices over this period, in sharp contrast to 654 from the nine practices testing this integrated approach.

Demand for advice was often 'hidden' in the nine practices and is likely to increase with predicted welfare cuts. If scaled up and sufficiently resourced to incorporate locality model referrals, this integrated approach could ensure that all healthcare professionals do a little to effect change at different life stages. This could help reduce GP workload and strengthen efforts to tackle Glasgow's high levels of poverty and persistent health inequalities.

What was the main learning?

Money advice outcomes

Those seeking advice were more likely to be single women, older, unfit for work, and living in social housing. When asked, two thirds had no contact with advice services in the past year.

The majority were living below a standard poverty measure (before housing costs) for a single person, with two thirds on less than £10,000 and around 1-in-5 on less than £6,000, per year.

Among the 654 seeking advice, 214 were supported on at least two advice issues, 182 received some type of financial gain, 108 were supported to manage debts, and 124 were referred on to other support services.

Disability-related benefits made up half of the £1.5 million gains with almost £100,000 for child or maternity benefits. Rent and council tax arrears were significant debts. Homeless and housing, followed by mental health were the key reasons for accessing other support.

The return for every £1 invested into the project was £25, which was a conservative estimate.

Project set up and benefits

Advice workers welcomed new ways of working, such as having access to medical evidence and drafting letters signed off by the GP to be used at benefits reviews and appeals. The workers viewed practices as a 'trusted hub' that could help reduce stigma and encourage people to be more open about their money worries.

The project benefits included some practice staff reporting an easing of workload and reduction in welfare-related appointments, new working relationships that allowed staff to directly refer to advice workers, and a subsequent increase in GPs referring to advice services.

As the project developed, changes were made to how advice workers could access medical evidence and to the process of producing supporting letters. Both changes led to opposing views among some advice and practice staff.

If this approach was scaled up, then securing longer-term funding and applying consistency in accessing evidence and producing letters were key areas requiring further attention.

What are the implications?

The demand for money advice was often 'hidden' in these GP practices and likely to increase with a predicted rise in poverty levels and continuing cuts in welfare budgets expected up until 2020/21.

Social housing tenants were important beneficiaries, and housing and homeless issues were the main reasons people were referred on to other support services. Therefore, local advice service partnerships may wish to consider if people are accessing timely advice whether offered in general practice, housing associations, or the local high street.

Scaling up this type of approach to cover Glasgow's 80 Deep End GP practices has been estimated to cost £564,000 and could achieve around 8,300 referrals. Extending coverage across all of the city's 146 practices was estimated at around £982,500 and could achieve an estimated 14,400 referrals.

Commissioners of advice services could explore the merits of seeking more secure funding to scale up, in such a way that agreed outcomes are aligned with the Scottish Government's roll out of Community Link Workers in Deep End GP practices across the city.

The new Scottish Social Security Agency presents further opportunities to share the learning more widely to ensure that social security does become the best for those being served, including people often 'hidden' in general practices serving the most deprived populations.

Introduction

Background

A report on the impact of the UK government's welfare reform on Scotland's 354 council ward areas identified Glasgow as being over represented among the 20 wards facing the highest financial loss. Calton in Glasgow faced the highest annual loss (£880) per working-age adult with St Andrews in Fife having the lowest loss (£180)[1]. Many of the city's worse affected wards have levels of deprivation considerably higher than the Scottish average and neighbourhoods with disproportionate numbers of adults living with a limiting disability. Persistent problems with two important disability-related benefits may be exacerbating this picture. A new Scottish Government report on welfare reform pointed to a recent UK legal ruling which could result in an estimated £3.7 billion in backdated Personal Independence Payment (PIP) awards[2]. Following years of reported errors, 180,000 people moved onto Employment Support Allowance (ESA) could be entitled to back-payments averaging about £5,000[3].

Encouraging take-up of welfare benefits by providing money advice services through healthcare services, was recognised as an important aspect of tackling Scotland's health inequalities[4]. In Greater Glasgow, healthcare professionals have engaged with advice services to support people at different life stages. In 2002, over 15 months a nurse-led service targeted older people across 24 general practices in Glasgow City with high levels of deprivation. Offering money advice to 630 older people in their homes led to more than half claiming benefits totaling just over £1.1 million[5]. In 2010, an emphasis on child poverty led to the roll out of the Healthier, Wealthier Children (HWC) project which provides advice to pregnant women and families attending services, such as midwifery or health visiting, across NHS Greater Glasgow and Clyde (NHS GGC)[6;7]. Between 2010 and 2018, the project achieved 15,238 money advice referrals and £17.6 million in gains for women and families across NHS GGC. In Glasgow City, HWC was subsumed into the established locality model, which primarily allows healthcare professionals to refer people to advice services based in health centres across Glasgow.

Integrating money advice in general practice – testing a local approach

During 2014/2015, partnership work between the General Practitioners (GPs) at the Deep End project[a] and others led to a series of outputs, which supported a decision to test an alternative to providing advice in the seven health centres across northeast Glasgow[8;9]. In December 2015, a money advice worker was embedded in two local Deep End general practices. Known as the Deep End Advice Worker Project (DEAWP), the project was supported by a realignment of local HSCP resources and temporary funding from a social

[a] Deep End general practices serve the 100 most deprived populations in Scotland based on the proportion of patients with postcodes in the most deprived 15% of Scottish data zones.

housing provider. Important learning over six months showed that the two practices participated in achieving impressive outcomes, which included 165 people receiving gains totalling nearly £850,000, of which PIP and ESA benefits accounted for two thirds of the gains[10]. Co-locating the advice worker in the two practices and changes in delivering advice services contributed to positive outcomes for a sizeable number of people on low incomes that had no past contact with advice services.

Integrating advice services into general practice has been well established over the last 25 years across Scotland, with around 50 practices delivering this approach[11]. However, with 80 of the 100 Deep End general practices in Scotland situated in Glasgow, this integrated approach had never been full tested in the city. Therefore, the positive results gained from placing an advice worker in the two local Deep End practices presented further opportunity to test this approach.

During 2017/18, funding of £77,985 (a combination of external funding and in-kind local support) was primarily used to embed three advice workers across a total of nine general practices, including the two DEAWP practices. Each practice would have access to a half-day session provided by the advice workers. The funding also ensured that NHS health improvement staff could provide support and co-ordination, and allowed the Glasgow Centre for Population Health (GCPH) to undertake an evaluation of the rollout across the nine practices.

About the nine general practices

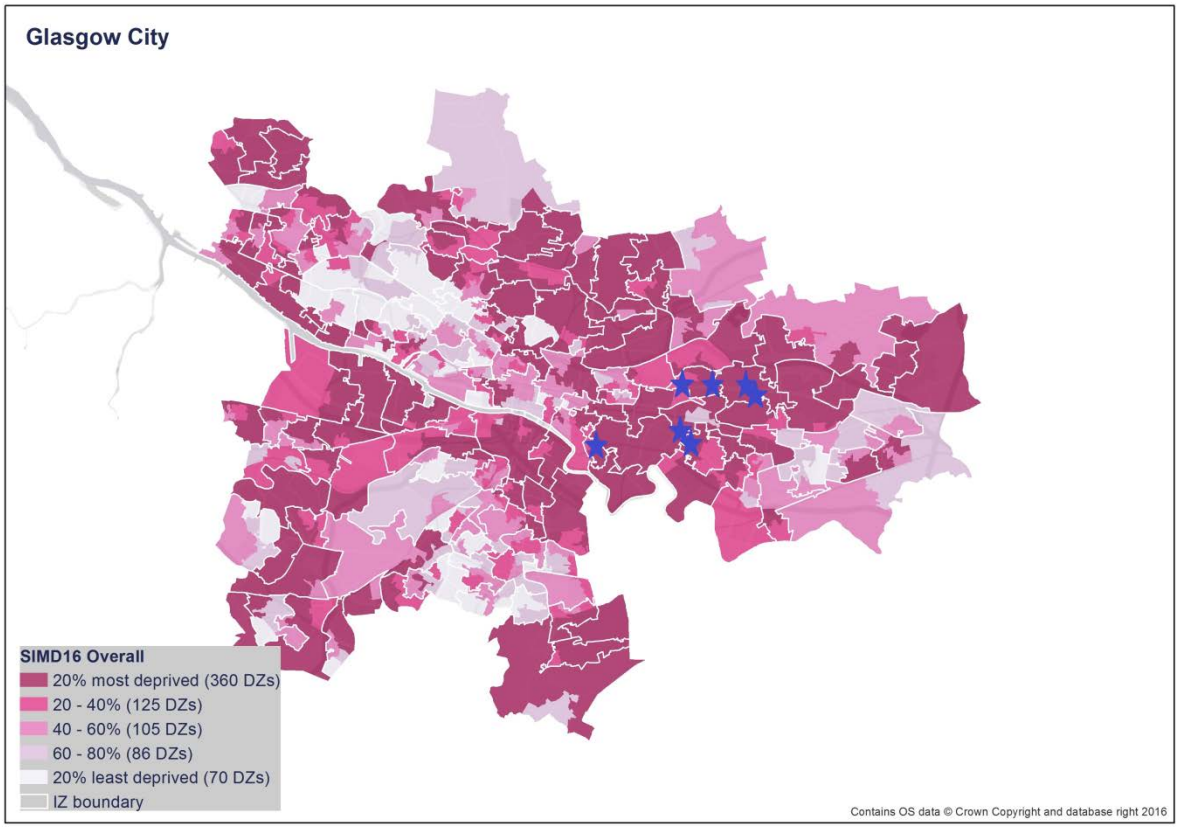
The nine general practices operate across northeast Glasgow and have a list size ranging from around 3,000 to over 6,500 patients with an average approaching 4,300. In total, the nine practices serve around 40,000 patients and are part of the 80 Deep End general practices in Glasgow.

As can be seen from Figure 1 below, all of the nine practices operate in areas with levels of deprivation considerably higher than the Scottish average. Neighbourhood profiles reveal that 25% of adults claimed out-of-work benefits with 26% of people reporting a limiting disability[b]. In the most recent period (2008-12), life expectancy was 71.3 years for men and 77.6 years for women, which is notably lower than the Scottish average, particularly for men.

All nine practices are represented by seven stars on the map below, as in two cases two practices were located in the same medical centre (see Figure 1).

[b] Understanding Glasgow. *Profiles, Neighbourhood profiles, NE Sector.* http://www.understandingglasgow.com/profiles/neighbourhood_profiles/1_ne_sector

Figure 1: Location of participating Deep End general practices on Glasgow City SIMD map.



Source: map downloaded from SIMD.scot

General practice cluster groups

In Scotland, contractual changes led to the introduction of GP Cluster Groups during the financial year 2016/17. Each general practice is represented at periodic meetings by Practice Quality Leads with a Cluster Quality Lead facilitating and guiding the group and liaising with their local HSCP. Each cluster group will agree a programme of work that is relevant to the local population.

As of November 2017, there were 20 cluster groups in Glasgow City ranging in size from a population of 24,000 to 68,000[12]. Some of the quality improvement work undertaken by cluster groups includes management of chronic obstructive pulmonary disease, cervical screening rates, flu immunisation uptake and diabetic patient education programme.

In northeast Glasgow, there were seven cluster groups. Eight of the nine practices participating in this study belonged to the same cluster group with the remaining practice belonging to another cluster group. The initial learning from embedding a money advice worker in the two DEAWP practices was an important factor for the main cluster group of eight practices to agree that integrating advice workers into local practices would be relevant to the local population.

What does the evidence so far show?

It is not the aim of this report to provide an extensive review of the evidence for integrating money advice into primary care (for a more in depth review see The Low Commission 2015 report on the role of advice services in health outcomes[13]). Moreover, although this evaluation did not investigate health outcomes, it is worth noting that the Low Commission report found that advice staff working directly with the NHS produced real benefits for people's health which resulted in lower stress and anxiety, better sleeping patterns, more effective use of medication, smoking cessation, and improved diet and levels of physical activity.

Within the context of this evaluation report, integration of money advice services within general practices in Scotland is not a new approach, for example advice services have been embedded in 25 practices in Lothian and five in Dundee. Furthermore, a social return of investment study of practices in Dundee and Edinburgh[14] found that people (albeit a small number) reported improved health and wellbeing, felt less stigmatised with increased feelings of self-worth and improved access to services. Primary care staff reported making better use of their time to focus on medical interventions, had a better understanding of welfare benefits and money advice issues, and increased job satisfaction. A more recent 2018 report looked at differences in survey answers among GPs and found that those using referral methods were more positive than those who signposted to advice services in all areas except for the effect on people's health and wellbeing, where the results were very similar. These areas included overall care for people, amount of time in consultations, ability to focus on and treat clinical health issues, number of repeat visits about non-clinical issues and engaging well with other service providers. The report suggests that while most GPs see positive effects on people's health and wellbeing and overall care, the use of more integrated referral services is a key factor in whether they see positive effects on the areas to do with efficiency of consultation and demands on their time[15].

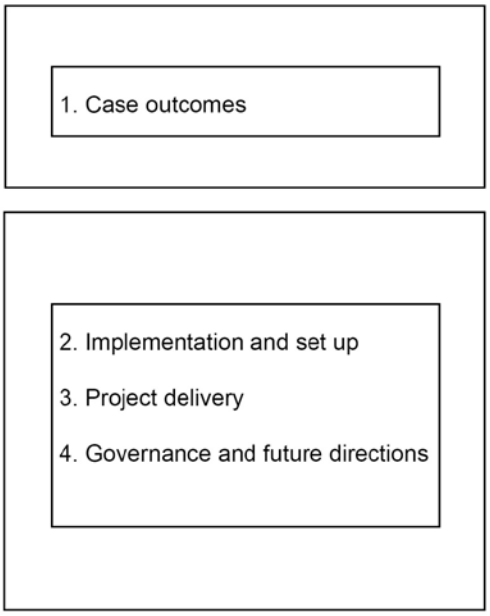
In terms of ongoing development of the evidence and resources, the Improvement Service (national organisation for local government in Scotland) is undertaking a mapping exercise of welfare rights integration in general practice across Scotland. The Scottish Public Health Network alongside NHS Health Scotland and the Improvement Service are also developing resources to support HSCPs, general practice, NHS health boards and the money advice sector to implement the model. Lastly, the Scottish School of Primary Care is undertaking a 'deep dive' piece of research into how co-location of advice services is of value to primary care in Tayside.

Evaluation aims

The primary evaluation aims were to explore both the money advice case outcomes of the project and the processes of setting up and delivering the project, as well as governance, and potential learning for the future directions of the project.

There were four aims, which can be seen in Figure 2 below:

Figure 2: Outcomes and process aims.



Methods

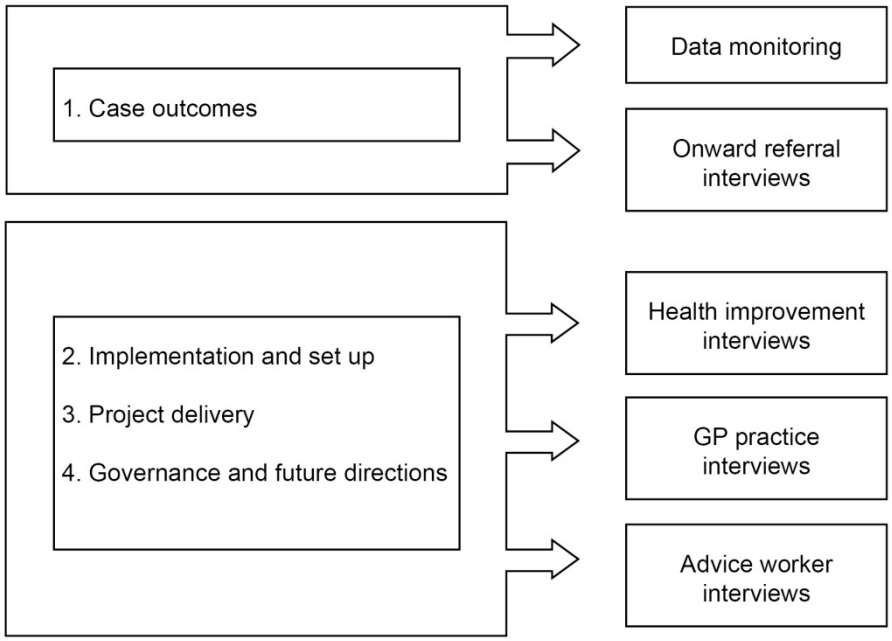
The evaluation was in two parts – the money advice case outcomes and the processes of integrating money advice staff in the practices. The evaluation of the 12 months of the service was focused on evaluating both the project outcomes and processes.

It was decided to focus evaluation resources on areas that had not previously been explored in similar evaluations. For example, it was decided to not focus on people's experiences of the services, as this has been covered in detail specifically for general practices[14], in wider health services[16], and the Healthier, Wealthier Children project [6;7] and of social prescribing in a wider sense than just providing money advice[17].

Structure of methods

As can be seen in Figure 3 below, each of the four aims of the evaluation are mapped to one or more of the methods used to collect and analyse data. Each method is discussed in more detail below.

Figure 3: Visualisation of evaluation aims mapped to methodological approach.



Money advice monitoring data

As part of their case management system, the advice agency collected data on background and outcomes for each client. Anonymised data for the 12 months until the end of March 2018 was provided to researchers at the GCPH, and outcomes data was produced by matching separate worksheets together.

Data matching and analysis was done using SPSS statistics software.

In September 2017 an additional question was added to the advice monitoring data. People engaging with the money advice service were asked if they had accessed the service in the previous 12 months.

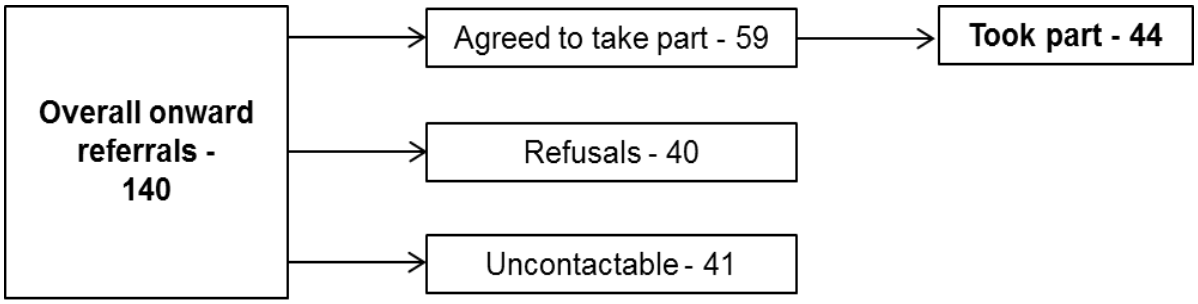
Interviews with advice clients referred to other services

In order to look at whether people were taking up onward referrals from the advice workers to access additional support, a short telephone survey was developed and conducted by researchers from the GCPH in May 2018. The money advice staff identified all those who had received onward referrals from advice workers, and contacted them to find out if they would be willing to take part in the survey. The subsequent telephone interviews were conducted from the money advice offices.

The money advice data spanned the 12 months until the end of March 2018, therefore there were more people with onward referrals included in this telephone survey sample, as it included anyone who had been referred up until May 2018.

Figure 4 below shows the sample approach. Of the 140 people who had received referrals, 59 agreed to take part in the survey, with 40 refusals and 41 unable to be contacted. Overall, 44 surveys were carried out, a response rate of just over 31% of all onward referrals.

Figure 4: Onward referral sample.



The telephone survey data were collated and grouped according to the themes of interest.

Health improvement interviews

The health improvement staff member with lead responsibility for implementing the service in the general practices was interviewed by the GCPH research team in November 2017. A follow-up interview was undertaken in July 2018.

General practice interviews

Staff from eight of the nine general practices took part in a group discussion with the GCPH research team between March and June 2018, at lunchtimes within the practices. As many staff as possible were encouraged to attend, though often this was affected by who was available on the day. Between two and seven staff took part from eight of the nine practices.

In order to try and ensure as many of the practices as possible took part in the discussions, the initial introduction of the evaluation team and subject was done by the Health Improvement worker, who arranged an appropriate time and date for the discussions to take place. The group discussions were audio recorded and transcribed. In order to ensure as much anonymity as possible for participants within the practices where quotes are used, practices are not identified and generic job titles are used.

Money advice worker interviews

All three of the money advice workers involved in the project were interviewed by GCPH researchers. The interviews took place in May 2018 at the money advice offices.

All qualitative interviews with practice staff and money advice workers were audio recorded and transcribed. The transcripts from both sets of interviews were analysed thematically by two members of the research team separately. The team then met and discussed all emergent themes.

Ethics

NHS ethical approval was not required for this piece of research, as it fell under the remit of a service evaluation.

Findings

Findings are presented according to the four main aims of the project:

1. Money advice outcomes
2. Project implementation
3. Project delivery
4. Governance and future directions.

1. Money advice outcomes

This section will explore in detail the money advice service outcomes including advice referrals and engagement with services, demographic composition of people referred to the services, financial gains and managed household debt, specific interventions, such as claiming entitled benefits, and onward referrals to other services.

Advice referrals and engagements

Overall, 654 people were referred to money advice services with an engagement level of 68.9%, or 451 engagements. Of the remaining 203 (31.1%) referrals, 95 did not engage, 54 could not be contacted, and 38 declined the service. At the time of the production of the data (June 2018), 16 were pending.

As some people were referred more than once, the overall number of *recorded referrals* was 665. Table 1 shows a breakdown of the *recorded referrals* for the year by practice, with the overall number made by each practice in the second column. The third column shows the average number of monthly referrals by practice. The fourth column shows the number of referrals for each practice as a percentage of the overall list size of each practice. Comparing overall referrals as a percentage of the list size gives a more standardised indication of referrals than the overall referral numbers alone. The final column indicates the date at which each practice joined the pilot.

Table 1. Overall number of recorded referrals by practice (April 2017 – March 2018).

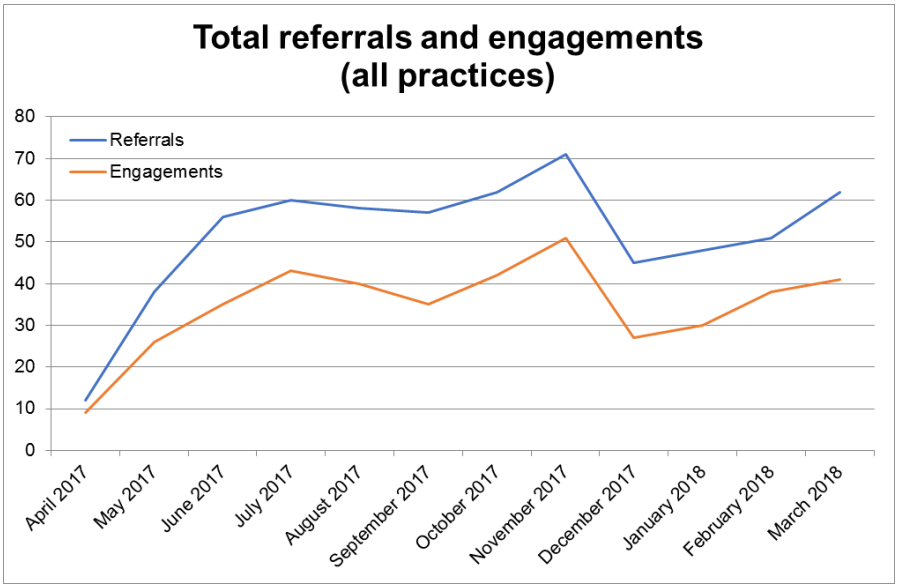
Practice code	Total number of recorded referrals (n=665)	Referrals per month (average)	Referrals as a percentage of list size	Start date
1	124	10.3	3.8	April 2017
2	135	11.3	2.8	April 2017
3	83	8.3	2.0	May 2017
4	69	6.9	1.8	June 2017
5	38	3.8	0.7	June 2017
6	36	3.8	0.9	June 2017
7	71	8.4	1.1	June 2017
8	51	6.8	1.7	July 2017
9	58	7.7	1.7	July 2017

Practices 1 and 2, which were involved in the initial co-location of an advice worker between December 2015 and March 2016, had the highest overall number of referrals, as well as the highest monthly referrals. Both practices accounted for 38.9% (n=259) of all recorded referrals.

Before commenting on the total number of referrals and engagements for the year (see Figure 5 below), it is worth noting that six of the nine practices joined the project between June and July 2017. After a steady rise from April to July 2018, there was a slight drop over the summer months, until September, when both referrals and engagements start to climb again. Referrals and engagements drop off from November to December, but start to rise again from January 2018.

Overall, the referrals and engagements for each individual practice over the year do not reveal any consistent pattern or trend – see Appendix A.

Figure 5: Total number of recorded referrals and engagements for all practices (April 2017 – March 2018).



Of the 665 *recorded referrals* data were available on the practice staff who initiated the referral – see Table 2.

Table 2. Overall number of referrals by staff at each practice (April 2017 – March 2018).

	Referrer			
Practice	**General practitioner**	**Health visitor**	**Practice nurse**	**Healthcare assistant**
1	113	11	-	-
2	125	6	4	-
3	76	-	4	3
4	60	-	2	7
5	38	-	-	-
6	25	-	11	-
7	60	-	11	-
8	45	-	-	6
9	34	-	-	24
665 (100%)	**576 (86.6%)**	**17 (2.6%)**	**32 (4.8%)**	**40 (6%)**

Across all nine practices, GPs (86.6%) made the most referrals, followed by healthcare assistants (6%), practice nurses (4.8%) and health visitors (2.6%), respectively

Demographic composition of clients

This section presents demographic information on those who were referred to the service (654 people) and those who engaged with the service (451 people, or 68.9%). For those who were referred but did not engage there is less background information available. However there is also some demographic data missing for those people who did engage with the service.

In each of the tables, the referrals column shows the percentage of each demographic that made up the overall advice referrals. The engagements column shows the proportion that engaged after being referred to advice services.

In terms of gender, 55% (n=359) of all referrals were for women with 70% (n=252) engaging with advice services (see Table 3). Although women were more likely to be referred, the level of engagement with advice services was roughly the same for men and women who received a referral.

Table 3. Total advice referrals and engagements by gender (April 2017 – March 2018).

Gender	**Number of referrals (% overall referrals)**	**Number of engagements (% referrals)**
Female	359 (55%)	252 (70%)
Male	226 (35%)	163 (72%)
Not known	69 (10%)	36 (52%)

Table 4 shows the age range of all people referred to and engaging with advice services. Those aged 46 or over accounted for 50% (n=356) of those referred to the service. Engagement increased with age, with 55% of those aged 16-25 engaging compared with 78% of those aged 66 or more.

Table 4. Total advice referrals and engagements by age range (April 2017 – March 2018).

Age range	Number of referrals (% overall referrals)	Number of engagements (% referrals)
0-15	3 (0%)	1 (33%)
16-25	49 (7%)	27 (55%)
26-35	91 (14%)	53 (58%)
36-45	113 (17%)	71 (63%)
46-55	138 (21%)	97 (70%)
56-65	153 (23%)	115 (75%)
66+	65 (6%)	51 (78%)
Not known	42 (6%)	36 (86%)

In terms of ethnicity, the majority of those referred to advice services were White Scottish (56%; n=365) with high levels (92%; n=337) engaging with the service. 'Not known' ethnicity was the second largest response (32%; n=211) of which 26% (54) engaged. There were low levels of project engagement with Black African/Caribbean (1%; n=11) and Asian (1%; n= 7) minority ethnic groups. See Appendix B for a breakdown of total referrals and engagements by ethnicity.

Data on economic status revealed that by far the largest group in terms of referrals and engagement were those unfit for work, representing 42% (n=275) of referrals. Engagement with the service among this group was high (90%; n=248). 'Not known' economic status was the second largest referral response (32%; n=210). See Appendix C for a breakdown of total referrals and engagements by economic status.

A breakdown of household composition revealed that 37% (n=242) were single adults while 17% (n=114) of households (couple and lone parent) had dependent children (see Table 5).

Table 5. Total advice referrals and engagements by household composition (April 2017 – March 2018).

Household composition	Number of referrals (% overall referrals)	Number of engagements (% referrals)
Single adults	242 (37%)	217 (90%)
Couple (no dependent children)	76 (12%)	72 (95%)
Couple (with dependent children)	39 (6%)	37 (95%)
Lone parent (with dependent children)	75 (11%)	66 (88%)
Other	7 (1%)	5 (71%)
Not known	215 (32%)	54 (25%)

Data on housing status revealed that 40% (n=264) of those referred were renting from a registered social landlord with 9% (n=56) owner occupiers. Similar to the high levels of engagement found among the unfit for work, 89% (n=235) of social housing tenants engaged with the service. See Appendix D for a breakdown of total referrals and engagements by housing status.

In terms of income, 65% (n=422) of those referred had an annual household income of less than £10,000, dropping to 19% (n=123) with less than £6,000 (see Table 6).

Table 6. Total advice referrals and engagements by income band (April 2017 – March 2018).

Income band	Number of referrals (% overall referrals)	Number of engagements (% referrals)
£0-£6,000	123 (19%)	107 (87%)
£6,001-£10,000	299 (46%)	129 (43%)
£10,001-£15,000	86 (13%)	79 (92%)
£15,001-£20,000	62 (9%)	54 (87%)
£20,001-£25,000	16 (2%)	16 (100%)
£25,001-£30,000	16 (2%)	15 (94%)
£30,001-£40,000	13 (2%)	13 (100%)
£40,001+	4 (1%)	4 (100%)
Not known	35 (5%)	34 (97%)

In response to a question introduced in September 2017, when asked about past contact with money advice services, among the 326 responses, 65.7% stated that they had not accessed the advice agency in the last 12 months.

Financial gains and debt managed

Over 12 months, £1,502,129.54 worth of financial gain was secured for people who engaged with the services, and £470,448.86 worth of debt was identified and managed. These figures give a return on investment of £19.26 financial gain for every £1 invested, or when debt managed/negotiated is also taken into account, a return on investment of £25.29[c].

Further analyses of the £1.5 million in financial gains showed that, of the 182 that reported a gain, the average amount per person was £8,253.46, while the median amount was £1,453.49. It should be noted that the available data goes up to March 2018 and any financial gain awarded after this time was not included. Table 7 shows the overall financial gain across the nine practices.

[c] Calculated using the total project cost of £77,985 for 12 months.

Table 7. Overall financial gain by general practice (April 2017 – March 2018).

Practice code	Total gain
1	£325,536.48
2	£401,608.96
3	£205,102.14
4	£185,461.26
5	£55,615.37
6	£98,786.50
7	£161,047.19
8	£29,212.29
9	£39,759.35
TOTAL	**£1,502,129.54**

Overall, just over £470,000 in household debt was under negotiation (see Table 8). The total figure includes housing debt, non-housing debt, and council tax arrears under negotiation. Of the 108 people negotiating debt, the average amount of debt per person was £4,356.01, while the median amount was £1,993.80.

Table 8. Total amount of debt under negotiation by practice (April 2017 – March 2018).

Practice code	Total debt under negotiation
1	£81,835.15
2	£96,928.42
3	£66,921.12
4	£29,679.11
5	£28,867.80
6	£26,920.70
7	£82,412.82
8	£31,184.12
9	£25,699.62
TOTAL	**£470,448.86**

Table 9 shows the type of advice intervention that the person was referred to the service for, along with the total gain for each of the interventions, as well as the number who had a financial gain for the particular issue. The table count for each intervention, such as Personal Independence Payment or Carers Allowance, does not add up to an overall number of engagements, as some people had more than one intervention. Advice cases where no gain had been reported by the date of the data extraction were excluded.

Table 9. Overall financial gain by intervention (April 2017 – March 2018).

Intervention	Total gain	Count of people
Personal Independence Payment (all)	£401,534.91	107
Employment Support Allowance (all)	£388,292.19	96
Income Support	£123,330.84	25
Housing Benefit/Local Housing Allowance/Housing related	£120,350.89	52
Child benefit/tax credit/child related/maternity related	£96,101.88	39
Pension credits/Pension related	£90,088.84	12
Attendance allowance	£76,911.68	22
Carer's Allowance	£74,736.23	25
Disability Living Allowance (all)	£52,371.99	15
Council Tax Reduction	£38,332.89	41
Jobseeker's Allowance (Income-based)	£11,570.69	3
Bereavement Allowance/Funeral payment	£8,891.89	2
Scottish Welfare Fund	£8,268.82	28
Working Tax Credit	£6,697.39	6
Universal Credit	£2,471.30	2
Chest, Heart and Stroke Scotland Grant	£2,177.11	7

By far the two most frequent advice interventions were for illness or disability related support – 107 awards for Personal Independence Payment (PIP) and 96 awards for Employment Support Allowance (ESA). Both PIP and ESA awards accounted for over half (£789,827) of the overall £1.5 million in gains for all advice uptake over the year. Income support, paid to those on very low incomes, accounted for just under a tenth of all financial gain but yielded the highest per person gain of £4,933 with housing issues accounting for a similar amount. It is worth noting that almost £100,000 of the financial gain was for child or maternity related support.

Type of money advice outcomes

Overall, 507 money advice outcomes were recorded for 214 people, with an average of 2.4 outcomes per person (see Table 10).

Table 10. Case outcomes for all cases with outcome listed (April 2017 – March 2018).

Case outcome	Total
Benefit award	131
Backdate amount	113
Client advised on energy efficiency/awareness or fuel poverty	60
Medical priority for housing awarded	27
Debt written off	25
Collaborative supporting letter issued	22
Bus pass award	20
Client received budgeting support	18
Welfare reform explained and discussed	14
Client advised on all appropriate saving options	13
Other	64
Total	507

The most common advice outcomes were ‘Benefit award’ and ‘Backdate amount’. Both accounted for 244 outcomes, or almost half of all outcomes. However, it should be noted that not having an outcome did not necessarily mean that the person did not have a financial gain, and vice versa. Specific outcomes that totalled less than 10 were aggregated to ‘other’. See Appendix E for a full breakdown of all advice outcomes.

Onward advice referrals

Within the money advice monitoring data, 124 people received an onward referral from the advice agency to another service or organisation. Table 11 shows there were a total of 166 reasons recorded in the case files for these onward referrals.

Table 11. Number of and reason for onward referrals (April 2017 – March 2018).

Reason	Total number and reasons
Homelessness	32
Housing support/housing options	32
Mental health support	18
Fuel poverty	14
Money advice	12
Welfare rights	12
Financial capability	8
Employability	4
Health and wellbeing	4
Employment	1
Other	29
TOTAL	**166**

Homeless- and housing-related issues accounted for over a third (n=64) of all recorded reasons for onward referrals to other agencies, by far the largest proportion. More than one in 10 (n=18) involved accessing mental health support.

Among the 44 people that took part in the short telephone survey on uptake of additional support, 16 (36%) said they had not received an onward referral to any other agencies/sources of help by their advice worker and one had no memory of being referred onwards. Overall, 27 (61%) said they had been referred onwards.

Of the 26 people that made contact with the agency/source of help, there were 18 positive outcomes, two had not yet had an outcome, and seven had a negative outcome. The reasons for negative outcomes were given as: not hearing back from the agency (three responses); the agency could not help (two responses); and in one case each the other agency took too long or the person failed the assessment.

Thirteen participants that received an onward referral were very positive about the advice workers and the money advice agency more widely. See the comments presented in Box 1.

Box 1. Advice clients’ comments on receiving an onward referral.

"[The advisor] has been an excellent advisor. Every member of staff has been empathetic and lovely. Wish it was rolled out through the whole of Glasgow."

"Just wanted to say … Within a month of contact with [the advisor], found it wasn't as bad as it seems. Very dramatic difference in a very short space of time, more than money advice – a face, added value, little things, like [the advisor] making sure he wrote everything down for me as he knew I'd forget. Can't thank them enough, credit where credit's due."

"…have been absolutely brilliant, [the advisor] has been a godsend, wouldn't have been able to do the forms myself."

"…[the advisor] was a gentleman, he really knew his stuff. Got granted PIP and I'm over the moon."

"He was excellent. Clarified everything, informed me of lots of other things, and said I could go back to him at any time. We talked about benefits ... He certainly had information available if I'd needed it. Can't speak highly enough of him."

"[were] so personal – been in touch with three people and it seems they are all communicating with each other. Don't know if it is a small place but it feels as if they all chat to each other and they'll put you onto the right person. The support has been second to none."

2. Project implementation and set up

This section on the project implementation and set up will look at the partners' views on the wider context of providing advice in healthcare settings, understanding of the aims and benefits of the project, day-to-day running, and the process of embedding advice staff across the nine practices.

Wider context

Reflecting on the existing locality model of using health centres as the main access point for advice referrals, four practices stated that it was not effective. The open access appointment system, which included accepting practice staff referrals, was considered far too busy and did not achieve many referrals. The three advice workers from the specialist money advice agency had experience of this model, as well as working in other healthcare settings, such as the ongoing Healthier, Wealthier Children project and providing advice services in a local psychiatric hospital.

An early GP advocate of the project raised awareness of the positive outcomes during the DEAWP phase and potential benefits to those attending the GP cluster group. Although there were some initial group concerns, such as additional work for receptionists and accommodation challenges, the majority were willing to participate with high expectations as to how participation might result in significant financial gains. Among the advice workers, there were some questions as to whether the high levels of commitment during the DEAWP phase were evident as the project developed.

Project aims

Although there was a degree of consensus on the project's aims, the weight and attention given to particular aspects varied and may have influenced subsequent operationalisation across the practices. GPs involved in the early stages emphasised the need to continue having a central role in the design to ensure that changes did not lead to increased workloads but resulted in a win-win situation for staff and advice clients. For advice workers, closer working relationships with GPs, accessing medical records (which did not occur in the locality model) and being located in practices were considered important. The health improvement emphasis was on increasing advice referrals and incorporating money advice as a treatment option for GPs. More specifically, there was an interest in testing whether this approach could be scaled up with the focus on clinician-led referrals:

> "*…the diverse characteristics and nuances of GP practices… the proposal will test if the new model of service provision can be woven into their everyday working practices and secure positive outcomes for patients*"[d].

[d] Note from the external successful funding application.

Project benefits

Locating advice workers in general practices appeared to confer a range of benefits which could be divided into two categories: benefits for advice clients and benefits for advice workers and practice staff.

- Benefits for advice clients

The practice was seen as a 'trusted hub' which reduced stigma and promoted uptake in a discreet setting, according to advice staff: *"others don't know they're in a queue for money advice"*. Consequently, people were more open and engaged when discussing money worries. Practice staff also noted that aligning advice appointments with the practice culture was viewed as ensuring people valued their appointment more than under the locality model. In some instances, people saved on transport costs by not having to go elsewhere. Positive impacts on people's mental health when money worries were addressed and unexpected financial gains for those accessing advice for the first time were both reported by practice staff. This latter benefit was borne out by the monitoring data. Although one practice reported that some retired and financially better off people did not want to engage, the benefits of helping people on low income manage debt and improve their situation were welcomed, as summed up by a GP advocate of the project:

> *"You can see the figures, there's a lot of money spent on other projects that don't necessarily have their robust outcomes."*

- Benefits for advice workers and practice staff

Possibly linked to the practice being seen as a 'trusted hub' for people seeking advice, some advice staff saw working there as providing more prestige when compared with working in other community venues. Practice staff having worked with the same advice worker under the locality model found the worker more relaxed and approachable when embedded within the practice. Some practice staff reported an easing of workload and reduction in people requesting appointments for welfare-related letters, which allowed them to concentrate on core clinical tasks.

3. Project delivery

This section looks at specific elements of the project delivery, namely start-up resources, referral processes and feedback, engaging other healthcare professionals, accessing medical evidence and producing letters of support. It will conclude by exploring how partners viewed the process of embedding the project and wider connections developed as the project progressed.

Start-up resources

Providing practice accommodation for advice staff presented initial challenges that led to creative solutions, such as reconfiguring existing space into consulting rooms and using available rooms on the day. Advice staff adapted to operating in the practice by ensuring that other resources were available to undertake their role, such as computer logins and

telephone access. Some practices appeared to have achieved a ‘gold standard’ by ensuring that resources and induction information were in place prior to advice workers being in post, according to health improvement staff.

Advice referral process

Despite some initial obstacles, the referral process appeared straightforward, avoided additional paperwork, and was described as being helpful when engaging people with multiple health conditions and ‘hidden concerns’. Initial waiting times were considered better when compared with the locality model. As the project developed and workloads increased, practice staff put forward a range of suggestions to improve uptake and reduce waiting times:

- Give people an appointment card or contact letter, and use the practice telephone number to contact those unlikely to answer an unknown number.
- Allow all staff to refer and directly book an appointment, instead of going through the money advice head office. Some receptionists were actively involved in screening calls or face-to-face contacts to ascertain if the person could be referred, with others ensuring that GPs endorsed the referral. One practice, after discussion with advice staff, directly booked advice appointments, with others suggesting that appointments could be more flexible, instead of a fixed one-hour appointment.
- Adopt a more flexible approach to allocation of the half-day advice sessions to recognise the different practice sizes, which ranged from around 3,000 to over 6,500 people.

Advice referral feedback

Feedback on advice referrals could be improved, according to four practices. Email summaries added to medical records were considered the right level of feedback. However, it was reported that the summaries were stopped and not reinstated despite requests. Two practices reported not receiving any feedback with another unclear as to whether they were entitled to know if a case was resolved, or whether they should receive aggregate data on all referrals.

Providing feedback on the numbers referred and reported financial gains was seen as encouraging healthy competition and allowed practices to see if others were making more use of the service, according to health improvement staff. Suggestions to improve feedback included practice visits, advice workers being available to address specific issues, sharing updates and providing a short letter or checklist on advice outcomes.

Engaging other healthcare professionals

With healthcare assistants, practice nurses and health visitors as a group accounting for less than one in seven referrals, timely opportunities were identified to improve project engagement. Chronic disease management reviews[e] undertaken by practice nurses were seen by some practice staff as providing opportunities to inquire about money worries, particularly when asking screening questions about depression and anxieties. Commenting on the benefits of co-locating advice services in general practice, a GP noted that when health visitors undertake assessments of new babies and engage with teenage mothers:

> *"It just seems silly that they're (teenage mothers) willing to come to the practice and not willing to go to a place (money advice service)"*

A practice hosting a Community Addiction Team worker stated that the worker was also referring people for advice.

Producing supporting evidence

Under the locality model of advice workers operating across the seven health centres, producing supporting evidence, such as a letter to support welfare-related claims, could often involve the following:

1. The specialist money advice agency would occasionally refer advice clients to a Law Centre to obtain legal aid to pay for a medical letter.
2. The Law Centre would then contact the GP to request medical evidence with the subsequent fee paid to the practice.
3. The medical letter of support could be used at benefits reviews and appeals by the advice agency or by the Law Centre when representing a client in court for rent arrears hearings.

In December 2015, the two practices that participated in the DEAWP work agreed on a new approach to producing evidence, which differed from the locality model and was seen as a key step in supporting claimants and not generating extra work for practices. Rolled out across all nine practices, it involved the three advice workers having access to medical evidence to support the process of preparing applications and producing reports and letters of support that could be used at benefits reviews and appeals. This new approach involved the GP approving and signing off the letter of support.

A positive outcome from this approach was that some practices stopped charging a fee for providing a medical letter, although there were some instances of a fee being requested for a housing letter. One practice still produced some letters without advice worker input.

Introduced changes as to how the letters of support were produced became a strong theme among project partners. This was evident when some practices introduced a disclaimer

[e] Chronic Disease Management (CDM) involves active management of long-term conditions, primarily in General Practice, and applying standards of care around them. CDM includes Chronic Heart Disease, Diabetes and Stroke among other conditions.

stating that the letter was now being produced by the advice agency and not the practice, but endorsed by the GP. The change was explained by some practice staff as being due to the short-term nature of the project and the possibility that the service may no longer be available. Some of these reservations were observed at the outset by health improvement staff. However, this change was not consistently applied with two practices agreeing not to add the disclaimer to their letters, which prompted an advice worker to observe:

> "*…people know each other… 'you got my pal one [letter], this is the same project, why can you not get me one?'"*

Advice workers speculated whether adding the disclaimer devalued the letters of support, as the advice service was actively involved in benefit reviews and appeals. Therefore, disclaimer letters produced by their service were seen as a conflict of interest. Some tribunals stated that disclaimer letters could not be submitted as evidence during appeals. In contrast, advice workers reported that letters without the disclaimer did *"definitely make a difference"*.

Accessing medical evidence

Advice worker access to medical evidence was only given after obtaining a client's written consent with one practice requesting further clarification of consent when the person attended their next money advice appointment. The three most commonly used online medical record systems in primary care are EMIS, Docman and Vision, which allow professionals, such as GPs and practice nurses, to record, share and use vital information. The meaning of 'access' to the three systems differed not only between advice and practice staff, but also across practices. The different approaches could generally be classified as belonging to one of three:

- Full access: advisors could log into the system and have full access to the person's records but only as 'read-only'. In other words, they were not able to make any changes to the records.
- Intermediate access: advisors could access basic information and summaries, but not the whole record.
- Basic access: advisors could access information through clinical and reception staff, either by face to face conversations, looking at records together, or receiving printed summaries.

Seven of the nine practices described offering one of the three types of access to medical evidence. Three practices offered full access to EMIS and Docman but with one practice not allowing access to Vision. Two practices described intermediate access, which could be defined as restricted access to online records, such as on a read-only basis, but not full access. Finally, two practices provided a basic level of access. This entailed providing summaries but no access to online records.

Views on accessing medical evidence

There were distinctly different views on accessing medical evidence with advice workers expressing more positive views than practice staff.

Advice workers

On the whole, advice workers adopted a positive position on having access to supporting medical evidence. This could be summarised as being able to clarify a person's health status, which in turn would support more effective interventions, and could be preventative in nature. Supporting people to clarify their health status (diagnosis, medications, treatments and so on) was considered important due to a lack of awareness, which was reported as a frequent occurrence when providing advice in health centres or in a local psychiatric hospital. A better understanding of an individual's circumstances was viewed as being more helpful when completing benefit forms, developing an appeal or compiling letters of support. Access to accurate, up-to-date evidence was considered preventative, if it resulted in someone not having to attend a stressful benefits appeal[f]. The medical evidence was also cited as having a positive impact at the tribunal service.

Access to medical records was considered preferable to the summaries offered under 'basic access', as it was viewed by advice workers as helping to reduce practice workload. The summaries were seen as providing limited information on a person's health status and did not reduce workload for all parties:

> *"…if six people in and you've got to ask constantly back and forth… bit of a burden at times…. reception busy… but they're always accommodating." Advice worker*

> "*If no access then it turns into another locality that we sit in – what difference then? Nothing, if we don't have access to records*." *Advice worker*

General practice staff

In contrast to advice workers, the position of practice staff could be characterised as: increasing anxieties on whether access should be relaxed or extended with calls to address specific issues, such as clinical governance concerns. Three practices providing basic or restricted access were concerned about relaxing or extending access and expressed a need for a clearer position across all nine practices. Two practice managers responded by undertaking audits to ensure that advice workers were only accessing information related to their roles. When concerns re-emerged within the GP cluster group, two other practices stopped access to online records and asked the advice worker to speak to the reception staff who would then contact the GP. Interestingly, one practice offering basic access to medical evidence achieved some of the best outcomes in terms of referrals, financial gains and debt management. However, two other practices questioned the merits of limiting access to evidence:

> *"…probably won't result in it being done as well, having to go a lot on what [the] patient tells [the advice worker]*"

[f] A person can ask the Department of Work and Pensions to look at a benefits decision again, which is known as a 'mandatory reconsideration'. If they disagree with this outcome, they can appeal to an independent tribunal.

"Well, we don't understand why the drug counsellors got access, why would a money advice person not get access? I know that it's more clinical, the drug access, but [the advice worker] doesn't go on unless it's actually necessary."

The specific practice concerns were clinical governance challenges around confidentiality, engaging with advice workers as non-NHS employees, and responding to the introduction of the new General Data Protection Regulation (GDPR) which aims to give control to individuals over their personal data and to simplify regulation within the European Union.

Embedding

The concept of advice workers being embedded across the practices differed slightly between practice staff, advice staff and health improvement.

General practice staff

Having an advice worker housed in the practice and being able to make direct referrals were important aspects for most practice staff. Some emphasised closer working relationships but this was not a strong theme. Practices that joined the project later on recognised that it was not fully embedded but that there were promising signs, such as workers building relationships with return advice clients. This was supported by the monitoring data. Two practices involved in the DEAWP stage expressed clear views on how the advice worker could support the embedding process.

For some practice staff, it was important that the worker understood the practice culture, staff roles and aligned advice services to day-to-day surgeries. They needed to become an established part of the team by avoiding frequent advice worker turnover, be capable of working independently and gain professional trust, particularly when engaging with vulnerable people. Adaptable communication skills that could be deployed in a 'time challenged' environment were also considered important.

Advice workers

Advice workers responded to working in a 'time challenged' environment by engaging receptionists, grabbing opportunistic catch-ups, knocking on the GP's door if they had a "major concern", or in some instances taking the view that some GPs were too busy to engage with. Inviting workers to attend practice meetings on a quarterly basis was seen as a way to support further integration and encourage shared aims.

Closer working relationships were considered important for advice workers who observed differences in 'friendliness' across the practices. Although there was a sense that a lack of friendliness had a detrimental impact on referrals, this was not reflected particularly in the advice data.

Health improvement staff

For health improvement staff, the process of embedding the project was characterised as ensuring it became *"part of the practice menu of services available*", as well as leading to a *culture* of referral, for example looking at who in each practice was referring.

Factors hindering embedding

Reported factors hindering the embedding process included limited working relationships and levels of communication, particularly with GPs. Indeed, to some extent all project partners were aware that some practice staff were unaware that the project even existed. In response, offers were made (which were not taken up) to provide training and awareness sessions and updates for new staff on the project's wider benefits, such as addressing money worries, promoting wellbeing and reducing workload.

Despite the challenges identified by advice staff, practice staff considered the project an "*excellent service*" and preferable to the locality model. Moreover, advice workers welcomed their new working links in surgeries, receiving direct referrals and having a degree of access to medical evidence, which was not possible under the locality model.

Extending partnership connections

Beyond embedding the project, one GP suggested that the advice service could have an influencing role with external agencies, such as housing providers and the Department of Work and Pensions. Another GP advocated closer ties with Community Links Worker[g], which was already happening in another practice.

Creative working links were developed in supporting people with mental health problems and money worries. This involved a Community Link Worker (CLW) and money advice worker, both based in the same general practice. The CLW referred someone with a mental health problem to the advice worker to address money worries. Likewise, the advice worker referred someone to the CLW to consider accessing mental health support. Both workers had a 'shared' client with anxiety problems and benefits concerns. This led to the CLW attending an independent medical assessment for PIP, in order to provide some support to the client. This arrangement *"worked out quite well"*, according to the advice worker who was dealing with the client's ongoing benefit concerns.

There was some evidence of wider connections being explored beyond solely offering money advice in the practice. Commenting on the process of gathering medical evidence on a person's daily functions (*"getting in and out the bath and stuff like that"*), an advice worker encouraged people to speak with practice staff if there was a potential need for onward support, such as an occupational therapist assessment or accessing mental health services.

[g] A Community Link Worker supports people to access local resources or services and is based in a general practice serving a deprived community. The Scottish Government has committed to rolling out a workforce of 250 across Scotland.

4. Governance and future directions

This concluding findings section will explore project ownership with a particular focus on the health improvement role and the role of the GP cluster group. The implications of scaling up the project will briefly be explored.

Health improvement role

At the outset, health improvement (HI) staff had a brokering role, particularly across the seven practices that joined between May and July 2017. The role included:

- Ensuring practice staff were briefed on the pilot aims and objectives and the referral process was established and operating effectively.
- Supporting set-up and ensuring resources were in place, such as access to telephones, computers, medical evidence, letters of support, and securing practice accommodation.

This role naturally tapered as the project evolved over the 12 months and involved the HI lead receiving updates, problem solving and being informed of any significant operational changes. The main changes were the introduction of the disclaimer to the letters of support and access to medical evidence being restricted or withdrawn as the project progressed.

Reflecting on the role, the HI lead noted that input could have been 'scaled back' after setting up the project, followed by a move to quarterly feedback meetings with practices. In terms of challenges, project changes were sometimes implemented without the HI lead being informed. This was difficult as the lead was accountable for supporting implementation and facilitating the embedding process but both advice and practice staff had different lines of accountability.

The HI lead's intermediary role was valued by advice workers in terms of preparing the newer practices and ensuring a welcoming approach. Despite some initial concerns about top-down and constraining processes, at least three practices welcomed the input. Although some accepted the input, others preferred to be left to their own devices after the initial set up knowing that they could contact the lead if required. One of the most successful practices was proactive in that they took ownership and in collaboration adapted the project to fit with their practice, according to the lead.

General practice cluster group

There was an expectation that project decisions would be taken at the GP cluster group to ensure a degree of uniformity on service delivery, and that any project changes at a practice level would be discussed with the practice manager, according to the HI lead. However, this did not occur in the way it was anticipated, as the limited time available would result in broad issues being discussed. Consequently, the HI lead had to engage afterwards with individual practices to address specific aspects of the project. Nevertheless, the HI lead was very positive about having access to the cluster group.

On the other hand, some practice staff questioned if too much time was given over to discussing the project at the cluster group. Advice workers expressed frustration that cluster

group practices were not consistent in their approach towards key elements of the project, such as access to medical evidence.

Scaling up

Scaling up has been defined as delivering an innovation in a way that increases the numbers benefiting while ensuring the original design and measures were maintained[h]. In terms of scaling up this project, some practices expressed a need for more secure long-term funding or an exit strategy if this was not forthcoming. There was consensus among advice workers for more consistency across the practices in terms of accessing records and producing letters without the disclaimer to achieve better outcomes. Both advice and practice staff recognised the need to address the data protection and governance issues with a suggestion that the Scottish Government could have a role to play.

[h] Scaling up is a contested definition. For more on definition see http://whatworksscotland.ac.uk/wp-content/uploads/2015/06/WWS-EB-evidence-review-Scaling-Up-Innovations-June-2015.pdf

Discussion

Accessing and engaging advice services

Over 12 months, the project achieved a range of positive advice outcomes. There were 654 referrals which led to 451 (68.9%) engaging with advice services. This led to around £1.5 million in gains for 182 people. Disability-related benefits accounted for over half of the gains and almost £100,000 was for child- or maternity-related support. Support to manage household debts totalling more than £470,000 was given to 108 people. Among the 124 people referred to other services, homeless and housing issues accounted for over a third of all reported reasons with more than 1-in-10 accessing mental health support.

In terms of household income, two thirds of all advice referrals reported living on less than £10,000 annually, which falls below the poverty measure for a single adult.[i] Although the majority of all referrals were indeed more likely to be single, older women, and unfit for work, 1-in-6 reported living with children. Therefore, if some families referred for advice were living on less than £10,000, then this falls below the poverty measure for a single adult.

It was concerning that a high percentage (65.7%) reported no past contact with advice services, which supports a similar DEAWP finding involving two practices. On a positive note, high uptake of advice was evident across different household income groups, but with one notable exception. People living on £6,001-£10,000 per year were more than twice as likely not to attend compared with all other income groups. Improving uptake will be important as they accounted for 46% of all referrals. Lessons could be learned from people living on less than £6,000, as this group accounted for 123 referrals, of which 107 (87%) engaged with services.

These outcomes raise pressing questions, such as how many households continue to live in similar circumstances and remain unaware of this support? This is worth exploring, even if we only consider tackling debt. Among those receiving support the median debt was £1,993. This is equivalent to one fifth of annual household income for those on less than £10,000. An important health outcome as strong relationships exist between debt and the presence of mental health disorders, including depression, problem drinking, drug dependence and suicide completion[18]. All contributing towards the fatal burden of disease in Scotland's most deprived areas being three times higher than the least deprived areas[19].

Testing a local integrated approach

Testing this local approach over 12 months led to 654 advice referrals compared with 1,264 under the locality model, over a comparable timescale.[j] In other words, nine practices achieved the equivalent of more than half of all HSCP referrals across northeast Glasgow. A breakdown of the 1,264 locality referrals showed that 724 were directly from NHS staff, of

[i] The Scottish relative poverty threshold for a single person with no children was £10,200 annually, before housing costs (2014-17). https://www.gov.scot/Publications/2018/03/3017/3

[j] Annual data on money advice services funded by Glasgow City's Health and Social Care Partnership – northeast locality. Email communication: Health Improvement Senior, North East Health Improvement Team.

which 64% were from health visitors. This is perhaps unsurprising as tackling child poverty remains a priority since the launch of the Healthier, Wealthier Children (HWC) project, which was subsumed into the locality model. More noteworthy, among the 35 practices that did not participate in the study but had access to the locality model, there were only 71 referrals.

Despite ongoing workload challenges, GPs were responsible for nearly nine out of ten referrals. The two DEAWP practices accounted for nearly four out of ten referrals and around half of the £1.5 million gains. Possible explanations for the two practices achieving such impressive outcomes include established working relationships with the advice worker from December 2015 onwards, participating in the study two to three months ahead of others, and having two GPs that were advocates of this type of work. This advocacy role helped introduce the concept of the project into the local GP cluster group, which then supported dissemination of information during the initial stages.

Integrating advice into general practice was viewed as creating a 'trusted hub', which is an important benefit that should not be overlooked when considering the high percentage reporting no past contact with advice services. Some practice staff also reported an easing of workload and reduction in welfare-related appointments. Despite some concerns about project delivery, this integrated approach was favoured over the locality model.

Are there merits in scaling up this integrated approach?

With both practice and advice staff favouring this approach, could a supply and demand lens help identify and address challenges, if scaling up was progressed? In other words, did increasing the supply side (*health improvement input, advice staff embedded in nine practices and practice staff referring*) lead to an increase in demand (*more accessible advice in neighbourhoods with higher levels of deprivation and people with disabilities, alongside some of the biggest financial losses from welfare changes*)?

Demand side challenges

The demand identified in this study was often 'hidden' in busy practices, and is likely to only increase in the foreseeable future. The latest report on poverty and income inequality across Scotland identified a rise in poverty among children and single women, and higher poverty rates among families living with someone with a disability and minority ethnic groups[20] (see study limitations for comments on ethnicity). The report also recognised that lower income households receive a larger proportion of their income from social security payments than earnings. This is an important point as the UK welfare reforms from 2010 onwards will result in Scotland's welfare budgets in 2020/21 being £3.7 billion lower than had the reforms not been introduced[2]. A situation that will only add to the identified losses already facing Glasgow's most deprived council ward areas.

Supply side challenges

Despite this difficult landscape, health visitors continued to play an important role in mitigating child poverty, and this study shows that GPs engaged working-age adults, as well as families with children. Therefore, responding to increasing demand across the life stages would require a corresponding increase in advice service capacity.

Is there a role for Specialist Link Workers?

A Specialist Link Worker (SLW) has been identified as potentially having a key role to play in addressing these demands, and defined as providing specialist advice and casework on welfare and financial problems, and advocating on issues like housing and debt management[11]. Based in general practices, the SLW was viewed as complementing a Community Link Worker (CLW), in that addressing money worries (SLW role) would support people to make informed decisions about improving their health, planning for the future and learning new skills (CLW role). The key SLW functions would include:

- accepting advice referrals from midwives and health visiting teams, general practice and primary care multi-disciplinary teams
- initiating onward referrals to community-based organisations and the new Scottish Social Security Agency Outreach Team
- generating referral pathways with Community Link Workers in general practices.

Arguably, the money advice agency involved in this study has developed expertise in delivering on aspects of the proposed SLW model. The same agency was a partner in the nurse-led approach to support older people in 2002 and HWC launched in 2010, as well as this integrated approach from December 2015 onwards. Likewise, the three advice workers initiated a significant number of onward referrals with one worker establishing referral connections with a Community Link Worker based in the same GP practice.

This wider learning could help develop local connections with Scotland's new Social Security Agency which is responsible for future delivery of devolved benefits, such as some early years and disability-related benefits.

Is there scope to strengthen and extend healthcare professionals' roles?

Extending and promoting referral pathways could ensure that healthcare professional groups are at least doing a little to effect change, which in turn could support two priorities in Glasgow's primary care improvement plan, namely reducing GP workload burden and tackling health inequalities[21]. Poverty is recognised as an important factor behind the high levels of poor mental health in the city's deprived areas. For that reason, scaling up could support others' efforts to reduce mental health inequalities by boosting household incomes, tackling debts and ensuring onward referral to support services. On the other hand, it will be important to avoid an unintended rise in requests for GP appointments to solely access advice services.

Health visitors' efforts to mitigate child poverty could be supported by all general practice and primary care multi-disciplinary team members taking a more active role in referring pregnant woman and families for advice. Equally, with GPs taking the lead on referring working-age adults, especially people with disabilities, others could play a more active role. Practice nurses in Glasgow City undertook the majority of the 58,244 chronic disease management reviews completed in 2015/16[k], and will continue to play a key role in disease management. They could play a more active role in improving uptake of unclaimed disability-

[k] Chronic Disease Management Review data for Glasgow City (2015-16). Email communication: Practice Nurse Support and Development Team Manager, NHS Greater Glasgow and Clyde.

related benefits among people with chronic diseases. Equally, both district nurses and health visitors played a central role in improving uptake of attendance allowance among older people in 2002. Revisiting this learning could ensure that older people are part of an integrated referral pathway.

It is unsurprising that some reception staff were involved in the referral process. Learning from elsewhere could ensure that they help avoid an unintended rise in requests for GP appointments. Audits undertaken in a large Edinburgh practice showed that around 6% of appointments were signposted onwards, and Community Link Workers attached to 20 practices in Edinburgh were able to support practice staff to signpost[l].

The local health improvement (HI) workforce has played an intermediary role with various healthcare professional groups and the same local money advice agency over the last 20 years. The institutional memories acquired by this workforce could support scaling up and other work, such as the roll-out of Community Link Workers and the Scottish Social Security Agency's local outreach teams. Although the HI workforce will not be considered in the next section look at funding, there will be capacity issues that require attention if they become actively involved in scaling up.

- *Funding*

Since 2016, integrating advice work in local general practices has relied on short-term funding, and the current round of funding has an employability emphasis, which is expected to end on 31 March 2019. Temporary funding was a concern for some practice staff and influenced their commitment to the project, particularly around changes to the letters of support. Putting aside these concerns, for every £1 invested, this study identified a return of more than £25. A conservative estimate that does not include financial gains and debts managed after the data collection cut-off point (March 2018), or other estimated benefits from people receiving onward support from other agencies, such as housing.

The estimated costs of providing one advice session a week per practice across Glasgow's 80 Deep End practices was around £564,000 and could achieve approximately 8,300 referrals, and if extended to the city's 146 practices would cost around £982,500 and achieve around 14,400 referrals[21]. Both figures are based on the current approach to offering advice services and not the Specialist Link Worker model, which has been estimated at £850,000 to cover the 80 Deep End practices in Glasgow[m].

These costs are unlikely to be met within the current levels of HSCP funding of advice service across Glasgow, which already faces budgetary pressures and also relies on short-term funding. Therefore, sharing the project's successful outcomes and learning more widely could be a step towards exploring other more secure funding streams, such as through national agencies.

[l] Email communication: Kate Burton, Scottish Public Health Network.

[m] Based on 20 SLWs each providing one half-day session per week per practice in four GP practices. This would cover Glasgow's 80 Deep End GP practices at a cost of £850,000, which is based on the full-time cost (£42,500) of a SLW, and includes follow up case work. Email communication: Kate Burton, Scottish Public Health Network.

- *Adapting project delivery and resources*

Almost no participating practice interpreted or operationalised the project elements in the exact same way. This is unsurprising as they are not a homogenous group, and being geographically grouped did not necessarily ensure that they would all work in the same way. Therefore, offering some degree of choice over delivery, such as who can refer, could help both advice and health improvement staff know in advance each practice's delivery model.

Accommodation pressures were identified in this study and will need to be considered if more advice staff or the SLW model is integrated into general practices. During 2018/19, the number of Community Links Workers in Glasgow's general practices will rise from 18 to 27 with plans to increase to 35 in 2019/20.

The GP cluster group played a supportive function in the initial stages, but it was less clear how effective the group was in supporting ownership, delivery or decisions that affected individual practices. This was evident when changes made to accessing evidence and letters of support were not consistently applied. The cluster group was a very new entity when the project was being rolled out, so the learning could support future decision-making among cluster groups if this work develops.

Looking at specific delivery issues, there may be merit in exploring if letters of support with or without the disclaimer were submitted to appeals or tribunals, and to examine the subsequent outcomes. Equally, practices could consider undertaking risk assessments to establish parameters and to help address governance concerns, although issues such as access to medical evidence may require external inputs, such as from the Local Medical Committees or Scottish Government.

Finally, it was beyond the remit of this study to assess the impact of specific changes. In particular, in what way did levels of access to medical evidence or changes in producing letters of support impact on advice outcomes or GP workload. Further exploration of these themes may be of interest to others including those undertaking the 'deep dive' primary care research in Tayside, and the new Scottish Welfare Advice and Health Partnership group, which aims to tackle health inequalities, improve health and reduce pressure on NHS services.

Could housing and health partnerships be strengthened?

Beyond the merits of scaling up this approach, other opportunities to increase uptake of advice may exist. In other words, ensuring people get the right support, at the right time and in the right place, regardless of whether the advice service is provided in general practice, housing associations, or the local high street.

Housing was an important theme as four out of ten people referred were social housing tenants. Rent and council tax arrears were features of household debt, and homeless and housing accounted for over a third of all onward referrals, by far the largest proportion. With social housing tenants more likely to have access to advice services provided by their housing provider, this raises a series of questions.

1. Do arrears prevent some social housing tenants from accessing services funded by housing providers?
2. Does general practice enable particular advice seeking among some social housing tenants, such as disability-related claims or seeking a ‘housing letter’ from a GP?
3. Has demand outstripped supply, or is there still capacity for local funders (council, housing and HSCP) to ensure optimal uptake of advice services?
4. Finally, are some social housing tenants randomly accessing this project without knowledge of other available advice services?

These questions will require attention, as a recent Citizens Advice Scotland report found that rent arrears among their clients grew by over 40% between 2012 and 2017[22]. The report recommended addressing Universal Credit (UC) issues linked to housing payment and ensuring tenants receive the best advice and support when facing arrears or potential eviction. Although UC was not a prominent issue in this study, this situation is likely to change as the full roll-out of UC takes place across Glasgow.

Study limitations

There were noticeable gaps in the advice referral monitoring data with high rates of 'unknown'. There was a consistent 'unknown' rate of 32% across all of the following demographic measures: housing status; household composition; economic status; and ethnicity. Taking ethnicity as an example, it is recognised that people from minority ethnic (non-White) groups are more likely to be living in poverty compared with those from the 'White-British' group[20]. The high rate of 'unknown' in the ethnicity of all referrals to the advice services makes it difficult to make a definitive statement. In other words, were minority ethnic (non-White) groups truly underrepresented within this project, or a 'hidden subgroup' in the high 'unknown' response rate?

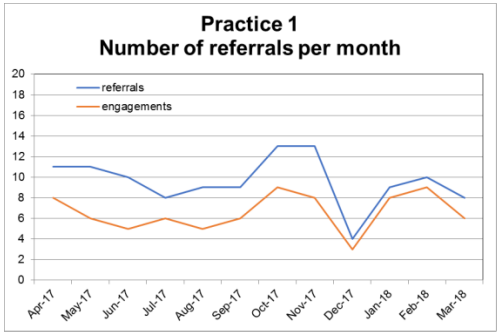
Although all staff from the participating practices were encouraged to take part in the group discussions, between two and seven staff took part from eight practices. Therefore, other potentially important views were not reported. They include those engaged with the project but not participating in the group discussions, those aware but not engaging with the project, and those unaware of its existence.

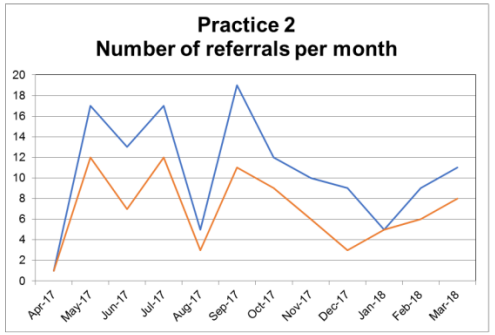
Conclusion

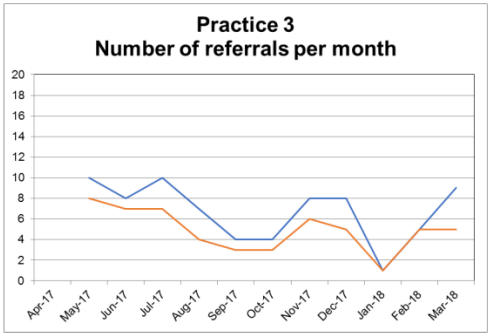
Health service staff that become 'benefit aware' are more likely to refer over time[13]. Therefore, we could expect engagement with this project and the number of referrals to increase across practices as the approach progresses. Integrating all referral pathways in such a way that leads to all healthcare professionals each doing a little to effect change across the life-course will avoid placing an unnecessary burden on GPs and contribute significantly towards tackling Glasgow's rising poverty levels and persistent health inequalities.

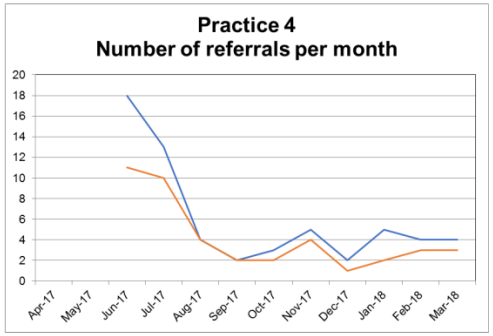
Within this context, there is scope for Glasgow City funding partners from health, housing and council to come together to consider this learning and the merits of developing a case to scale up this approach, in such a way that agreed outcomes are aligned with the roll-out of Community Link Workers. Finally, within a challenging welfare landscape, the new Scottish Social Security Agency with its emphasis on inclusive values presents further opportunities to share the learning more widely, thus ensuring that social security does indeed become the best for those we serve. This of course includes the 'hidden' populations served by general practices working in the most deprived areas of Scotland.

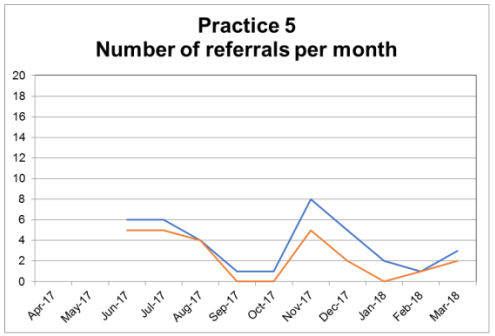
Appendix A. Referrals and engagements by general practice.

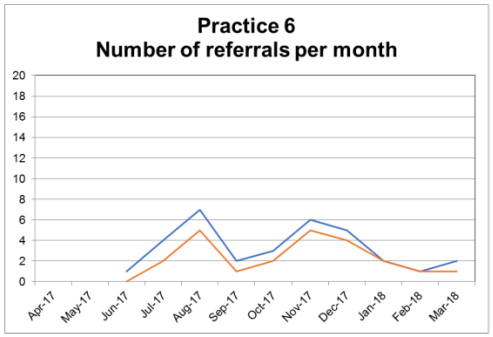


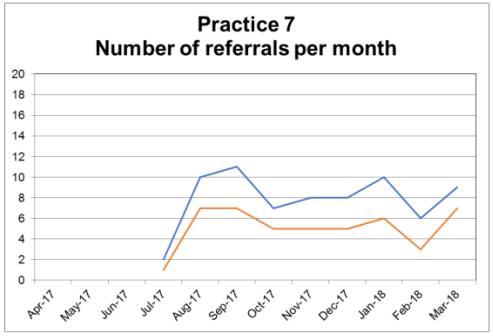


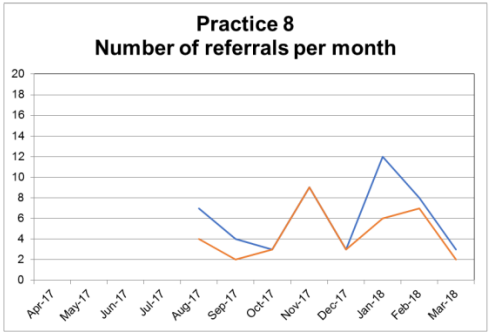


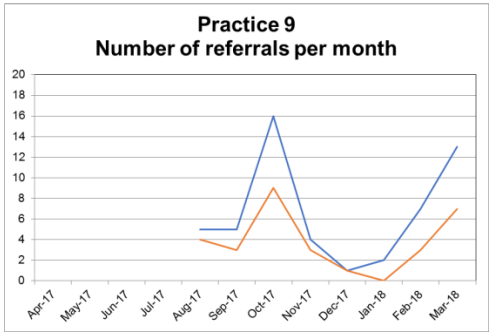












Appendix B. Total referrals and engagements by ethnic origin (April 2017 – March 2018).

Ethnic origin[n]	Number of referrals (% overall referrals)	Number of engagements (% referrals)
White Scottish	365 (56%)	337 (92%)
White/ White British/ White Irish/ White other British	43 (7%)	31 (72%)
Eastern European/ Any other White background	2 (0%)	2 (100%)
Asian – Chinese/Indian/Other/Any other Asian background	7 (1%)	7 (100%)
Black African/Caribbean/Any other Black background	11 (1%)	10 (90%)
Other background	7 (1%)	6 (86%)
Any multiple ethnic background	3 (0%)	3 (100%)
Not known	211 (32%)	54 (26%)
Prefer not to say	1 (0%)	1 (100%)

[n] Due to small numbers, ethnic background categories have been combined.

Appendix C. Total referrals and engagements by economic status (April 2017 – March 2018).

Economic status	Number of referrals (% overall referrals)	Number of engagements (% referrals)
Unfit for work	275 (42%)	248 (90%)
Working full time (over 30 hours)	15 (2%)	11 (73%)
Working part time	7 (1%)	6 (86%)
Working part time (16 - 29 hours a week)	14 (2%)	14 (100%)
Working part time (less than 16 hours a week)	2 (0%)	2 (100%)
Asylum seeker	2 (0%)	2 (100%)
Job seeker	26 (4%)	23 (88%)
Looking after family/home (including carer)	33 (5%)	30 (91%)
Maternity leave	2 (0%)	2 (100%)
Permanently retired	49 (7%)	47 (96%)
Registered unemployed	2 (0%)	1 (50%)
School/Higher/Further Education	7 (1%)	5 (71%)
Not known	210 (32%)	54 (26%)
N/A	1 (0%)	1 (100%)
Other	5 (1%)	4 (80%)

Appendix D. Total referrals and engagements by housing status (April 2017 – March 2018).

Housing status	Number of referrals (% overall referrals)	Number of engagements (% referrals)
Owner occupier	56 (9%)	53 (95%)
Part-owner	1 (0%)	1 (100%)
Shared ownership	1 (0%)	1 (100%)
Registered social landlord	264 (40%)	235 (89%)
Rent – local authority	3 (0%)	3 (100%)
Private tenant	47 (7%)	43 (91%)
Rent free	1 (0%)	1 (100%)
Living with family – paying rent	1 (0%)	0 (0%)
Sofa surfer	7 (1%)	7 (100%)
Homeless	12 (2%)	12 (100%)
Hostel	1 (0%)	1 (100%)
Supported accommodation	3 (0%)	3 (100%)
Not householder	40 (6%)	33 (83%)
Other	2 (0%)	2 (100%)
N/A	1 (0%)	1 (100%)
Not known	214 (32%)	54 (25%)

Appendix E. All advice outcomes for all cases with outcome listed, for year April 2017-March 2018.

Case outcome	Total
Benefit award	131
Backdate amount	113
Client advised on energy efficiency/awareness or fuel poverty	60
Medical priority for housing awarded	27
Debt written off	25
Collaborative supporting letter issued	22
Bus pass award	20
Client received budgeting support	18
Welfare reform explained and discussed	14
Client advised on all appropriate saving options	13
Discussed affordable credit	8
Repayment plan	7
Gain: benefits and/or tax credits	6
Other support/advice	6
Supporting letter issued	5
Assisted with fuel poverty	4
Client opened a new bank account	4
Client using less expensive forms of credit	4
Blue badge awarded	3
Alternative housing found	2
Benefit/tax credit – one-off confirmed (gain)	2
Client with increased income	2
Sequestration (a bankruptcy term)	2
Advice only	1
Case concluded successfully	1
Companion bus pass	1
Council tax	1
Disabled Adaptions Awarded	1
Disabled rail card	1
Referral to G-Heat	1
Rent	1
Single person council tax discount	1
Total	507

References

[1] Scottish Parliament. *Welfare Reform Committee 5th Report, 2014 (Session 4) Report on Local Impact of Welfare Reform*. Edinburgh: Scottish Parliament; 2014. Available at: http://www.parliament.scot/S4_Welfare_Reform_Committee/Reports/wrR-14-05w.pdf (accessed December 2018)

[2] Scottish Government. *2018 Annual Report on Welfare Reform.* October 2018. https://www2.gov.scot/Resource/0054/00541015.pdf (accessed December 2018)

[3] Jenkins S, Peachey K. ESA underpayment: Who is entitled to backdated benefits? *BBC News*. 18 October 2018. https://www.bbc.co.uk/news/uk-45903514 (accessed January 2019)

[4] Scottish Government. *Equally Well: Report of the Ministerial Taskforce on Health Inequalities.* Edinburgh: Scottish Government; 2008. Available at: https://www2.gov.scot/Publications/2008/06/25104032/0 (accessed December 2018)

[5] Hoskins R, Tobin J, McMaster K, Quinn T. Roll-out of a nurse-led welfare benefits screening service throughout the largest Local Health Care Co-operative in Glasgow: An evaluation study. *Public Health* 2005;119:853-861.

[6] Naven L, Withington R, Egan J. *Maximising opportunities: final evaluation report of the Healthier, Wealthier Children (HWC) project*. Glasgow: GCPH; 2012. Available at: https://www.gcph.co.uk/publications/359_maximising_opportunities_final_evaluation_report_of_the_hwc_project

[7] Naven L, Egan J. *Healthier, Wealthier Children: learning from an early intervention project*. Glasgow: GCPH; 2013. Available at: https://www.gcph.co.uk/publications/457_healthier_wealthier_children_phase_two_evaluation

[8] GPs at the Deep End Report 25. *Strengthening primary care partnership responses to the welfare reforms*. https://www.gla.ac.uk/media/media_385914_en.pdf (accessed December 2018)

[9] GPs at the Deep End Report 27. *Improving partnership working between general practices and financial advice services in Glasgow: one year on*. https://www.gla.ac.uk/media/media_437144_en.pdf (accessed December 2018)

[10] Sinclair J. *Building Connections: co-locating advice services in general practices and job centres*. Glasgow: GCPH; 2017. Available at: https://www.gcph.co.uk/publications/745_building_connections_co-locating_advice_services_in_gps_and_job_centres (accessed December 2018)

[11] Improvement Service. *Specialist Link Workers (Welfare Rights Advice) in General Practice. Briefing Paper*: *February 2018*. http://www.improvementservice.org.uk/welfare-advice-and-health-partnerships-publications.html (accessed December 2018)

[12] Groden R. *Report on GP Clusters and GP Engagement*. Glasgow: Glasgow City Integration Joint Board Public Engagement Committee; 2017. Available at:

https://glasgowcity.hscp.scot/publication/item-no-10-gp-clusters-and-gp-engagement (accessed December 2018)

[13] The Low Commission. *The Role of Advice Services in Health Outcomes: Evidence Review and Mapping Study*. London: Advice Services Alliance; 2015. Available at: https://www.thelegaleducationfoundation.org/wp-content/uploads/2015/06/Role-of-Advice-Services-in-Health-Outcomes.pdf (accessed December 2018)

[14] Carrick K, Burton K, Barclay P. *Forecast Social Return on Investment Analysis on the Co-location of Advice Workers with Consensual Access to Individual Medical Records in Medical Practices*. Livingston: Improvement Service; 2017. http://www.improvementservice.org.uk/documents/money_advice/SROI-co-location-advice-workers.pdf (accessed December 2018)

[15] Budd C. *Advice in practice: Understanding the effects of integrating advice in primary care settings.* London: Citizens Advice/Royal College of General Practitioners; 2018. https://www.citizensadvice.org.uk/Global/Public/Impact/Understanding%20the%20effects%20of%20advice%20in%20primary%20care%20settings_research%20report%20%28final%29.pdf (accessed December 2018)

[16] Macmillan Cancer Support. *Annual report and accounts 2017*. https://www.macmillan.org.uk/_images/macmillan-cancer-support-annual-report-2017_tcm9-326894.pdf (accessed December 2018)

[17] Mercer S, Wyke S, Fitzpatrick B, McConnachie A, O'Donnell K, Mackenzie M, Bakhshi A, Chng NR, Grant L, McLeod J. *Evaluation of the Glasgow 'Deep End' Links Worker Programme*. Edinburgh: NHS Health Scotland; , 2017. Available at: http://www.healthscotland.com/documents/29438.aspx (accessed December 2018)

[18] Glasgow Centre for Population Health. *Briefing paper 54: The public health implications of rising debt*. Glasgow: GCPH; 2018. Available at: https://www.gcph.co.uk/publications/858_briefing_paper_54_the_public_health_implications_of_rising_debt (accessed December 2018)

[19] ScotPHO. *The Scottish Burden of Disease Study, 2016: deprivation report*. Edinburgh: NHS Health Scotland; 2018. Available at: https://www.scotpho.org.uk/media/1656/sbod2016-deprivation-report-aug18.pdf (accessed December 2018)

[20] Scottish Government. *Poverty & Income Inequality in Scotland: 2014-17*. https://www.gov.scot/publications/poverty-income-inequality-scotland-2014-17/ (accessed December 2018)

[21] Glasgow City Joint Integration Board. *Glasgow City Primary Care Improvement Plan 2018-21.* December 2018. https://glasgowcity.hscp.scot/publication/glasgow-city-integration-joint-board-primary-care-improvement-plan-2018-21 (accessed January 2019)

[22] Gowans R. *Rent Arrears: Causes and Consequences for CAB Clients*. Edinburgh: Citizens Advice Scotland; 2018. https://www.cas.org.uk/system/files/publications/rent_arrears_oct_2018.pdf (accessed December 2018)

Glasgow Centre for Population Health

www.gcph.co.uk