



# The Deep End Advice Worker Project:

embedding an advice worker in general practice settings

Jamie Sinclair

Glasgow Centre for Population Health

September 2017

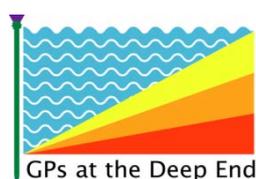
## Acknowledgements

First and foremost, thank you to the practitioners and partner organisations involved in the delivery of the project. Without their input, the work and this paper would not have been possible.

Specific thanks must also go to Douglas O'Malley and Janet Tobin (Health Improvement), Sharon McIntrye (Wheatley Group), Tony Quinn (Greater Easterhouse Money Advice Project), Oonagh Robinson and James Egan (Glasgow Centre for Population Health), Graham Watt (Deep End GP Group), Ronnie Burns and Maria Morris (McKenzie GP practice) and Gillian Dames (Lafferty GP practice), for their comments on earlier drafts of this report.

More broadly, input from Kate Burtons (NHS Scotland), Carolyn Brennan (Scottish Government Leading Improvement Team) and Nicholas Watson (What Works Scotland) helped position the paper in relation to the broader policy landscape. Specific mention must also be given to Pete Seaman, Joe Crossland and Jennie Coyle at the Glasgow Centre for Population Health for their comments regarding structure, content and presentation.

The report cover image is taken from the NHS Scotland Photo Library.



## Contact

For enquiries, please contact the report author  
Jamie Sinclair, Building Connections Programme Manager  
E: [jsinclair@glasgowkelvin.ac.uk](mailto:jsinclair@glasgowkelvin.ac.uk)

## Table of Contents

<b>Acknowledgements .....</b>	<b>2</b>
<b>Partner organisations .....</b>	<b>4</b>
<b>Summary.....</b>	<b>6</b>
<b>Introduction .....</b>	<b>12</b>
<b>Context .....</b>	<b>12</b>
<b>The Deep End Advice Worker project.....</b>	<b>16</b>
<b>The development of the Deep End Advice Worker project .....</b>	<b>17</b>
<b>Methods .....</b>	<b>20</b>
<b>Findings.....</b>	<b>23</b>
<b>Components of practice.....</b>	<b>28</b>
<b>Discussion .....</b>	<b>38</b>
<b>Conclusion.....</b>	<b>40</b>
<b>Recommendations .....</b>	<b>40</b>
<b>References .....</b>	<b>42</b>
<b>Appendix 1: GP and practice manager interview topic guide .....</b>	<b>46</b>
<b>Appendix 2: Advice worker interview topic guide.....</b>	<b>47</b>
<b>Appendix 3: GEMAP service overview .....</b>	<b>48</b>

## Partner organisations

### **Building Connections**

Based in Glasgow, Building Connections aims to better understand how collaborative services can support people experiencing poverty. It is responsible for a series of demonstration projects which work across, and within, the public and third sectors. These projects are developing and testing models of embedding support services (e.g. financial and social security advice, employment support, mental health advice) into the everyday practice of partner organisations. Joseph Rowntree Foundation (JRF) are the core funders, with additional support provided by Glasgow Kelvin College, the NHS, GCPH, the Scottish Government and What Works Scotland.

### **General practitioners at the Deep End (Deep End GPs)**

The Deep End GPs Group is a collaborative endeavour involving GPs working in the 100 most deprived communities in Scotland. The group is concerned with the relationship between poverty, health and welfare reform, and the subsequent impact on general practice's ability to deliver primary healthcare. Through research, and the development of several practical interventions, the Deep End GPs aim to raise awareness regarding the disproportionate resource pressure experienced by general practices in the 'deep end' and offer practical solutions to common problems experienced by practices serving these communities.

### **Glasgow Centre for Population Health (GCPH)**

GCPH seeks to generate insights and evidence, support new approaches, and inform and influence action to improve health and tackle inequality. Working with a wide range of stakeholders, they conduct research of direct relevance to policy and practice; facilitate and stimulate the exchange of ideas, fresh thinking and debate; and support processes of development and change.

### **Greater Easterhouse Money Advice Project (GEMAP)**

GEMAP offer free and confidential advice to local communities in the north east of Glasgow. This includes financial planning, debt management, housing advice and support navigating the social security system to ensure people receive their full entitlements. Through one-to-one and peer mentoring support they aim to help clients to fully contribute to the social and economic life of their communities.

### **Lafferty, Macphee, Dames & Smith General Practice (Parkhead, Glasgow)**

This GP practice has 4,711 patients and is staffed by four GPs, five part-time administration workers, one full-time practice manager, one full-time secretary and two practice nurses. The practice delivers primary healthcare and works closely with partners in the community to offer holistic health support.

### **McKenzie & Burns General Practice (Parkhead, Glasgow)**

This GP practice has 3,192 patients and is staffed by two GPs, two full-time administration workers, one full-time practice manager and a part-time nurse. The practice delivers primary healthcare and works closely with partners in the community to offer holistic health support.

### **NHS North East Health Improvement Team (Glasgow)**

The North East (Glasgow) Health Improvement Team work is driven within a strategic context focused on reducing health inequalities. Key priorities include: building structurally and socially resilient communities; building mental wellbeing and resilience; and promoting a culture of good-health in the city.

**The Wheatley Group**

Wheatley are a housing, care and property-management group which provide homes and services to over 200,000 people in 17 local authority areas across Central Scotland. Wheatley are committed to improving housing, care and regeneration at a national level. They also have their own Charitable Trust, The Wheatley Foundation, which aims to “Make Lives Better” for thousands of disadvantaged and vulnerable people. The Foundation’s key areas of interest are: reducing poverty; improving access to employment and education; increasing digital inclusion; and improving access to sports and the arts.

## Summary

### Introduction

The current economic climate has significantly impacted the resources available to public and third sector organisations supporting people experiencing poverty. Reductions in public sector spending and the consequential impact upon third sector funding, in conjunction with broader legislative changes to social security and the impact of poverty upon local communities, although challenging, offers the opportunity to rethink traditional service delivery models, across, and within, the public and third sectors.

In response to these evolving financial, legislative and service delivery landscapes, and building on the longstanding history of GP practices as valuable community hubs, the Deep End Advice Worker project developed and tested approaches to delivering advice services from two GP practices in Parkhead, Glasgow. Through the delivery of finance, debt, social security and housing advice from a trusted setting (i.e. general practice), the project aimed to improve social and economic outcomes for people in the local area. It also sought to reduce the time medical staff spent on non-clinical issues.

A range of data collection methodologies were employed to help understand the impact of the project and its supporting processes. With a view that this data could contribute to the evidence base regarding the delivery of advice from general practices, broader policy discussions regarding social security and service delivery, and the further roll-out of the service.

The project has been operating since December 2015 and is located in the McKenzie & Burns and the Lafferty, Macphee, Dames & Smith general practices. Greater Easterhouse Money Advice Project (GEMAP) deliver the on-site advice service. An advisory group consisting of one GP from each general practice, GEMAP, the Wheatley Group, the NHS North East Health Improvement Team, The Deep End GP group, Glasgow Centre for Population Health (GCPH) and the Building Connections programme, supported the design, development and evaluation of the project.

### Advice in general practice settings

General practices are recognised as neutral hubs through which local communities can access a range of support, over and above primary healthcare. Throughout the United Kingdom, general practices work collaboratively with the public and the third sector to deliver a range of support services, such as targeted advice for particular demographic groups and financial and debt advice. Examples of such collaborations are evident in Edinburgh, Dundee, Liverpool, London and throughout Wales.

### The Deep End Advice Worker project

Drawing from the learning of similar projects, the Deep End Advice Worker project intentionally positioned the advice service as an additional form of assistance that the GP practices could offer to patients. The approach placed significant importance on the assimilation and acceptance of the advice worker into the practice. Accordingly, we have framed the project as an *embedded* model, as opposed to a co-located approach.

The two GP practices involved in the project serve the fifth and eleventh most deprived populations in Scotland, based on the proportion of patients living in the 15% most deprived Scottish datazones, as measured by the Scottish Index of Multiple Deprivation (SIMD). Six GPs across two practices support a combined population of 7,903 patients. The advice worker delivered support on issues including housing, social security support, financial inclusion and debt management.

### **Referral process**

The advice worker delivered the service for half a day per week in each practice. GPs and frontline staff made referrals through a secure online system. Referrals were explicitly framed as an additional form of support, not a replacement for a GP appointment. Once a referral had been received, the GEMAP advice worker arranged face-to-face appointments with patients. First meetings took place in a consultation room in the patient's practice. Both practices provided the advice worker with a private consultation room to work from. If preferable, the advice worker arranged a home visit to deliver the service.

The advice worker utilised a broad repertoire of social and interpersonal skills, in conjunction with their expert knowledge on issues such as housing, social security and financial management, to provide tailored support to people accessing the service. If appropriate, they referred people onto additional forms of specialist community support, such as carers', mental health and homelessness organisations.

### **Methods**

The project utilised quality improvement methodologies to make explicit, and improve, the practical processes underpinning the advice service. This was supplemented by more traditional data collection methods, including semi-structured interviews and the quantitative analysis of financial outcomes. Most importantly, the data collection and analysis was conducted concurrently and focused upon identifying opportunities to improve the project as it was delivered.

This approach was supported by the Building Connections programme and an advisory group which met every six weeks. The Building Connections programme manager worked from the GP practices on a bi-weekly basis between April 2016 and December 2016, which allowed for extensive engagement with practitioners (clinical and non-clinical) in an informal, yet focused manner. The advisory group examined emergent data, such as the demographic profiles of people accessing the service, the financial outcomes secured through successful social security applications and qualitative data collected by Building Connections. This multi-dimensional approach helped capture a significant amount of knowledge regarding the impact of the project and experiences of people delivering the service. This learning underpinned the development of several interventions designed to improve the project.

### **Findings**

#### **Referrals, new clients and financial gain**

Between December 2015 and May 2017 the project secured the following outcomes:

- 276 referrals
- Of these, 235 had never previously accessed GEMAP's services (85% of total referrals)
- 165 people engaged with the service once referred (65% engagement rate)

- £848,001 worth of financial gain secured through income maximisation work
- £155,766 worth of debt identified and managed

The median amount of financial gain for successful applicants amounted to £6,967 per person, per annum. Around half of the people accessing the service were referred onto additional forms of community support. Nearly one-in-five were supported on a housing issue, including 25 people for homelessness support services. Nearly two-thirds of people accessing the services were tenants of registered social landlords.

The service worked predominantly with people experiencing significant poverty, with 78% (128 people) living on household incomes of less than £15,000 per annum. Women were significantly more likely to access the service, particularly those between the ages of 26 and 55. Health concerns were prominent among the 165 people accessing the service, with 268 self-reported health issues. Within this group 68% (112 people) reported mental illnesses, 58% (96 people) stated they had a long-term illness and 21% (35 people) reported mobility or other physical impairments.

### **Components of practice**

#### **Embedding advice services into general practices**

Between December 2015 and May 2017, the two practices involved in the project (with an embedded GEMAP advice worker) made 276 referrals to GEMAP. GPs made 74% of these. This is significantly higher than other comparable projects. The remaining 26% of referrals were made by clinical support staff and administration staff.

As a point of comparison, in the same 17-month time period, the other 42 general practices in north east Glasgow (without embedded advice workers) but who were still able to refer patients via an online system, made 24 referrals to GEMAP's service.

Our findings suggest a key feature underpinning the difference in referral figures (and inherent GP engagement levels) is the development of familiarity and trust between a single financial advice worker and the two practices, with each respecting the other's knowledge and expertise.

Complementing the development of strong relationships between practitioners, the project intentionally sought to minimise barriers to accessing the service. For example, each practice provided the advice worker with a consultation room from which to deliver the service. The advice worker dressed in similar attire to practice staff and GPs, and mirrored the traditional GP call for attendance when people were waiting in the practice waiting room. By adopting a similar approach to the existing practice staff, the nature of the work carried out by the advice worker was indistinguishable from that of GPs, and ensured people could access the service discreetly.

#### **Access to medical records**

Access to medical records (with written patient consent) provided the advice worker with a multi-dimensional view of patients' circumstances, allowing him to triangulate three sources of information (i.e. patient input, GP perspective and medical histories). It also acted as the catalyst for continuous engagement between the advice worker and GPs, and the collaborative production of

supporting medical statements for health-related benefits (which were ultimately signed off by the GP).

Compared with two similar sites (health centres in north east Glasgow), where GEMAP advice workers do not have access to medical records the project secured significantly higher financial gains for clients. For example, across five key benefits the project secured £644,819 through 174 individual awards, while in the comparator sites, £594,235 was secured through 287 individual awards.

### **Collaborative working**

Through the work of Building Connections and the advisory group, the project developed a robust understanding of the mechanisms underpinning the project and the experiences of practitioners. Our findings suggest positioning practitioner knowledge as a central component of the project was integral to its development. The experiences of GPs, the advice worker and practice staff delivering the service helped identify, deliver and refine the project's supporting processes. Equally importantly, placing significant importance on normalising the advice worker's presence within the practice was fundamental to the project's impact. These approaches are clearly transferable to multiple service delivery contexts which involve partners from a diverse range of professional backgrounds.

### **Conclusion**

Healthcare settings are broadly recognised as locations which are trusted by local communities and offer the opportunity to extend the reach of a range of additional forms of support. The Deep End Advice Worker Project has demonstrated the value of utilising GP practices as neutral hubs to deliver social security, housing, financial and debt advice. Equally as important, our learning has identified a series of principles or characteristics which underpinned the development of the project and could be applied to other settings, both within the healthcare system and more broadly speaking, across the public and third sectors.

Ultimately, building embedded models of service delivery demands that the experiences and knowledge of practitioners are central in their design, delivery and ongoing development. Our experience suggests that utilising the combined experience of practitioners helps identify interventions which can improve frontline services. The value placed on their insight and expertise also appeared to contribute to a sense of empowerment and ownership among practitioners involved in the practical delivery of the service (e.g. the advice worker, GPs, practice administration staff).

The project demonstrated an ability to increase incomes and reduce costs for people. The majority of people referred to the service had not previously accessed GEMAP's services (despite their 15-year history of delivering advice services in the area). Patient relationships with practice staff, including GPs and non-clinical support staff, were continually articulated as the defining factor in their engagement with the service. The provision of an embedded advice worker, specific to each practice, broadened the repertoire of support GPs could offer patients. GPs suggested this contributed to stronger patient-doctor relationships, helped reduce their non-clinical workloads and freed up time to deliver primary healthcare.

Finally, our findings suggest that access to medical records allows advice workers to better represent people across a range of social security applications. This access, in conjunction with the steps taken to embed the advice worker into the everyday work of the practice, acted as the catalyst for the development of strong relationships between practice staff and the advice worker.

Reinforcing these statements, our quantifiable data (referrals, engagement rates, new client ratio, financial gain and debt management figures, and onward referrals) highlight how this approach contributes to improved economic outcomes for people accessing the service (when compared with practices without embedded advice workers, or advice services without access to medical records).

## **Recommendations**

- The methodologies adopted by the Deep End Advice Worker project (and the broader evidence base) should be further developed and tested in other geographies. Future interventions should focus on areas with high levels of poverty. However, it is important this geographic approach is layered with explicit consideration of communities disproportionately at risk of poverty (e.g. people with children, lone parents, certain ethnic minority communities and people with disabilities). Focusing future work in this manner will allow for a better understanding of how embedding advice into the day-to-day work of general practices can support particular target groups.
- Practice staff and advice providers should be involved to the greatest extent possible in the design, delivery and development of future interventions. Embedding their knowledge of the specific working environments, everyday practices, organisational cultures and even patients accessing the service is vital to the development of the methodology. This will ensure the approach adapted by the project remains grounded in the locally specific contexts future projects are based within.
- Particular attention should be given to ensure the presence of advice workers based within general practices is normalised. Access to medical records, a designated consultation room from which to deliver the service and support to develop relationships within the general practices is fundamental to this process.
- The traditional role of advice workers should be reconsidered. The trust and goodwill advice workers develop with people offers them an opportunity to deliver a more holistic service. Advice workers should be supported to develop a broader repertoire of skills and knowledge, which will allow them to better understand an individual's social circumstances and aspirations. This will enable them to support people through both direct advice and into additional forms of support (e.g. employment, education and personal development programmes).
- The implications of the project should be considered in relation to current funding arrangements for advice services at a local and national level. Our findings, in conjunction with evidence from similar projects suggest that exploring the scaling up of advice provision in GP practices could increase the reach of advice services and reduce the non-clinical work of general practices. This process may not necessarily require additional funding, but rather, a realignment of current investment to deliver similar services to a broader population.
- Further work should be completed regarding the impact of the financial gain, debt identification and management, and cost reduction outcomes achieved by the project upon

the day-to-day lives of patients accessing this service. Although feedback from the advice worker presents a particularly positive picture, a more in-depth understanding is needed.

- The value of individuals operating in a similar vein to the Building Connections programme manager should be considered and tested in different locations. In particular, further examination of the processes that the Building Connections programme manager adopted, the skillsets and characteristics required to operate in this role and the perceptions of practitioners they engage with is required to fully appreciate the value of this role.

## Introduction

This report presents the learning from a project which delivered an embedded advice service within two GP practices in Parkhead, Glasgow. First, we provide detail of the service delivered, along with background information on the legislative and social context. Next, we introduce the history of the project and its supporting service delivery mechanisms. Data collection methods are then presented. The penultimate section explores the emerging evidence and identifies key components of practice, which are applicable to broader general practice, primary care and other public sector service delivery environments. Finally, we present a number of conclusions and recommendations for future work.

### **Advice in healthcare settings**

The use of healthcare settings to support communities to access social and economic advice services is demonstrated through a well-documented evidence base<sup>1-7</sup>. Throughout the United Kingdom a diverse range of direct and indirect social and economic support is delivered from, and through, primary and secondary healthcare settings and services. For example, locations such as general practices and health centres are widely utilised to deliver advice to communities. In Glasgow alone, the Macmillan Cancer Journey Project, the Links Worker Programme and the Healthier Wealthier Children Programme, utilise acute cancer services, general practices and antenatal and community child health services to deliver a range of support programmes<sup>8-10</sup>.

More specifically, the nature of general practices and their inherent ability to engage with entire communities offers significant opportunities to engage with diverse populations, regardless of individual socioeconomic standing or demographic characteristics<sup>11-14</sup>. In this case, the Deep End Advice Worker project sought to utilise general practice settings to deliver a targeted advice service in the east end of Glasgow.

## Context

### **Advice in general practices**

General practice has a long history of providing additional economic and social support to patients. This way of working is continued in the present day, with general practices across the United Kingdom working collaboratively with the public and third sectors to deliver a range of support services.

For example, in Wales, GP practices are a central component of the Better Advice, Better Lives programme, delivered in approximately 90 locations (the majority of which are general practices), in every local authority in the country<sup>15</sup>. On a smaller scale, Derbyshire's healthy advice project (99 practices), Liverpool's advice on prescription programme (93 practices) and the co-ordinated delivery of advice in general practices in Bradford (54 practices) provide targeted social security, financial, housing and debt support<sup>5,16,17</sup>. In Scotland, since 2002, projects in Edinburgh (25 practices) and Dundee (five practices) have delivered targeted advice through embedding advice workers into the everyday work of general practice. In Aberdeen, a recent pilot utilised a range of primary care settings, including GP surgeries, to deliver a broad range of support services<sup>18</sup>.

Recent evaluations of the work in Bradford (2005), Derbyshire (2010), London (2012), Aberdeen (2016), Wales (2016) and Glasgow (2017) examined the benefits associated with the provision of advice in general practice settings<sup>3,13,17-20</sup>. This included, increased time for healthcare professionals to focus on their respective areas of expertise and significant financial gain for people accessing the services provided. In addition, the majority of the authors suggested the provision of advice in general practice settings could contribute to improved health outcomes, through increasing people's incomes, and in recognition of the direct link between low income and poor health outcomes. Complementing these evaluations, the London Health Network (LHN) recently published a business case detailing the value of delivering welfare advice in general practice settings<sup>7</sup>.

Strengthening this business case, is a recent 'social return on investment' (SROI) analysis regarding the delivery of advice in GP practices in Edinburgh and Dundee. Produced by the Improvement Service, in conjunction with NHS Lothian, Dundee City Council and Granton Information Centre it stated every £1 of investment would "*generate around £39 of social and economic benefits*"<sup>21</sup>.

### **General practitioners at the Deep End (Deep End GPs)**

The Deep End GPs Group is a collaborative endeavour involving GPs working in the 100 most deprived communities in Scotland<sup>22</sup>. Three quarters are based in Glasgow<sup>12</sup>. The group is concerned with the relationship between poverty, health and welfare reform, and the subsequent impact on general practice's ability to deliver primary healthcare<sup>11,14,23</sup>.

Through research, and the development of several practical interventions, the Deep End GPs have explored approaches to supporting general practices located in areas of high deprivation. Interventions include the provision of specialist community support, extended appointment times and more generally, the implementation of integrated care for patients accessing specific Deep End GP practices<sup>6,24,25</sup>. Ultimately, the group is focused on reducing the non-essential workload of GPs and the creation of additional time to deliver primary healthcare. More strategically, they advocate a redesign of current general practice funding arrangements and argue resources should be more favourably weighted towards practices in areas of social and economic deprivation<sup>26</sup>.

### **The inverse care law**

First articulated in 1971, the inverse care law states that people requiring heightened support, experience significant difficulties accessing it. From a general practice perspective, it appreciates "*the difference between what primary care teams are able to do in deprived areas and what they could do if they were better supported*"<sup>27</sup>. With this in mind, the Deep End GP Group suggest general practices in high deprivation areas are less able to support their patients, due to the pressures caused by multiple social, economic and health needs and a primary health system which is weighted towards referral to secondary specialist or acute services in hospital settings<sup>26</sup>. In a general practice context this is in fact quite a simple concept: practices with the largest numbers of vulnerable patients have the least spare capacity to address their patients' needs.

### **Health**

A significant body of evidence details the relationship between low incomes and poor health<sup>27-29</sup>. This includes healthy life expectancy, excess mortality rates and mental wellbeing. Research by the GCPH states 24% of Glasgow's working-age population is impacted by a disability which may affect

the kind of work, if any, they can do<sup>30</sup>. The disparity in health outcomes due to deprivation is particularly evident in Glasgow, with recent research positioning the city as having the *“the lowest, and most slowly improving life expectancy in Western Europe (and) the widest mortality inequalities in Western Europe”*<sup>31</sup>.

### **Welfare reform**

The disproportionate effect of welfare reform on people living in poverty, alongside reduced funding for appropriate advice services and increases in demand for support services could be considered fundamental to the development of the Deep End Advice Worker project. Recent research illustrates the heightened impact of the welfare reforms on the poorest sections of society and the increased resource pressures experienced by general practices serving these populations<sup>11,13,32,33</sup>. This is primarily due to the reassessment of people’s medical conditions and requirement of additional medical information for certain health-related benefits<sup>11,13</sup>. On this note, the Scottish Government recently framed changes to the social security system as likely to:

*“Have negative impacts on the health and well-being of some people in Scotland, closely linked to their loss of income, which may result in increasing levels of poverty and disadvantage. Much of this impact is uncertain...”*<sup>34</sup>.

In monetary terms claimants in Scotland were expected to experience an £1,130 million financial loss due to the 2010-2015 welfare reforms. In addition, the post-2015 welfare reforms are predicted to result in a financial loss of £1,040 million for claimants in Scotland, per year, by 2021. More specifically, the most recent reforms are predicted to result in a reduction of £167 million worth of income per annum in Glasgow, or £400 per working-age adult, every year<sup>35</sup>.

These figures demonstrate the specific impact of the reforms on already economically vulnerable communities. Ultimately, Scotland’s poorest communities are expected to be most significantly impacted by the legislative changes and inherent financial reductions. Future reforms are predicted to adopt a similar pattern. Beatty and Fothergill are unequivocal in their analysis of the post-2015 reforms, stating: *“there is a clear and unambiguous relationship: as a general rule, the more deprived the local authority, the greater the financial hit”*<sup>35</sup>.

### **Broader legislative changes**

It is important to appreciate that the ongoing welfare reforms are intended to operate in conjunction with broader legislative changes. Increases in personal tax allowances, the new national minimum wage, increased childcare support and discretionary housing payments are cited as mitigating factors in relation to the predicted financial losses<sup>35</sup>. In addition, increased employment levels (including better in-work progression routes) and improved employment-focused support services are fundamental to the current UK government’s future vision of social security. Analysis by Sheffield Hallam University, however, suggests changes to taxation, wages and entitlement, even with increased employment, may not counterbalance the expected financial losses<sup>35</sup>.

## Devolved powers

Adding another layer to the social security landscape is the introduction of the Scotland Act 2016 and the development of a Scottish social security agency. This agency will administer and deliver 11 benefits<sup>a</sup> and 15% (£2.8 billion) of the total UK social security spend. Initial estimates suggest 1.4 million people are in receipt of the devolved benefits<sup>36</sup>. Of these, around 500,000 people receive Disability Living Allowance (DLA), Personal Independence Payment (PIP) and Attendance Allowance (AA)<sup>37</sup>.

In regards to people in receipt of DLA, PIP and AA, which account for over a third of those affected by the devolved powers, Glasgow contains the highest number of current recipients in Scotland<sup>38</sup>. The highly concentrated geography of recipients in Glasgow suggests the area will be of particular strategic and operational significance: the city's inherent diversity, high levels of poverty and complex advice landscape will require careful consideration if the agency is to successfully engage with the significant number of people affected by the devolved powers.

---

<sup>a</sup> The Scottish Parliament, through the Scotland Act 2016, will be responsible for the following benefits: Attendance Allowance; Carer's Allowance; Disability Living Allowance; Personal Independence Payment; Industrial Injuries Disablement Benefit; Severe Disablement Allowance; Cold Weather Payment; Funeral Payment; Sure Start Maternity Grant; Winter Fuel Payment; Discretionary Housing Benefits.

## The Deep End Advice Worker project

### Project aims

The project aimed to:

- develop and test approaches to improving the accessibility of financial, social security and housing advice through working in partnership with two Deep End GP practices
- improve social and economic outcomes for people supported by the project
- explore the impact of the project both on people delivering and accessing the project
- better understand the supporting processes of the project and generate evaluative insight to support broader service improvements in this area.

### Project origins

The Deep End Advice Worker project originated from a Deep End GP event in June 2015<sup>23</sup>. At the session, the Wheatley Group pledged to embed one of their 'My Great Start' financial inclusion workers in two GP practices in north east Glasgow. This commitment acted as the catalyst for the project development, with two further rounds of funding from the NHS ensuring the continuation of the project until March 2018.

### The general practices

The project is based in two general practices in Parkhead Health Centre. They are classed as the fifth and eleventh most deprived GP practices in Scotland (out of a total 951 practices). The McKenzie & Burns practice supports 3,192 patients and is staffed by two GPs, two full-time administration staff, a full-time practice manager and a part-time nurse. The Lafferty, Macphee, Dames & Smith practice supports 4,711 patients and is staffed by four GPs, five part-time administration workers, one full-time practice manager, a practice secretary and two nurses.

### Parkhead

Recent Scottish Index of Multiple Deprivation (SIMD) data positions Parkhead as one of the 20% most deprived areas in Scotland. Some neighbourhoods within the area, are classed as the 5% most deprived in the country<sup>39</sup>. Parkhead is situated within the Calton ward, which is expected to be worst affected by the welfare reforms, with every working-age adult predicated to lose £880 of income per year. For context, the average loss in Glasgow is £550 per working-age adult, per annum. In comparison, in St Andrews, Fife, a relatively affluent area, adults are expected to lose £180 per annum<sup>40</sup>.

The average healthy life expectancy of residents in Parkhead, or the number of years, on average, people are likely to spend in good health, is 47.3 years for men and 49.7 years for women<sup>41</sup>. In comparison, the average healthy life expectancy in Glasgow is 56 years for men and 58.5 years for women<sup>42</sup>. As a general overview, residents in Parkhead experience poorer than average outcomes across a range of indicators, including children in poverty, people in employment and people in income deprivation<sup>41,42</sup>.

## The development of the Deep End Advice Worker project

### **Advisory group**

The initial investment from the Wheatley Group supported the project for a three-month period and underpinned the formation of an advisory group in December 2015. The group consisted of the Deep End GPs, one GP from the McKenzie & Burns practice and a GP from the Lafferty, Macphee, Dames & Smith GP practice, the NHS North East Health Improvement Team, Greater Easterhouse Money Advice Project (GEMAP), the GCPH, the Wheatley Group and, latterly Building Connections. Initial meetings focused on the remit of the project, the advice services on offer and practicalities of embedding the service in GP settings. To minimise the impact on the day-to-day work of the practices, the meetings were held in the health centre where the two practices are based.

From January 2016 onwards, the group met approximately every six weeks to examine referral figures, emerging data (e.g. financial gain and debt identified) and to discuss the experiences of practitioners. From this quantitative and qualitative data, the meetings aimed to identify improvements to the referral process underpinning the service and better understand the working mechanisms supporting the project.

### **Building Connections**

In April 2016, the Building Connections programme manager joined the project. Funded by the Joseph Rowntree Foundation and employed by Glasgow Kelvin College, the post-holder is responsible for a programme of work focused on developing approaches to delivering collaborative services which adopt the embedded model of service delivery discussed in this paper. For example, it is currently supporting the delivery of two practical demonstration projects involving the Department for Work and Pensions (DWP).

The demonstration projects with the DWP aim to improve social and economic outcomes for people through embedding expert financial, debt, mental health, social security and addictions support from two jobcentres in north east Glasgow. These support services are delivered by a cross-section of public and third sector partners. The emergent learning themes from the DWP projects, in conjunction with the Deep End Advice Worker project, is contributing to an evidence base which is focused upon the principles, or characteristics of successful collaborative working across, and within, the public and third sectors.

Through discussions with partners, it was agreed that the Building Connections programme manager would support the delivery of the Deep End Advice Worker project and capture the emergent learning. Physically basing themselves in the two practices on a bi-weekly basis allowed the programme manager to quickly identify the supporting processes through regular engagement with practitioners. Through drawing on the principles of improvement science, their previous experiences of supporting similar projects (e.g. the on-going work with the DWP) and more traditional forms of research and evaluation, they were (in conjunction with the advisory group) able to simultaneously support practitioners to improve the project referral processes, collect data regarding its impact, and explore the experiences of people involved in delivering the work.

### **Types of advice**

The advice worker delivers 'tier one' and 'tier two' advice on issues including housing, social security support, financial inclusion and debt management. Tier one advice includes basic information about rights, entitlements and services. Tier two provides specialist advice as well as practical support, for example, help filling out application forms and assistance with debt problems. The advice worker also refers to GEMAP's specialist 'tier three' advice services, responsible for representing people at tribunals for refused or contested social security applications.

### **Referral process**

From its outset, the project sought to position the advice service as an in-house service offered by the GP practices. The advice worker works from each practice for half a day per week (Friday morning and afternoon). If a patient articulates a social concern to their GP, they are informed of the service and if interested, a referral is made. Alternatively, if a GP, (with their prior knowledge of an individual's circumstances), identifies a potential social concern, the service is offered to the patient.

As the project developed, administration staff were also supported to make referrals to the service. For example, if a patient explicitly stated that they required assistance with a non-medical issue (e.g. a housing letter, or the provision of supporting evidence for a social security claim) while arranging an appointment to see their GP, administration staff offered the service and made referrals when appropriate. Referrals to the advice service were explicitly framed as an additional form of support offered by the practice, not a replacement for GP appointments.

Paperwork required for a referral was intentionally kept to a minimum. GPs were not required to complete referral forms. They informed the practice manager or administration staff of a patient's interest, who then emailed GEMAP with the individual's contact details via the 'NHS.net' secure email system.

Upon receiving a referral, the advice worker makes three attempts to contact the individual. If no contact is made, the case is closed. If closed, a letter is sent to the patient informing them of their case's 'closed' status. Once contact has been made with an individual, the GEMAP advice worker conducts an initial telephone 'triage' call which explores the underpinning issue(s) behind the referral. Once the support need is identified, the advice worker arranges a face-to-face appointment.

### **Appointments**

The first appointment takes place in a consultation room in the general practice. Home visits were available on request. The initial appointment aims to identify the most appropriate form of support. The advice worker's expert knowledge, coupled with their strong working relationships with local community organisations ensures a broad spectrum of direct (e.g. social security, housing, financial) and indirect (e.g. referrals to community organisations) advice is available.

### **Accessing medical records**

With written consent, the advice worker is able to access patient medical records. Copies of signed consent forms are attached to the patient's medical record and GEMAP's case file. Once consent is granted, the advice worker requests access to the patient's medical summary from the practice staff.

If necessary, the full medical record is requested. Access to full medical records tends to take place when clarification is needed regarding aspects of a medical summary, or more detailed information is needed for social security applications. The consent document, signed by the patient, explicitly grants GEMAP access to their full medical record.

### **Costs**

The project costs approximately £10,500 per annum. This includes one day of service delivery per week, one day of supporting office work per week, management costs and reporting costs. Analytical and evaluation support is provided 'in-kind' by the GCPH, the Deep End GP group, the north east Health Improvement Team and Building Connections. GP engagement with the project did not result in additional costs. Advisory group meetings were arranged to suit their availability and the regular presence of the Building Connections programme manager in the practices ensured GPs could engage with the data collection processes, without the need for locum cover.

## Methods

Here we present the evaluation questions guiding the Deep End Advice Worker project and the methodological framework. Data collection methods and analytical approaches which aided our understanding are also provided.

### Evaluation questions

To support our understanding of the project and its practical delivery, the following questions were utilised to generate evaluative insight:

1. To what extent have the collaborative efforts of (the Deep End Advice Worker project) partners improved economic outcomes for people accessing the service?
2. What were the experiences of people accessing the service?
3. What were the experiences of healthcare professionals, practice staff and advice providers delivering the project?
4. To what extent have small changes in the processes underpinning the project improved outcomes for people accessing the advice service?

Through focusing our efforts on answering these four key questions, the project sought to simultaneously understand its supporting mechanisms and people's experiences of the project; improve the service in real time; and contribute to the evidence base regarding the provision of advice services in general practice settings.

### Methodological approach

Quality improvement methodologies were utilised to make explicit, and improve, the practical processes underpinning the advice service. Underpinned by a *systems thinking approach*, it is concerned with positively disrupting normal working practices and encouraging different working behaviours. This is achieved through testing small-scale changes to existing service delivery processes, collecting data regarding the impact of these changes and ultimately, measuring the interventions against agreed targeted outcomes.

In Scotland, quality improvement occupies a prominent position in health improvement discourse, government policy and public sector service design and delivery<sup>43,44</sup>. In the context of the Deep End Advice Worker project, it challenged partners to reflect on:

- how GPs, practice staff and the advice worker interact to deliver the service
- the relationship between the advisory group and practitioners in the design and development of the project
- the impact of physically delivering advice from a general practice environment
- the processes supporting the delivery of the project and the emerging social and economic outcomes
- whether these outcomes could be improved through changing elements of the processes underpinning the services.

Against these areas of interest, the work adopted several complementary data collection and analysis processes. For example, at each advisory group meeting referrals were analysed by several

key patient characteristics (e.g. age, gender, economic and household status, income, ethnicity) to identify who was (and wasn't) accessing the service. Advisory group meetings were also an opportunity to examine the latest financial outcomes for service users, and to explore the experiences of practitioners involved in the delivery of the work. This process contributed to the identification of potential refinements to the service.

### **Qualitative data collection**

Semi-structured interviews were held with three GPs (one from the Burns practice and two from the Lafferty practice) the advice worker and the practice managers. Interview questions were developed (with input from the advisory group) to examine how the project operated and to explore the experiences of people involved in the work (see Appendices 1 and 2).

The regular presence of the Building Connections programme manager (bi-weekly between April 2016 and December 2016) facilitated more informal engagement with GPs, practice staff and the advice worker. This resulted in approximately 15 individual conversations with the two lead GPs from each practice, the advice worker and the practice managers and staff.

These engagements focused on gaining an understanding of practitioners' experiences of delivering the project and making its supporting mechanisms explicit. This also helped develop knowledge regarding how the project fitted into the day-to-day delivery of primary healthcare in general practice. Through collating this information, practical interventions were identified which aimed to improve the referral process. To better appreciate the impact on people accessing the service, the advice worker provided several anonymous case studies detailing patient experiences.

Approximately 25 conversations (via telephone and face-to-face) with individual members of the advisory group provided another source of data. A documentary analysis of advisory group meetings and original funding documents contributed to a robust understanding of the project's history and ongoing development.

Extensive written notes were taken throughout all interviews and discussions. These interactions were intentionally not audio recorded, as the introduction of recording devices were viewed as a potential barrier to developing the relationships needed to properly understand the project.

### **Reflective practice**

Throughout their time working from the practice, the Building Connections programme manager kept a journal detailing observations and reflections on the project. The practice of making regular journal entries is widely documented as having positive benefits on improving understanding and encouraging reflection<sup>45,46</sup>. Written notes and formal minutes from five advisory group meetings also contributed to this reflective process.

### **Analysis**

#### **Referral and financial data**

On a bi-weekly basis referral figures were plotted longitudinally to track trends in the volume of referrals from each practice. As mentioned in the methodological approach above, throughout the project the advisory group analysed the emergent data at each meeting. The data presented in the

remainder of this report reflects an in-depth final analysis, conducted by the Building Connections programme manager. To ensure a level of relative robustness, findings from the final analysis were initially shared with, and confirmed by, the GEMAP Chief Executive. They were then distributed to the advisory group for further confirmation. Table 1 provides an overview of the project's economic impact.

### **Qualitative data**

Handwritten notes from the semi-structured interviews and conversations with practitioners were transcribed electronically on the day they occurred. Notes from meetings were also transferred to electronic formats. Journal entries were recorded electronically.

Electronic versions of interactions and experiences were organised by practice and/or participant (e.g. McKenzie Practice: GP 1). Each respondent's engagement with Building Connections was printed and read through twice, before developing an initial set of codes. These codes were then applied across the entire dataset and were used to develop a series of themes. The themes were then checked to ensure they were distinctive enough to be classed as separate themes.

The learning themes were then distributed to the advisory group and practitioners (for confirmation) through a series of written outputs, one-to-one discussions, draft versions of this report and at advisory group meetings. Partners were encouraged to question and constructively critique the emergent learning. This process ensured the data reflected practitioner experiences, highlighted future areas for exploration and confirmed the emergent learning themes.

### **Ethics**

Utilising the Health Research Authority 'is my study research' tool and through engaging with colleagues in NHS Health Scotland, it was determined that the evaluation fell into the category of 'service evaluation' and therefore did not require ethical approval. Verbal informed consent was provided by participants contributing to the report.

## Findings

### Referrals, new clients and financial gain

Between 11th December 2015 and 31st May 2017 the two practices made 276 referrals to the advice service. Across the two practices, GPs made 74% of the referrals. The remaining referrals were made by practice nurses and non-clinical practice staff.

Eighty-five percent of people referred had never previously accessed GEMAP's services. The percentage of new GEMAP clients were calculated from the total referrals (including pending). Therefore, 'new GEMAP clients' refers to people referred, not necessarily those engaging with the service.

Table 1 provides a high-level overview of the referrals, new clients, financial gain and debt management outcomes secured by the project, broken down by each practice.

**Table 1. High level outcomes: both practices. 11th December 2015 – 31st May 2017.**

	Referrals	Engaged with service (%)	Pending	Declined/ did not engage (%)	Financial gain	Debt identified	New GEMAP clients (%)
<b>Lafferty practice (4 GPs – 4,711 patients)</b>	148	93 (70)	15	40 (30)	£547,720.25	£53,915.66	120 (81)
<b>McKenzie practice (2 GPs – 3,192 patients)</b>	128	72 (60)	7	49 (40)	£300,281.04	£101,851.05	115 (90)
<b>Total</b>	276	165 (65)	22	89 (35)	£848,001.29	£155,766.71	235 (85)

#### Notes

- (1) Percentage rates for engaged and did not engage have been calculated through removing the pending cases from the total referrals.
- (2) Across all outcomes, percentage rates have been rounded to the nearest multiple of 5%.

Table 2 offers a more in-depth analysis of the financial gain secured by the project. It breaks down income maximisation by benefit and highlights the total financial gain, number of people supported, the application success rate and median award amounts. The majority of these benefits are devolved to the Scottish Government.

For reference, the figures are calculated on a per annum basis. This approach is consistent with standard reporting procedures for the sector. For example, an individual who successfully applies for the PIP daily living benefit would receive a weekly rate of £82.30 (at the enhanced level). This is multiplied by 52, to give a total annual figure of £4,279.60.

**Table 2. Financial gain by social security award.**

	ESA	PIP	Severe Disability Premium*	Housing Benefit/LHA	Carers Allowance	Child Tax Credits and Child Benefit**	JSA	Council Tax	DLA	Attendance Allowance	Scottish Welfare Fund
<b>Total financial gain</b>	£338,775.55	£217,496.56	£66,832.35	£61,402.49	£33,567.10	£26,695.10	£22,393.27	£15,533.27	£13,428.34	£8,713.96	£3,036.02
<b>Number of awards</b>	48	36	10	17	8	6	5	15	5	2	15
<b>Median gain (per annum)</b>	£5,893.71	£4356.98	£5,565.44	£3,826.96	£3,499.40	£3,364.36	£3,926.51	£846.94	£1,678.60	£4,356.98	£88.88
<b>Maximum award (per annum)</b>	£23,415.22	£11,838.82	£10,963.58	£6,454.17	£8,747.21	£9,468.85	£8,694.40	£3,224.00	£4,831.30	£5,820.16	£1,440.00

**Table 3. Financial gain by practice.**

	ESA	PIP	Severe Disability Premium	Housing Benefit/LHA	Carers Allowance	Child Tax Credits and Child Benefit**	JSA	Council Tax	DLA	Attendance Allowance	Scottish Welfare Fund
<b>McKenzie practice total</b>	£110,480.06	£75,009.06	£41,969.63	£16,270.49	£12,597.40	£17,226.20	£5,918.95	£5,796.63	£1,269.71	£5,820.16	£310.28
<b>Lafferty practice total</b>	£228,295.49	£142,486.87	£24,862.72	£45,132.00	£20,969.66	£9468.85	£16,474.32	£9,736.64	£12,158.63	£2,893.80	£2,725.74

Notes:

We have utilised the median amount of financial gain, as this better represents the typical financial gain (as extreme figures are removed).

At this moment there are 62 outstanding cases. The outcomes from these cases are still to be reported. Therefore we have chosen to detail the number of awards secured through the project without speculating on the results of the outstanding cases.

\*We appreciate the Severe Disability Premium is not viewed as a stand-alone benefit, but rather, an addition to certain health benefits. However, our view is that the significant amount of financial gain secured through this add-on demands explicit mention in our findings.

\*\* The project has grouped together Child Tax Credits and Child Benefits to illustrate the ability of the work to support families with children. A detailed breakdown of these benefits IS provided in the next section.

### **Income maximisation**

The median amount of financial gain for successful applications equates to £6,967.96 per client, per annum. Four individuals received over £20,000. The highest individual amount secured totalled £40,250.14. This included a budgeting loan, an Employment and Support Allowance (ESA) award and a Personal Independence Payment (daily living and mobility allowance).

Two-fifths (£338,775.55) of the financial awards secured by the project were the result of ESA claims. The advice worker submitted 48 successful applications. This benefit remains reserved to the UK government.

A quarter of the total financial gain resulted from Personal Independence Payment (PIP) applications (£217,496.56). In May 2017 the median payment for PIP applications was £4,356.98. As a point of comparison, in January 2017 the median award for applications sat at £2,918.63 per annum. The significant increase in the median award is potentially reflective of the processing times for PIP applications (i.e. in January 2017 a number of cases were still being processed by the DWP).

Applications for housing benefit/local housing allowance secured £61,402.49 worth of financial gain. In total, 108 people (39% rising to 65% once 'pending' cases and cases where no information is available is removed) were tenants of registered social landlords. The project also engaged with 19 private tenants, 15 home owners and five people experiencing homelessness.

Applications for Child Tax Credits and Child Benefit resulted in £26,695.15 worth of financial gain. Within this group, four people received a combined total of £24,725.56 worth of Child Tax Credits. Two people received £1,969.59 worth of Child Benefit. Considering approximately one-in-three children in Glasgow live in poverty, there is clearly further work needed to ensure economically vulnerable families are able to access support services and receive the social security support they are entitled to.

The advice worker secured £55,709.40 for 15 people across Carer's Allowance, Disability Living Allowance and Attendance Allowance applications. These benefits are devolved to the Scottish Government.

In total, the project supported 167 successful applications across a range of benefits. In addition, 62 cases are still to be reported. Within this, 119 of the successful cases, or 71% of the total welfare rights work completed by the project, fall under the auspices of the Scottish Government. This includes devolved and soon-to-be-devolved benefits, the majority of which are health-related.

### Cost reductions

Complementing their income maximisation work, the advice worker provided several 'cost reduction' services (see Table 4).

**Table 4. Cost reduction support.**

Type of cost reduction support	Number of people supported
Assisted with fuel poverty	51
Using less expensive forms of credit	12
Bus pass issued	15
Managing money better (self-reported)	2
Bank account opened	3
Credit union account opened	2
<b>Total</b>	<b>85</b>

The service identified and put management plans in place for approximately £155,000 worth of debt and delivered 85 separate cost-reduction outputs (predominantly focusing on fuel poverty and using less expensive forms of credit).

### Onward referrals

As well as providing direct support to people accessing the service, the advice worker made 124 referrals to additional forms of community support. Table 5 lists the key destinations of these referrals.

**Table 5. Overview of key destinations of onward referrals.**

Destination of onward referral	Number of referrals
Homelessness support	25
Food bank	18
Fuel poverty support	15
Financial support	13
Occupational therapist	13
Carers support	12
Mental health support	9
Other (e.g. refugee support, garden maintenance, peer mentoring)	25
<b>Total</b>	<b>130</b>

The project was unable to track whether an onward referral resulted in engagement. However, around half of the people accessing the service were referred to additional forms of community support.

## **Housing**

In addition to the income maximisation work on Housing Benefit and Local Housing Allowance, the service supported five people to secure alternative housing and ensured two people at risk of eviction, remained in their homes. The collaborative work of the advice worker and GPs resulted in 17 people receiving a medical priority for housing applications. As highlighted above, 25 people were also referred to homelessness support services. In total, nearly 20% of the people accessing the service were supported on a housing-related issue.

## **Multiple forms of support**

Of the 165 people who engaged with the service, the majority were supported to access multiple benefits. Just under half received help to access two forms of social security support, while around a third received advice on between three and four separate issues. The data suggests a small number of people required intensive advice across a range of concerns, with 5% (eight people) supported on between six to nine issues.

## **Demographic data**

The demographic data suggests women are more likely to access the service than men. It also reflects broader evidence regarding the uptake of advice, with younger people and ethnic minority communities less likely to engage with support services. The service is predominantly used by White Scottish people, reflecting the demographic profile of the surrounding area.

Nearly two-thirds (65%) of people accessing the service were tenants of registered social landlords, with 19 people renting from private landlords. Only 15 people classed themselves as owner occupiers. Despite the significant support regarding homelessness by the advice worker (25 onward referrals, five people supported to find alternative homes and two people supported to stay in their homes) only five people stated they were homeless.

From the 165 people accessing the service, 268 health issues were self-reported. Of this group 112 people, or 68% of people who engaged with the service stated they had a mental health issue. Ninety-six people (58% of people engaged with service) had a long-term illness and 34 people (21% of people engaged) reported mobility issues, or other physical impairments. In relation to economic status and reflecting the high levels of self-reported health concerns, 110 (67%) people stated they were unfit for work.

From the available data, 78% (n=128) of people accessing the service had household incomes of less than £15,000 per annum. Considering the Scottish median income of £24,900 in 2014/2015 and the classification of poverty as 60% of the median income (£14,940) it is clear a significant number of people accessing the service are living in poverty.

## Components of practice

Here we introduce the core components of practice underpinning the delivery of the Deep End Advice Worker project. Although these findings are locally and contextually specific, they provide an insight into the social, cultural and physical conditions necessary to engage in work of this nature.

### **Approaches to embedding advice services into general practices**

From the outset of the project, partners explicitly sought to position the advice worker as a member of the general practice team. A retrospective analysis of the planning phase supporting the project (which lasted approximately two months and involved all members of the advisory group, with the exception of Building Connections) explicitly highlighted the intent of the project to embed the worker into the everyday work of both practices.

A number of steps were taken to help embed the advice worker into the practice team. For example, the provision of a consultation room in each surgery to deliver advice and access to medical records when required. The advice worker was welcomed and made to feel like a part of the practice team which was illustrative of the buy-in from partners:

*“...On the first day I was introduced to the practice staff and GPs by the practice manager(s). Everyone was helpful and accommodating. I was shown the rooms I would work in and also the usual health and safety stuff.”*

[Advice worker]

In addition, the willingness of GPs to engage with the advice worker from the outset of the work suggests the concentrated effort in the planning stages of the work and the subsequent collective agreement that the advice worker had to be part of the practice teams, paid dividends. The in-house positioning of the service and the ease of referral was something appreciated by all partners.

This shared understanding should not be under-estimated, as it provides an indication of how future projects should be developed. The collective input of the supporting organisations, coupled with their agreement on how the service should be delivered, simultaneously aided the identification of collective aims and ensured all parties were aware of their role in the project's development and delivery. This is not to say the project did not experience complexities in its service delivery phase, but rather, the commitment from all parties (and the underpinning shared vision), ensured potential barriers were efficiently overcome.

However, it should be noted that the partners and general practices involved in the project were self-selecting in deciding to engage with the project voluntarily. This clearly raises questions regarding the scalability of a project of this nature. However, considering similar services are now available in 25 practices in Edinburgh and five practices in Dundee, it is the view of the project that scalability is achievable. Accordingly, it is hoped the insight generated by this evaluation has the capacity to captivate the interest of general practices and advice agencies, particularly in areas of high deprivation, and ultimately, act as a catalyst for further testing of embedded models of service delivery.

### **Accessing medical records: a fundamental component of service delivery**

Access to medical records allowed the advice worker to triangulate three sources of information regarding an individual's circumstances (patient input from their appointment with the advice worker, the patient's medical records and the GP's perspective). The following case study illustrates this process.

#### **Case study 1: Accessing medical records**

Once informed consent is received, the advice worker requests access to a patient's medical summary. Utilising the information gained from their initial appointment with a patient, they examine the summary to identify appropriate supporting evidence for social security applications. If the necessary information isn't evident within the medical summary, they request specific information from their full medical record.

Using their analytical skills and knowledge of the social security system, the advice worker produces a draft supporting medical statement, which articulates the impact of an individual's health condition in relation to their social security application. They then engage with the patient's GP to ensure the draft statement represents the individual's health condition. This usually takes the form of a quick conversation in a consultation room.

On occasion, GPs make amendments to the draft statement. However, feedback suggests the advice worker's ability to extract relevant information keeps such amendments to a minimum. Next, a final copy of the supporting medical statement is given to the GP for final sign-off. GPs cross-check all information contained within the statement against the patient's medical records, amend where appropriate, then sign the supporting statement. This is then attached to the application and submitted to the relevant awarding body.

As demonstrated, access to medical records offers the advice worker multiple sources of information regarding an individual's circumstances. It acts as a catalyst for engagement with GPs (to better understand the specific circumstances of patients), while simultaneously reducing the non-essential workloads of GPs (as they no longer have to complete medical statements on behalf of patients). In turn, this provides the advice worker with a multi-dimensional perspective of the patient's circumstances and ensures they are able to appropriately represent them across a range of health-related social security applications.

The financial gains secured by the project, totalling £848,001.29 to date, provide an indication of the impact of this way of working. As a point of contrast, on several occasions the advice worker compared the support they were able to offer through this project with their work in Parkhead Health Centre, where they deliver an additional advice service (without access to medical records). Their ability to access medical records and engage with GPs regarding an individual's circumstances was framed as a fundamental difference between the services:

*"I can speak to patients about their circumstances, then speak to GPs directly and then access medical records if I need to. It means I can better complete forms/applications. I can write what needs to be written."*

[Advice worker]

As a further point of comparison, Table 6 illustrates the financial gains secured by the Deep End Advice Worker project and two health centres (Parkhead and Shettleston), where GEMAP advice workers do not currently have access to medical records. The comparison refers to the financial gains secured through applications for Attendance Allowance (AA), Personal Independence Payment (PIP), Employment Support Allowance (ESA) and Severe Disability Premiums (SDP). The project appreciates SDP is not a stand-alone benefit, however, the significant amount of financial gain (£66,832.35) secured through this particular benefit in the Deep End Advice Worker project, warrants its inclusion in the comparison.

Please note, we have merged the data from the two health centres to ensure a representative comparison can be made. By this, the advice worker works for half a day in each health centre, totalling one day of service delivery. At the Deep End Advice Worker project, they also deliver advice for one day in total (across the two practices).

**Table 6. Financial gain comparison.**

<b>Location</b>	<b>Number of cases</b>	<b>Total financial gain for AA, PIP, ESA, DLA and SDP applications</b>
Deep End Advice Worker project	174	£644,819.10
Parkhead and Shettleston Health Centres	287	£594,235.73

It is difficult to make definitive statements regarding the reasons for the significant differences in income maximisation, due to such work depending on the presenting circumstances of the individuals. However, it is clear the advice worker is securing higher financial gains, despite working on fewer cases in the Deep End Advice Worker project, when compared with two well-established outreach services based in health settings, in the north east of Glasgow.

Subsequently, viewing the financial figures in conjunction with the statements of the advice worker, suggests that the ability to access medical records improved their capacity to better represent people accessing the service, through equipping them with an in-depth knowledge of a patient's circumstances and history.

As a result, the process of triangulating data sources (e.g. patient input, medical records, GP perspective), both in terms of the relationships it requires between the GP and advice worker, and the knowledge it generates, can be considered the cornerstone of the project.

A reflection of these relationships, and the commitment of the GPs to the project, is their fundamental role in supporting its delivery. By May 2017, of the 276 referrals made to the service, 203 were made by GPs (74%). It should be noted GP referral figures peaked at 88% in January 2017. The difference between January 2017 and May 2017 is representative of the project's attempts to encourage frontline staff to make referrals.

In contrast, in the same 17-month time period, the other 42 general practices in north east Glasgow (without embedded advice workers) but who were still able to refer patients via an online system made 24 referrals to GEMAP's service.

Further comparisons can be made with similar projects in Scotland and the UK. For example, the delivery of advice from primary care in Aberdeen over a nine-month period engaged with 130 people, with a 25% GP referral rate<sup>17</sup>. While in Bradford, a large-scale programme of work, involving the delivery of advice from 30 GP practices engaged with 2,484 patients, but only 28% were referred by GPs<sup>18</sup>.

Importantly, although GPs were aware of existing support within the health centre and via an online referral system, they suggested the physical presence and regular engagement with the advice worker encouraged them to utilise the service:

*"We've been told about loads of things going on, loads of support, it is round the corner, but we just don't use it. But with the advice worker here, it's a lot easier."*

[GP 2]

*"...There isn't a need for lengthy meetings and it's all very practical."*

[GP 2]

The high GP referral rate and their reflections are important indicators regarding the impact of the project. It can safely be argued that the advice worker's ability to access medical records engaged GPs in a purposeful and meaningful manner. Reinforcing this perspective is the manner in which GPs and the advice worker describe their relationships:

*"...The relationships are good, I have got to know them all now and they are all approachable. It's just simply a chap on the door (if they are free) and we can talk about things there and then."*

[Advice worker]

*"...We know he is here and how he can help people."*

[GP 1]

Through framing their interactions through a service delivery lens, it is clear both parties view their relationship in pragmatic terms. In turn, this appears to be contributing to significantly higher engagement from GPs (74% of referrals), while simultaneously ensuring the advice worker is able to provide the best representation possible for patients accessing the service:

*"...It's actually been really good to be able to speak to GPs about people referred to the service. I can get a better understanding of their health, which means I can provide better quality supporting evidence."*

[Advice worker]

From this, access to medical records could be viewed as the fundamental factor in creating a parity of professionalism between the GPs and the advice worker. The advice worker's production of draft

medical statements can only be achieved if they are able to access medical records. This access reduces the workload of GPs, but still requires their expert medical knowledge, as they ultimately sign off any supporting evidence before final submission.

This process appears to strengthen the relationships between the two parties, through the requirement of regular engagement and communication regarding the individual circumstances of people accessing the service. Simultaneously, it removes any potential for a hierarchal relationship to develop, as both professionals must draw upon their respective expertise and knowledge to support patients to navigate the social security system.

Ultimately, the advice worker's extensive knowledge of the social security system and their ability to identify key health data within medical records (before producing draft summaries for GP sign off) coupled with the GP's more in-depth understanding of a patient's health, combine to ensure patients receive the support they are entitled to while also supporting the continued relationships between the two professionals. As the GP referral figures, income maximisation data and comparisons with other similar sites demonstrate, this process appears to be achieving a range of positive impacts.

#### **Access to medical records: reducing general practice workloads**

Engagement with three of the GPs from across the practices positioned the provision of advice as another form of support which they could offer patients, which in turn, helped reduce their workloads and created time to deliver primary healthcare. It should also be noted that the GPs explicitly stated their colleagues were of a similar opinion:

*"The project is taking a huge amount of pressure off me to support people with matters I don't know much about."*

[GP 2]

Through this embedded provision of advice, the GPs felt they were reducing the time spent supporting people with social security, and more broadly, non-clinical concerns:

*"It is contributing to reduced time spent by GPs on paperwork relating to benefits, (it) lets us get on with the job we are trained to do."*

[GP 3]

Recent research suggests it takes, on average, 47 minutes to complete the medical statement for employment and support allowance applications. This increases to 97 minutes for the medical information required for personal independence payment applications<sup>6</sup>. Subsequently, the sentiments of GPs regarding a reduction in their workloads can be considered a direct consequence of the additional support the advice worker provides. To be explicit, the advice worker's production of draft statements still require input and sign off from the GP before submission.

Although GPs stated they felt the project was reducing their workloads, the project was unable to provide quantitative evidence of this. However, the advice worker's groundwork in drafting the statements clearly requires less investment of GP time. Further work is potentially needed to better understand the impact of the work on GPs' time commitments.

In conclusion, it would appear accessing medical records and the advice worker's role in drafting supporting medical statements reduces the time GPs spend on non-clinical issues, while their input and sign off simultaneously ensures individual health conditions and histories are properly represented. Considering recent research regarding the length of time it takes to complete PIP and ESA benefits, this process could be viewed as a mechanism through which additional capacity to deliver primary healthcare can be achieved, allowing targeted support to be provided in areas of high deprivation.

### **General practices: neutral hubs to help improve the accessibility of advice services?**

Delivering advice in general practice settings offers the opportunity to overcome potential stigma associated with accessing social security support. In our project, delivering the service from general practices increased the reach of GEMAP, with 85% of people referred to the service new to GEMAP. This is despite their significant longstanding presence in the north east of Glasgow (and even the very health centre the two practices are based in). The broader evidence base referred to throughout this report reinforces this finding, suggesting general practices offer a unique opportunity to improve access to advice services.

It should be noted that although 85% of patients referred to the service were new to GEMAP, the project was unable to ascertain how many people had engaged with other advice services (e.g. through their housing provider or a citizens advice bureau). Qualitative feedback from the advice worker suggests a high proportion of people engaging with the service were accessing advice for the first time, but unfortunately we were unable to quantify this.

The project intentionally sought to minimise barriers to accessing the service. For example, the advice worker delivered advice from a consultation room in each practice, dressed in similar attire to practice staff and GPs, and mirrored the traditional GP call for attendance when people were waiting in the practice waiting room. By adopting a similar approach to the existing practice staff, the nature of the work carried out by the advice worker remained discreet.

Feedback from the advice worker stated several people accessing the service in the practice did so due to the anonymity it offered. In addition, the trusted status of general practices in local communities and the longstanding relationships with GPs were presented by several patients as motivating factors in their engagement. This feedback presents an insight into the project's success and offers a strong rationale for continuing work of this nature in the future.

Put simply, these processes, including its location in the general practices, minimised the likelihood of individuals being identified as attending an advice service. Unless people knew the advice worker on an individual basis, there were very few visual indicators differentiating them from GPs:

*"We are getting more success rates, less cancelled appointments, we've got long appointment times in a comfortable environment where no one knows why a person is attending, people are opening up more, the physical environment is fundamental."*

[Advice worker]

## **The role of Building Connections**

Collaborative projects, at an individual level, require nurturing, attention and support. To facilitate this process, Building Connections provided regular on-site support to the Deep End Advice Worker project. Operating as a conduit between practitioners, they ensured the smooth flow of information, experiences and ideas between the people involved in its practical delivery.

Through short, yet focused conversations with all practitioners, the Building Connections programme manager developed a robust understanding of the mechanisms underpinning the project and the experiences of practitioners. These understandings were utilised to support partners to identify opportunities to improve the referral process and delivery of the advice service. This approach positioned practitioner knowledge as integral to the project's development. Ultimately, the practical knowledge of people delivering the service, was explicitly presented as the most important form of knowledge among all partners involved in the work.

### **Case study 2: practical interventions designed to improve the service**

#### **Intervention 1: Overview of GEMAP services**

In the early stages of the project, engagement with practice staff and GPs suggested further work was needed to articulate the range of services offered by GEMAP. Accordingly, Building Connections worked with the advice worker to design a one-page handout. This was laminated and distributed to all staff for reference. Appendix 3 contains an example of this handout.

#### **Intervention 2: Simplifying feedback processes**

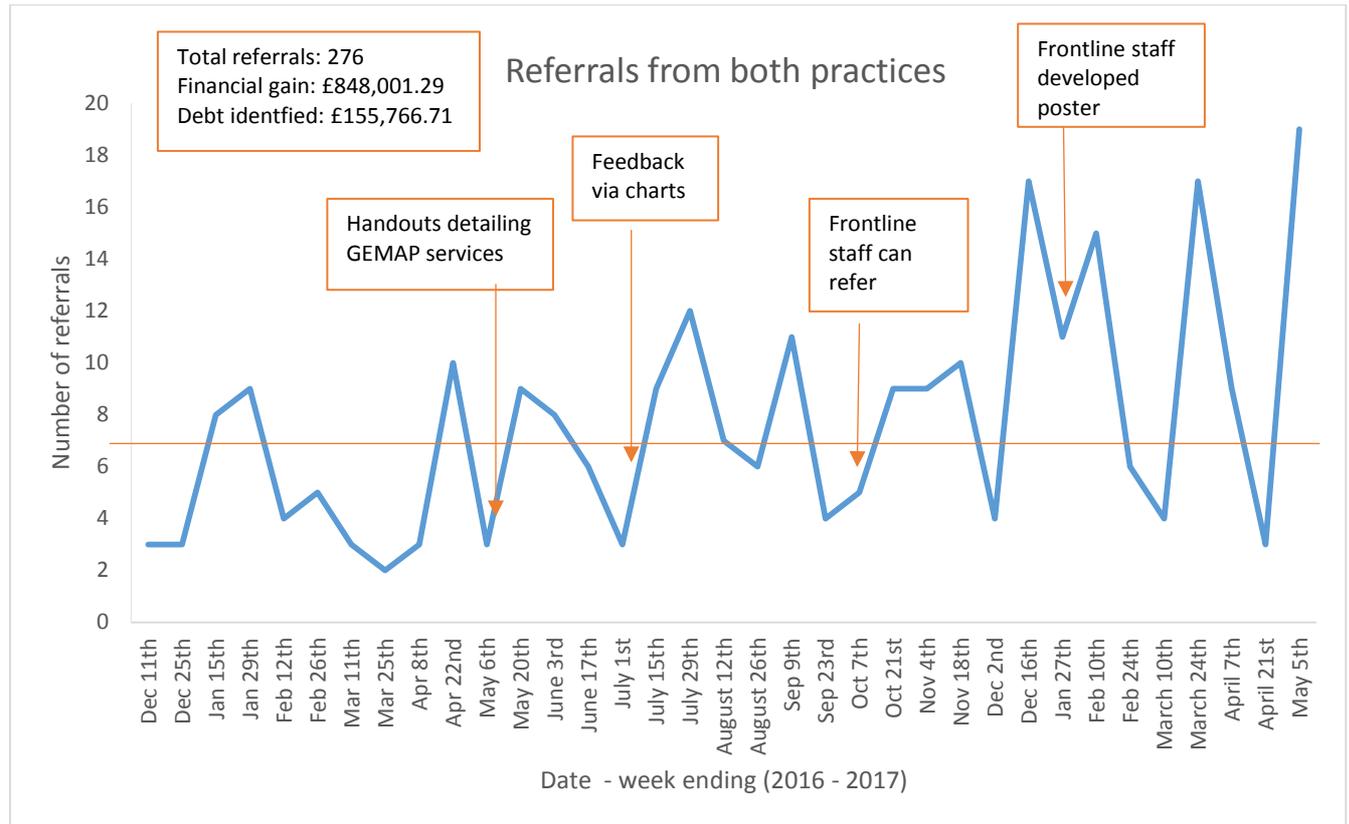
As demonstrated throughout this report, the project has collected a significant amount of data regarding engagement with, and the impact of, the service. To ensure this data was easily available and consumable, BC developed one-page handouts for each practice. Each handout aided longitudinal tracking of the referrals made by the practice and articulated the financial gain and debt identified as a result of the service.

#### **Intervention 3: Practice poster**

As non-clinical staff in one of the practices became more involved in the project, they suggested a poster at the reception could encourage further engagement. As a result they designed a poster and placed it at eye level on the receptionist counter. The physical design of the poster and its placement (at a location in the practice patients would regularly stand at when speaking to the receptionists) were completed entirely by non-clinical practice staff.

The importance of the role in supporting the understanding of the project and its value in identifying potential interventions was articulated by all partners involved in the project. Figure 1 details the interventions and their impact on referral figures.

**Figure 1: Referrals from both practices and service development interventions.**



Exploring the perceptions and experiences of practitioners and the advisory group, with a view that service improvements are always possible, helped focus partners on the nuances of the project, their role in its delivery and most importantly, how it could be improved. Feedback from practitioners explicitly highlighted the value of this support:

*"...(Building Connections) enabled us to put the concept of 'learning by doing' into practice in the pilot... They encouraged us to make changes to the project as it developed... Through facilitating joint working, I think their input really helped me to 'think out of the GP box'."*

[GP 2]

*"They assisted in making the project successful by helping implement any changes that were required. Because of this, referral figures increased and made everyone aware of the services GEMAP provided."*

[Advice worker]

Although the project appreciates that in the future a designated individual may not be available to carry out similar work of this nature, our experiences suggest the ongoing learning process facilitated by the involvement of Building Connections contributed to its development. Attendance at the practices allowed for a complete immersion into the environment that the work was physically delivered from, the development of relationships with practitioners involved in its delivery, and provision of a solid understanding of the practical realities of the project.

This approach resonated with all members of the project. Its focus on identifying improvements, while ensuring all parties were informed of potential changes, appeared to play a fundamental role in people's perceptions of the position:

*"...having an honest broker involved in the process. Someone looking at things dispassionately, seeing what works, seeing where there are difficulties or tensions. Then facilitating discussions to resolve them...(ensured) the dynamic of change has been much quicker."*

[Advice manager]

### **Practitioner knowledge, service design and service delivery**

Practitioner knowledge (e.g. advice worker, GPs, practice staff) occupied a central component in the design and delivery of the work. Although there are clear differences between the two practices, in terms of their patient caseload and service delivery structure, the knowledge of practice staff and the advice worker was consistently positioned as a fundamental source of expertise:

*"Our staff are assets, they can widen opportunities for people seeking support... it is through individual, informal chats (between practitioners), the work is building."*

[GP 2]

Valuing the experiences of practitioners ensured their knowledge was utilised, while also encouraging them to take responsibility for its delivery. This process supported the delivery of the project on multiple levels. It ensured all practitioners, from GPs to administration staff were given the opportunity to engage and contribute to the project. This approach intentionally sought to create a culture of learning and development, in which everyone's opinion was valued.

Subsequently, staff were empowered to implement their own discrete changes to the referral system. This is reflective of the autonomy the project created for the staff and the impact that adopting such an approach can have. For example, recently practice staff designed a poster and leaflet for patients arranging appointments. It details the range of advice services provided by the advice worker and states the service can be accessed upon request. The staff created this in their own time, including printing the leaflet at home (as they didn't have access to a colour printer in work).

Although this seemingly small action may on the surface, appear insignificant, it clearly demonstrates the value staff see in the work and its supporting processes. As a result, the project strongly recommends future work of this nature should forgo traditional top-down methods of service delivery and development, in favour of an approach which explicitly works with practitioners to deliver services.

### **The importance of the advice worker**

The advice worker's ability to develop relationships and build rapport with practice staff, coupled with the demonstrable impact of the project, played a fundamental role in the continued commitment of the practices and the success of the project.

On numerous occasions, the advice worker altered their working practices, language and styles of communication to aid the embedding process. This took multiple forms, including replicating language and terminology used by GPs and practice staff through to adopting the styles of writing found in medical summaries when jointly producing benefit applications or supporting letters with GPs.

In addition, the advice worker is on first-name terms with all practice staff and GPs. Sharing cups of tea and socialising on a personal level with practice staff was commonplace. Naturally, these social interactions occurred more regularly with non-medical staff, due to the time pressures of GPs. However, these interactions demonstrate their seemingly normalised position within the practices.

From these practical examples, the relationship between the advice worker's professional knowledge, interpersonal skills, and the development of the project is quite clear. Their ability to simultaneously maximise income, reduce costs and refer to partner organisations ensured the broadest range of support was available. However, perhaps more importantly, through tailoring their style and method of communication, they were able to transcend multiple professional environments (i.e. healthcare and advice). Without this element, which clearly demonstrates a range of professional, social and interpersonal skills, it is doubtful whether the project would have demonstrated the success it has.

In conclusion, the advice worker's skills ensured the efficient integration into a complex service delivery landscape. Their ability to quickly identify cultural norms and existing working processes contributed to the development of meaningful relationships with practice staff. This played a significant role in the 'embedding process', as they are now viewed as part of the practice teams. As a result, the technical abilities and personal characteristics of advice workers in future projects should be given careful consideration, as they are the 'outsider' responsible for delivering the service in a new environment. Ultimately, their ability to integrate into the practices and deliver an impactful service could be considered as pivotal to future work.

## Discussion

### **Collaborative working**

Embarking in multi-disciplinary, cross-sector collaborative projects can be a challenging process and requires individuals from disparate backgrounds to work together to deliver common aims. Throughout the course of the project, the advice worker's ability to work across two significantly different service delivery areas, healthcare and advice, and with several different groups of professionals (e.g. GPs, practice managers, practice nurses, practice staff), could be considered as pivotal to the outcomes secured by the work. In addition, the welcoming nature of general practice staff – in these cases a result of their self-selecting nature and involvement in the design of the service – could be positioned as a core factor underpinning the project's impact.

It is clear the specific attention paid to the more detailed aspects of the work also aided the project's development. Such support was achieved through the continued on-site presence of Building Connections and frequent advisory group meetings. The availability of Building Connections ensured every individual involved in the project had the opportunity to articulate their experiences and contribute to its development. They also acted as an additional resource 'on the ground', supporting practitioners to work through the complexities inherent within collaborative service delivery projects. Equally as important, the advisory group's collective knowledge and experience provided a valuable perspective on the emergent data and experiences of practitioners involved in the project's delivery.

Ultimately, through understanding, valuing and acting upon the experiences of people practically involved in delivering and supporting the project, the Deep End Advice Worker project efficiently and regularly implemented changes to its supporting mechanisms to test whether a better delivered and experienced service could be achieved.

### **Components of practice**

Perhaps the most fundamental component of the project is the importance it placed on understanding, valuing and acting upon the experiences of the people practically involved in the project's delivery. This approach was evident from the planning stages and throughout delivery. Ultimately, it was 'working with' practitioners as opposed to 'doing to'.

Moving forwards, simple referral processes which complement existing processes within each general practice, a physical space to deliver the service from within the practice, access to medical records and the engagement of GPs are fundamental to the success of future work. Accordingly and to reiterate a reoccurring theme, GPs, general practice staff and advice workers, with their expert knowledge of delivering primary healthcare and advice, must be central to the decision-making processes regarding why, how and when future projects are delivered. Their knowledge of working environments and practices should not be underestimated.

Throughout the report we have attempted to provide a detailed overview of the project's core components of practice. However, it is fundamental that colleagues involved in the delivery of future projects of this nature appreciate their unique context, histories and demographics. The components of practice provided are not intended to be prescriptive, but rather, offer a set of principles or approaches which could be utilised in other geographic locations. However, we must

stress that our experiences suggest careful consideration is needed regarding each of the learning themes detailed in this report.

### **Strategic significance**

Similar to the inverse care law, which suggests the people who require the greatest medical support experience the greatest difficulty accessing it, our findings suggest this also applies to social and economic advice services where the most vulnerable experience more difficulty accessing services than their more affluent counterparts. This clearly raises questions regarding current commissioning arrangements and suggests targeted advice in general practices could contribute to increasing the reach of support services. It could be argued that the project's findings, in terms of outcomes and their supporting process could subsequently be utilised as a blueprint, or guide, to delivering future work.

Although the project did not complete a social return on investment exercise, discussions with colleagues in Dundee and Lothian (who are also testing approaches to delivering advice in general practice settings) indicate similar results. Their findings present a return rate on investment of £39 for every £1 invested. Accordingly, the impact of the Deep End Advice Worker project and of the work in Dundee and Lothian should be of specific interest to commissioner and funding bodies seeking to maximise financial returns from their investment in advice provision.

It should be noted that partners involved in the project have recently secured funding to further develop the work in the east end of Glasgow. In total, nine practices in the east end of Glasgow will have an embedded advice worker by October 2017. An evaluation of the roll-out is expected in late 2018. Partners are also working with colleagues from Lothian and Dundee to develop a practitioner's framework, which intends to provide a series of non-prescriptive processes, practices and principles which could help inform the development of similar projects. This is due to be completed later in 2017.

It would also appear the approach adopted by the Deep End Advice Worker project has the capacity to contribute to the discussions regarding how the practical delivery of the recent Scottish Government commitment to delivering 250 'links workers' across Scotland, and the development of the Scottish social security agency, could operate in practice.

In particular, through viewing the links worker approach and delivery of advice in general practice settings, as two, complementary models, there may be opportunities to strengthen the provision of support for people in areas of high deprivation. Nearly half of the people engaged with the service have been referred onto an additional form of community support, which suggests there is some value in reframing the discussion from a binary either/or choice between a links worker and advice worker, to one which seeks to utilise their related skillsets.

In addition, the recent announcement of the structure for the new Scottish social security agency is particularly timely. The new agency will have a central processing function, complemented by a series of co-located, outreach services. It is envisaged that this approach will utilise existing infrastructure to deliver the face-to-face components of the agency. Considering the significant learning from the project on embedding services into the everyday practice of general practices,

there are clearly transferrable learning themes which could inform the implementation of the agency's outreach service.

## Conclusion

The complexity of healthcare settings, coupled with the complexity of poverty and its impact on the day-to-day lives of people would perhaps suggest a complex approach is needed to deliver advice in general practice settings. In fact, the Deep End Advice Worker project has demonstrated the value of simplicity. Through ensuring the service was built upon the experiences, expertise and knowledge of practitioners, the project complemented existing processes. Access to medical records allowed the advice worker to productively engage with GPs and better represent people. These regular engagements resulted in strong relationships between the advice worker and the general practices and better representation of individuals. In turn, the outcomes secured by the advice worker encouraged further engagement from GPs. The provision of non-partisan support helped partners and practitioners to identify where service improvements could be made through practical interventions.

Although the processes detailed above may not be tremendously complex, they are all dependent on the ability of people to productively engage with one another to identify and achieve shared goals. The project intentionally developed a structure that ensured people were able to contribute to its development as and when they saw fit. However, it is at this point the real complexity of replicating work of this nature becomes apparent. The skills and mindsets of individuals involved in this project and future endeavours are fundamental to their success. Subsequently, it is clear a strong appreciation and understanding of the importance of how people interact in the delivery of not only advice services, but all support services, is needed for future projects to achieve their desired impacts. Most importantly, work of this nature offers the opportunity to support people experiencing poverty, through the provision of expert advice in a venue which is accessible and trusted by local communities.

## Recommendations

The evidence presented in this report suggests there are clear opportunities for funders, commissioners, policy-makers and practitioners to consider, and where possible, act upon, the evaluative insight generated by the project. As a result, we recommend the following next steps:

- The methodologies adopted by the Deep End Advice Worker project (and the broader evidence base) should be further developed and tested in other geographies. Future interventions should focus on areas with high levels of poverty. However, it is important this geographic approach is layered with explicit consideration of communities disproportionately at risk of poverty (e.g. people with children, lone parents, certain ethnic minority communities and people with disabilities). Focusing future work in this manner will allow for a better understanding of how embedding advice into the day-to-day work of general practices can support particular target groups.
- Practice staff and advice providers should be involved to the greatest extent possible in the design, delivery and development of future interventions. Embedding their knowledge of the specific working environments, everyday practices, organisational cultures and even

patients accessing the service is vital to the development of the methodology. This will ensure the approach adapted by the project remains grounded in the locally specific contexts future projects are based within.

- Particular attention should be given to ensure the presence of advice workers based within general practices is normalised. Access to medical records, a designated consultation room from which to deliver the service and support to develop relationships within the general practices is fundamental to this process.
- The traditional role of advice workers should be reconsidered. The trust and goodwill advice workers develop with people offers them an opportunity to deliver a more holistic service. Advice workers should be supported to develop a broader repertoire of skills and knowledge, which will allow them to better understand an individual's social circumstances and aspirations. This will enable them to support people through both direct advice and into additional forms of support (e.g. employment, education and personal development programmes).
- The implications of the project should be considered in relation to current funding arrangements for advice services at a local and national level. Our findings, in conjunction with evidence from similar projects suggest that exploring the scaling up of advice provision in GP practices could increase the reach of advice services and reduce the non-clinical work of general practices. This process may not necessarily require additional funding, but rather, a realignment of current investment to deliver similar services to a broader population.
- Further work should be completed regarding the impact of the financial gain, debt identification and management, and cost reduction outcomes achieved by the project upon the day-to-day lives of patients accessing this service. Although feedback from the advice worker presents a particularly positive picture, a more in-depth understanding is needed.
- The value of individuals operating in a similar vein to the Building Connections programme manager should be considered and tested in different locations. In particular, further examination of the processes that the Building Connections programme manager adopted, the skillsets and characteristics required to operate in this role and the perceptions of practitioners they engage with is required to fully appreciate the value of this role.

## References

1. The Low Commission. *The role of advice services in health outcomes. Evidence review and mapping study*. London: The Low Commission; 2015.
2. Ashton J, Seymour H. *The New Public Health: The Liverpool Experience*. Milton Keynes: Open University Press; 1988.
3. Burrows J, Baxter S, Baird W, Hirst J, Goyder E. Citizens advice in primary care: A qualitative study of the views and experiences of service users and staff. *Public Health* 2011;125:704-710.
4. Dobbie L, Gillespie M. *The health benefits of financial inclusion: a literature review*. Glasgow: Scottish Poverty Unit; 2010.
5. City of Bradford Metropolitan District Council. *An evaluation of council funded services in Bradford*. Bradford: City of Bradford MDC; 2015.
6. Littler S. *Welfare benefits and a general practice: A study at Keppoch Medical Practice, Possilpark Health and Care Centre*. Glasgow: University of Glasgow; 2015.
7. London Health Network. *Welfare benefits advice through General Practices: A business case*. London: LHN; 2013.
8. Naven L, Withington R, Egan J. *Maximising opportunities: Final evaluation report of the Healthier, Wealthier Children (HWC) project*. Glasgow: GCPH; 2012.
9. Snowden A, Young J. *Evaluation of Glasgow: Improving the cancer journey programme*. Edinburgh: Edinburgh Napier University; 2016.
10. NHS Health Scotland. *Evaluation of the Links Worker Programme in 'Deep End' General Practices in Glasgow*. Edinburgh: NHS Health Scotland; 2016.
11. Watt G. *Deep End Report 25. Strengthening primary care partnership responses to welfare reform*. Glasgow: University of Glasgow; 2014.
12. Watt G. *Deep End Report 30. A role for Members of the Scottish Parliament in addressing inequalities in healthcare in Scotland*. Glasgow: University of Glasgow; 2016
13. Hopkins, N. *Evaluation of 'tackling money worries'*. Glasgow: Nick Hopkins Consulting; 2017.
14. Watt G. *Deep End Report 21. GP experience of welfare reform in very deprived areas*. Glasgow: University of Glasgow; 2013.
15. Welsh Government. *An assesment of the implementation of the 'Better Advice, Better Lives' scheme: Final report*. Cardiff: Welsh Government; 2015.

16. Derbyshire Citizens Advice Bureau. *GP Project Report 2015/2016*. Derbyshire: Derbyshire CAB; 2016.
17. Citizens Advice Bureau Liverpool South. *Advice on prescription project*. <http://www.southliverpoolcab.org.uk/index.php/en/about-us/2012-04-22-07-19-05/advice-on-prescription-project> (accessed September 2017)
18. Ross A, Myers F. Welfare rights advice in Primary Care. *Evaluation of the Aberdeen Model*. Edinburgh: NHS Health Scotland; 2016.
19. Greasley P, Small N. Providing welfare advice in general practice: referrals, issues and outcomes. *Health and Social Care in the Community* 2005;13(3):249-258.
20. Sherr L, Harding R, Singh S, Sherr A, Moorhead R. *Reducing poverty: welfare rights and health inequalities: a HAZ project. An evaluation of primary care based specialist welfare rights advice provision in Lambeth, Southwark and Lewisham*. London: HAZ; 2002.
21. Improvement Service. *Return on Investment: Welfare Advice in General Practice*. Edinburgh: Improvement Service; 2017.
22. General Practitioners at the Deep End. *GPs at the Deep End*. <http://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/> (accessed September 2017)
23. Watt G. *Deep End Report 27. Improving partnership working between general practices and financial advice services in Glasgow: one year on*. Glasgow: University of Glasgow; 2015.
24. Watt G. *GP use of additional time at Govan Health Centre as part of the SHIP project*. Glasgow: University of Glasgow; 2016.
25. Williamson A, Craig M. *Deep End Report 31: attached alcohol nurse Deep End Pilot (July 2015-2016)*. Glasgow: University of Glasgow; 2016.
26. Maclean G, Guthrie B, Mercer SW, Watt G. General practice funding underpins the persistence of the inverse care law: cross-sectional study in Scotland. *British Journal of General Practice* 2015;65(641):799-805.
27. Watt G. What can the NHS do to prevent and reduce health inequalities? *British Journal of General Practice* 2013:494-495.
28. Macintyre S. *Inequalities in health in Scotland: what are they and what can we do about them?* Glasgow: MRC Social and Public Health Sciences Unit; 2007.
29. NHS Scotland. *Health inequalities: What are they? How do we reduce them?* Edinburgh: NHS; 2015.

30. Understanding Glasgow. *Health, Disability, Overview*. [http://www.understandingglasgow.com/indicators/health/trends/disability\\_trends\\_scottish\\_cities/overview](http://www.understandingglasgow.com/indicators/health/trends/disability_trends_scottish_cities/overview) (accessed September 2017)
31. Walsh D, McCartney G, Collins C, Taulbut M, Batty GD. *History, politics and vulnerability: explaining excess mortality in Scotland and Glasgow*. Glasgow: GCPH; 2016.
32. Beatty C, Fothergill S. *The local impact of welfare reform*. Sheffield: Sheffield Hallam University, Centre for Regional Economic and Social Research; 2014.
33. Blaine D, Watt G. *Deep End Report 16: GP experience of the impact of austerity on patients and general practices in very deprived areas*. Glasgow: University of Glasgow; 2012.
34. Scottish Government. *Health and welfare reform*. <http://www.gov.scot/Topics/People/fairerscotland/HealthWelfareReform> (accessed September 2017)
35. Beatty C, Fothergill S. *The impact on Scotland of the new welfare reforms*. Edinburgh: Scottish Parliament; 2016.
36. Scottish Government. *Social Security for Scotland: Benefits being devolved to the Scottish Parliament – March 2017*. Edinburgh: Scottish Government; 2017.
37. Scottish Government. *A New Future for Social Security – Consultation on Social Security in Scotland*. Glasgow: Scottish Government; 2016.
38. Glasgow Centre for Population Health. *Response to the Scottish Government's consultation on Social Security in Scotland*. Glasgow: GCPH; 2016.
39. Scottish Index of Multiple Deprivation. *SIMD 2016*. <http://simd.scot/2016/#/simd2016/BTTTTT/14/-4.1982/55.8490/> (accessed September 2017)
40. Beatty C, Fothergill S. *The cumulative impact of welfare reform on households in Scotland*. Edinburgh: Scottish Parliament; 2015.
41. Understanding Glasgow. Profiles, Children and young people's profiles, Parkhead and Dalmarnock. [http://www.understandingglasgow.com/profiles/children\\_and\\_young\\_peoples\\_profile\\_s/1\\_ne\\_sector/21\\_parkhead\\_and\\_dalmarnock](http://www.understandingglasgow.com/profiles/children_and_young_peoples_profile_s/1_ne_sector/21_parkhead_and_dalmarnock) (September 2017)
42. Understanding Glasgow. *Children and young people's profiles*. [http://www.understandingglasgow.com/profiles/children\\_and\\_young\\_peoples\\_profiles](http://www.understandingglasgow.com/profiles/children_and_young_peoples_profiles) (accessed September 2017)
43. Chief Medical Officer. *Annual Report of the Chief Medical Officer. Population Health and Improvement Science*. Edinburgh: Scottish Government; 2012.

44. The Scottish Government. *The 3-Step improvement framework for Scotland's public services*. Edinburgh: Scottish Government; 2013.

45. Moon JA. *Learning journals. A handbook for reflective practice and development*. London: Routledge; 2006.

46. Leitch R, Day C. Action research and reflective practice: towards a holistic view. *Educational Action Research* 2000;8(1):179-193.

## Appendix 1: GP and practice manager interview topic guide

### **Deep End Advice Worker project**

The topics selected for this interview schedule are based on previous research on financial advice outreach in health/community settings. The questions are intentionally open and will be complemented with probing questions, dependent upon the response of the GP and/or Practice Manager.

### **GP and Practice Managers**

Q1) How do you refer people to GEMAP? *Probe for frequency of referrals and how they identify someone that may need financial support. Explore awareness of the services GEMAP offer.*

Q2) Tell me about your experience of this process? *Probe for positive/negative experiences. Explore impact upon their time and perception of value (i.e. do they see the benefit).*

Q3) Moving forwards, what do you think could improve access to GEMAP? *Probe for thoughts on how to improve the referral process (e.g. speed of access, data sharing, help identifying people that may be experiencing financial difficulties, staff training.).*

Q4) Any other thoughts or comments?

## Appendix 2: Advice worker interview topic guide

### **Deep End GP – Financial Advice Outreach Evaluation**

The topics selected for this interview schedule are based on previous research on financial advice outreaches in health/community settings. The questions are intentionally open and will be complemented with probing questions, dependent upon the response of the individual.

### **GEMAP Worker**

Q1) How do you receive referrals from the GP surgery? *Probe for experience of referral system, frequency and appropriateness of referrals, any difficulties encountered etc. Important to differentiate between GP surgeries if one worker covers both.*

Q2) Tell me about your experience of delivering financial advice from the GP surgery. *Explore relationships with staff, working cultures, staff knowledge of GEMAP services. Then focus on the actual engagement with clients (e.g. suitability of venue, levels of client engagement, feedback from clients).*

Q3) Moving forwards, what do you think could improve the outreach? *Probe for thoughts on how to improve the referral process (e.g. speed of access, help identifying people that may be experiencing financial difficulties, staff training etc.).*

Q4) Any other thoughts or comments?

## Appendix 3: GEMAP service overview



### **GEMAP – Services We Provide**

We are able to offer the following support to patients:

#### **Benefits: New Claims, Reconsiderations, Appealing Rejected Claims.**

*We work with people claiming benefits, including, but not limited to: Jobseekers Allowance, Employment Support Allowance and Personal Independence Payment (PIP). We can support people claiming Housing Benefit and Council Tax Reduction.*

#### **Debt: Organising Payment Plans, Working with Creditors, Household Bills.**

*We support people to manage and reduce their debt. This includes debt from credit cards, loans, payday loans, catalogue loans and other forms of debt, such as rent arrears, council tax and mobile phone bills.*

#### **Housing: Rent Arrears, Mortgage Arrears, Fuel Costs/Debts, Evictions and Homelessness Support.**

*For any housing issues, please speak to Robert. This is a broad area and he will be able to provide further information.*

#### **Budgeting: Financial Planning, Saving Plans, Affordable Credit, Opening Bank Accounts.**

*We offer specialist advice and training on money. We support people to help manage their money better.*

**We can also refer people to our partners, who help people get back into work through training courses, developing CVs, building computer skills, volunteering and apprenticeships.**

*Please note, once a patient has been referred, we will organise an appointment for our Friday surgery. If you have any questions, please contact Robert on:*

*Email:*

*Mobile:*

*Office:*





[www.gcph.co.uk](http://www.gcph.co.uk)