Improving partnership working between primary care and money advice services

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Preface

‘General Practitioners (GPs) at the Deep End’ are a group of GPs working in 100 general practices in the most deprived areas of Scotland; 76 of these practices are in Glasgow City.

Contents

Summary

The aim of this study was to explore how welfare reforms are affecting Deep End General Practices working in Glasgow City, and how they are responding to these issues. In particular, we were interested in how GPs work with money/welfare advice services, and how this partnership working could be strengthened to ensure that patients receive timely and effective advice and support. Interviews were conducted with six GPs working in some of the most deprived areas of the city; three NHS health improvement staff who have been supporting the delivery of advice services; and three commissioners of advice services from NHS Greater Glasgow and Clyde, Glasgow City Council, and the Wheatley Group, the housing, regeneration and care organisation.

KEY POINTS

Pressures placed on primary care as a result of welfare reforms and patients' financial problems

- The GPs reported that welfare reforms are harming the health and wellbeing of patients when their benefits are reassessed or payments are reduced or stopped. An absence or lack of money is having a particular impact on patients' mental health.
- Benefits issues generate considerable workloads for GPs, particularly when they are asked to provide evidence to support patients appealing decisions made by the Department of Work and Pensions (DWP).
- The GPs reported not having the time or resources to respond to requests for evidence. While some GPs provide information free of charge, others charge a fee. One GP stopped providing information in order to prioritise clinical work.

Supporting general practices to refer patients for financial advice

- GPs and other primary care staff are well placed as universal service providers to play a supportive role in addressing patients' financial problems. However, GPs differ in their approach with some making direct referrals to advice services while others use signposting.
- Efforts to increase GP referrals to advice services will require a referral process that is simple and non-disruptive during patient consultations. Health improvement staff are working towards simplifying the referral process for GPs.

- GPs suggested that other practice staff, such as receptionists and practice nurses, could refer patients to advice services. However, other staff may not have the knowledge of the types of local services that are available.
- A lack of clarity was identified among some GPs over which advice services can be trusted and which ones patients can be referred to.

Improving partnership work between primary care and other organisations

- When making requests for benefit appeal letters, it would be useful if advice services were specific about the evidence required from GPs to ensure an increased likelihood of positive outcomes for patients.
- GPs may be best placed to provide evidence for appeals on behalf of patients with longstanding mental health conditions that are being primarily managed by general practice. On the other hand, secondary care services, such as Community Addiction Teams, may be better placed than GPs to provide important information on how a patient's condition can affect their daily functioning.
- GPs would value feedback from advice services on the outcome of any referrals that they make. Knowing that patients were seen by an advisor, and whether there were any financial gains made as a result may encourage GPs to make more referrals in the future. Where GPs receive no such feedback, they may lose faith in advice services.
- It is important to build trust between GPs and advice services. Where advice workers are based in health centres, health improvement teams could act as a conduit to help foster relationships between advice services and GPs.

Challenges and opportunities to delivering advice services in Glasgow

- GPs were generally supportive of integrating advice workers within general practices, with some caveats about access to medical records.
- Commissioners of advice services and health improvement staff noted that it might not be possible to scale up an integrated model because of the number of general practices across the city.
- The funding of advice services remains a continuing challenge. For example, the funding contributed by the NHS comes from a non-recurring resource. However, additional funding opportunities are currently being sought to extend financial inclusion activities throughout Glasgow.

- Commissioners are conscious of the need for a more proactive approach on the part of advice services in order to target at-risk groups who may not attend regular drop-in services or outreach clinics.
- Increased demand is expected as additional welfare reforms take effect, such as the expansion of Universal Credit and continuing migration from Disability Living Allowance to Personal Independence Payments.
- The changes to disability-related benefits will have an especially large impact on Glasgow, which has the highest rates of sickness- and disability-related benefits claimants of any local authority in Scotland.
- Advice resources in Glasgow will be further stretched as efforts are made to reach groups who may not currently be engaging with services.
- The ongoing changes in the delivery and priorities of advice services in the city could provide opportunities to improve partnership work. The move towards a system of prioritising clients' needs and increased self-servicing online could free up workforce capacity to allow more 'face-to-face' time for complex cases.

Future work

- Partners from NHS Greater Glasgow and Clyde and the Wheatley Group continue to work with the Deep End GP project to support a demonstration project that involves co-location of an advice worker in two GP practices in north east Glasgow. Preliminary advice service data shows good service uptake and positive client outcomes.
- There are plans to devolve certain types of benefits, some of which have a health-related component, from Westminster to the Scottish Government and to set up a new Scottish social security agency in response to these changes. There is also commitment to recruit a sizeable workforce of Community Links Workers to support General Practices across Scotland.
- These forthcoming changes could serve as an important platform to bolster current efforts among primary care and advice services to address inequalities among the most vulnerable and excluded citizens.

Introduction

'General Practitioners (GPs) at the Deep End'[a] are a group of GPs working in 100 general practices in the most deprived areas of Scotland; 76 of these practices are in Glasgow City. In October 2013, GPs at the Deep End produced a report on their experiences of the UK government's welfare reforms in very deprived areas[1]. The report detailed GPs' concerns that welfare reforms were detrimental to the health and wellbeing of those affected.

One response to poverty and welfare reform in Glasgow has been the provision of money and welfare advice services (hereafter referred to as advice services). These services are commissioned by the Financial Inclusion Partnership (FIP), which consists of partners from NHS Greater Glasgow and Clyde, Glasgow City Council, and the housing, regeneration and care organisation the Wheatley Group. The FIP was founded in 2015 and aims to ensure that those most at risk of financial difficulties receive holistic services that meet their health, housing and employability needs.

In December 2013, the Glasgow Centre for Population Heath (GCPH) began working with Deep End colleagues to examine how primary care can strengthen connections with advice services to help mitigate the impact of welfare reforms in Glasgow. This involved organising and hosting two meetings that brought together colleagues from primary care, health improvement, universities, money advice services, and Glasgow City Council to develop effective responses to patients' financial problems in general practices. Two overarching outputs involved the production of Deep End reports that captured the journey between 2014 and 2015 of improving links between general practices and financial advice services in Glasgow[2,3].

There were three notable areas of work during this period that focused on reducing the time burden placed on GPs who are asked to provide reports for use by patients appealing against decisions made by the Department of Work and Pensions (DWP). Firstly, a Glasgow Deep End GP worked with the GCPH to submit a proposal to the Scottish Government's Health and Welfare Reform Development Fund. The proposal, which sought to develop software that would allow GPs to quickly produce reports to support patients' appeals, was unsuccessful. Secondly, a six-month post was created within Glasgow City Council to explore the use of medical information in appealing DWP decisions. This work emphasised the value of medical evidence in appeals, but also recognised how requests for such information put pressure on GP

[a] GPs at the Deep End project website:
http://www.gla.ac.uk/researchinstitutes/healthwellbeing/research/generalpractice/deepend/

practices. Finally, the GCPH supported a six-month sabbatical for a medical student to work in a Deep End GP practice, where she explored the interaction between general practice, advice services and the welfare system more broadly. This valuable work revealed the fragmented nature of partnership working between primary care and advice services, and highlighted the workload that welfare issues generate in deprived areas. One observation from this study was that it took approximately 47 minutes to complete an Employment Support Allowance (ESA) form, and 97 minutes to complete a Personal Independence Payment (PIP) form[4]. This work also led to the development of a toolkit for GPs in this practice that outlines local money advice services that patients can access, and provides information and resources on the benefits system for GPs.

Within this developing context, the GCPH undertook the present study, which involved Deep End GPs, health improvement staff working alongside local advice services, and the FIP commissioners involved in funding citywide services. The aim of the study was to explore the impact of welfare reform within Deep End practices, and how GPs are responding to this. In particular, we were interested in how GPs are currently working with advice services, and in how this partnership working could be improved in order help patients affected by welfare reforms.

Welfare reforms and health

Social security in the UK has undergone significant reforms since 2010. Examples of these include the replacement of Disability Living Allowance (DLA) with Personal Independence Payment (PIP), the introduction of a cap on the maximum amount of benefits a workless household can receive, and greater levels of sanctioning and conditionality on out-of-work benefits such as Jobseeker's Allowance (JSA) and Employment Support Allowance (ESA). Glasgow City will be especially affected by welfare reform, as figures from May 2014 show that the city has the highest proportion of sickness and disability and out-of-work benefit claimants of any local authority in Scotland[5]. In March 2015, a report submitted to the Scottish Parliament's Welfare Reform Committee estimated that welfare reform would result in the loss of approximately £239 million a year from Glasgow's economy, at a loss of £580 per working age adult[6]. This is the largest loss of any Scottish local authority. The report authors further note that as of Spring 2015, the full impact of welfare reform on Scotland had yet to take effect, and estimated that approximately 30% of the total financial loss to claimants in Scotland lay ahead. Moreover, a further raft of welfare reforms was announced in July 2015[7], which will cause even greater financial losses. Welfare reform therefore remains a pressing issue, the full extent of which is yet to be realised.

Welfare reforms are expected to have a negative impact on claimants' health, and widen existing health inequalities[8]. This is supported by anecdotal reports from GPs who describe how welfare reforms are harming patients' health and wellbeing[1,9]. A recent report of service providers' and service users' experiences in Glasgow further highlighted how issues such as benefits sanctions and disability assessments are causing considerable hardship and distress among those affected[10]. Moreover, researchers have reported a positive relationship between the number of Work Capability Assessments[b] being conducted within English local authorities, and increases in suicides, self-reported mental health problems and antidepressant prescribing within those areas[11]. The wider social impacts of welfare reform are also now beginning to come to light. Between the years 2010-13 for example, Trussell Trust foodbanks providing emergency food and support were more likely to open in local authorities where there had been greater central and local government cuts to welfare in the preceding 1-2 years[12]. Furthermore, the distribution of food parcels was greatest in those local authorities with higher rates of central government cuts to welfare and greater levels of benefits sanctioning.

Responding to welfare reforms in Glasgow City

The NHS Greater Glasgow and Clyde (NHSGGC) health board[c] has made significant investments into financial inclusion and mitigating the impact of welfare reforms. In Glasgow City, much of this work is supported by the Financial Inclusion Partnership (FIP)and the partnership is further supported by the Glasgow Advice and Information Network (GAIN), which consists of around 200 voluntary sector organisations. A key priority for the NHS has been to establish referral pathways between these advice services and health services, that NHS staff can use to refer individuals for financial and welfare advice. One example of this is the Healthier, Wealthier Children (HWC) project, where referral pathways were developed between early years staff, such as midwives and health visitors, and advice services to support pregnant women and families with children at risk of, or experiencing, poverty[13,14]. The HWC project was established in October 2010 and, as of February 2016, the project has resulted in approximately 10,300 referrals to advice services, with a total financial gain of approximately £10.8 million for clients.

Delivering welfare advice through general practices could have a number of positive outcomes for patients and GPs, such as: reaching a wider population who may not otherwise engage with mainstream services; legitimising advice and reducing

[b] The Work Capability Assessment (WCA) is designed to assess individuals' eligibility for out-of-work disability benefits. If individuals are found to be fit for work, then they are moved off out-of-work disability benefits. If individuals are found to have limited capability for work or for work-related activity, then they are moved onto Employment Support Allowance (ESA).

[c] NHSGGC comprises six local authorities, one of which is Glasgow City.

stigma; reducing the time GPs spend addressing benefits-related issues; and providing GPs with a tool for tackling some social determinants of poor health[15]. An example of close partnership working between primary care and advice services can be seen in NHS Lothian, where advice workers have been based in some general practices for over a decade and receive referrals from both practice staff and other NHS staff such as midwives and health visitors. The advisors are closely integrated within the practice and have access to the practice booking system and, with the consent of patients, medical notes[2,16].

In contrast to this integrated NHS Lothian model, in Glasgow there has been a low uptake of advice services within general practices in Glasgow. Between 2013 and 2014, 29,714 people accessed GAIN services, of whom 2,613 (9%) were referred via NHS-funded services. Only one in seven among the NHS advice service referrals were from GPs however (373 referrals) with a similar level among practice nurses (356 referrals).

Primary care in deprived areas

There is a strong correlation between financial losses caused by welfare reform and deprivation, where the largest losses are faced by the most deprived areas. The impacts of welfare reform are therefore concentrated in the areas where Deep End practices operate[17]. The GPs working in the most deprived areas of Glasgow recognise the role that general practice could play in supporting vulnerable groups affected by these reforms[3]. However, general practices in deprived areas are already tasked with managing high concentrations of long-term illnesses, chronic health problems, mental health problems, multi-morbidity – particularly co-morbid physical and mental health problems – and early mortality[18-21]. In addition, patients who attend deprived practices present with a greater number of psychosocial problems that they wish to discuss with a GP compared with patients in relatively affluent practices[18]. Despite this clear social gradient in health and social problems, the distribution of GPs and funding for general practices is flat across Scotland; practices operating in deprived areas do not receive additional resource to match the greater levels of clinical need within these areas[20,22]. Consequently, consultation durations are shorter in deprived areas, patients experience lower levels of enablement and practitioners report higher levels of stress[18].

In summary, there is a stark discrepancy between the level of need in deprived areas and the resources allocated to general practices working in those areas. This in turn restricts the potential for general practices to address health inequalities[23]. Therefore, any referral system from general practice to money advice services is unlikely to be successful if it places additional demands on GPs' time[3].

Study aim

The aim of this study was to explore how welfare reforms are affecting Deep End practices in Glasgow, and how GPs are responding to these issues. In particular, we were interested in how GPs work with advice services, and how this partnership working could be strengthened to ensure that patients receive timely and effective advice and support.

Method

Participants

Three groups of participants were interviewed: six GPs who are currently working in some of the most deprived areas of Glasgow; three NHS health improvement staff who have been working on supporting the delivery of advice services throughout Glasgow; and three commissioners of Glasgow's Financial Inclusion Partnership (FIP), which is responsible for commissioning and delivering advice services in the city. The commissioners have senior roles within NHSGGC, Glasgow City Council and the Wheatley Group.

Procedure

Semi-structured interviews were conducted with all 12 participants. The interviews were conducted between June and July 2015.

The content of the interview schedules was adjusted for each group of participants to reflect their professional roles and remits. The GPs were asked about how welfare reforms have affected their patients, how these issues have impacted their working practice, and how they currently respond when patients' present with financial difficulties or benefits issues. The FIP commissioners and health improvement staff were asked about how welfare rights advice is currently delivered throughout the city at a strategic level. All of the participants were also asked about what could be done to improve referral rates from primary care advice services, and whether money advice staff should be located within general practices. The topic guides used in the research are available in Appendices 1-3.

The aims of the research were described to participants prior to each interview, after which participants provided consent to take part. All of the interviews were recorded and later transcribed. Due to the small sample size and concerns over protecting the participants' anonymity, all participants were provided with an initial draft of the results and were given an opportunity to request that any information be removed.

Data analysis

Each interview was fully transcribed, and the data were analysed using a thematic analysis approach. Each transcript was read through once, after which an initial set of codes were generated and applied to the data upon subsequent readings. The aim of the analysis was to produce a rich description of the entire dataset, and so codes were applied throughout each transcript in order to capture as many features of the data as possible. These codes were then reviewed to search for patterns of shared meaning, and subsequently sorted into potential themes that captured these

similarities. The content of these themes was then reviewed, to check that the codes located within each were suitably similar so as to be included under the same heading. Similarly, the themes were compared against one another to ensure that the content of each was different enough as to justify them being labelled as separate themes.

Study findings

Four main themes were identified: the pressures placed on primary care as a result of welfare reforms and patients' financial problems; supporting general practices to refer patients to advice services; improving partnership working between primary care and other organisations; and the challenges of delivering advice services in Glasgow.

1. Pressures placed on primary care as a result of welfare reforms and patients' financial problems

Patients' financial problems and health

GPs described how changes to patients' benefits – such as benefits being reassessed, or benefits being withdrawn through sanctions – are a major source of distress for patients.

> *"…there are people who are getting sanctioned because they don't turn up for their interviews and they just have no money, and that is pretty disastrous. On top of that a lot of people are having their benefits that used to be DLA [Disability Living Allowance] reviewed, so their rates are being reduced to lower rates, or they're losing their mobility component. So suddenly they just have so much less and the cost of living hasn't really got significantly less."* [GP 1]

> *"I think probably the biggest one, and the most common, is people coming in and saying that they are on benefits already and they're being stopped, or they're being re-assessed, or they're being changed … they have a real fear, a genuine fear, that their money is going to be stopped and there's going to be a gap. And often there is. People then have physically no money and they come in and say 'What am I going to do?'. And the effect on their mental health is horrendous."* [GP 2]

> *"We have seen patients being taken off [benefits] where we, as professionals, completely disagree … and also a lot of patients were taken off benefits with mental health issues who are not supported through the process, who are just from one day to another told, "You can work," and it just puts them back a stage, and that increases our consultation times."* [GP 3]

In addition to problems with benefits, GPs also referred to the relatively high levels of deprivation and unemployment within the areas in which they work, as well as issues such as in-work poverty and debt.

Additional workloads generated by patients' financial problems

Issues pertaining to benefits and patients' financial problems create additional workloads for general practices, particularly when requests are made for GPs to provide supporting evidence for benefits appeals. These requests are frequent and come from several sources, including advice workers, housing organisations and patients themselves.

> *"On a daily basis we are… asked for letters of support for benefits and for appeals and for gardening, letters to mow the lawn and all of these sorts of things. We're being swamped by non-NHS work."* [GP 4]

Another GP described the frequency with which they are requested to complete Employment and Support Allowance (ESA) forms:

> *"Most days I would get one of these, maybe not most days, maybe two or three days a week you would get one of these; they're a frequent thing. Appeals and more in-depth reports are less frequent in numbers."* [GP 5]

This additional workload places significant pressure on primary care, and GPs reported lacking the resources needed to adequately respond to these challenges. Moreover, some of this work is not a contractual requirement of GPs, such as when patients themselves request letters to support appeals. General practices differ in their response to these non-contractual activities; some provide patients with supporting letters free of charge, while others charge a fee in response to the volume of requests that are received and the associated workload.

> *"We're advised that we shouldn't be writing appeal letters but we're in a deprived area, we've got a degree of humanity. We still write letters and we do them free of charge because it's in the interests of our patients and I don't see why they shouldn't get help. But it's a lot of work, and we have to be quite careful now. We used to do them when somebody said 'Can I have a letter?' but now we tend to say to them, 'Speak with somebody, see what you need, see when your appeal's coming up, and we'll try and help you.'"* [GP 2]

> *"We do usually make a small charge for them [letters] and it really is a disincentive ... or to make sure people really actually want it ... because if we said yes to everyone we would be absolutely swamped."* [GP 1]

Furthermore, where GPs are able to provide letters of support the time constraints that they work under may limit the quality of information that they are able to provide. As one GP describes:

> *"… I've got ten minutes. I pull out the paper and I scribble something on it and it's not targeted, it's just: 'What do I know about this patient? How's it affecting their function? Here's two sentences.' … and I think, 'Shame on you. Surely they need something more than that,' but I don't have the time."* [GP 5]

The time taken to produce letters of support may also detract from important clinical tasks. One GP reported how they had previously been able to provide letters for patients in the past, but had recently revised this policy in order to provide adequate medical care for vulnerable patients.

> *"… our workload has gone up even in the last year so tremendously that I'm now saying we can't do letters unfunded anymore, and even funded I can't do them because I can't extend the time I'm here, and we have to close the doors… ideally it probably should be in the GP workload, but if I have to look at our resources and weigh it up with an elderly patient with cancer who is sitting at home and hasn't been visited for months, then I'm now at a point where I say... because we have done so many letters in the last three years I notice how many patients we haven't visited and should have visited, and I now say, 'we have to prioritise,' and it's cruel."* [GP 3]

2. Supporting general practices to refer patients for financial advice

The role of primary care in supporting patients with financial problems

The FIP commissioners and health improvement staff all saw primary care as playing an important role in assisting patients with financial problems.

> *"…health is a universal service and it's well used by people living in poverty, it is probably the most effective universal mechanism to have contact. So that's what makes it relevant."* [Commissioner 1]

GPs also acknowledged the importance of adopting a social model of health, and of understanding the wider context of patients' lives.

> *"I think it's important that we ask those holistic questions, and I think as a doctor you should know about things that are upsetting the patient, like the relationship problems, or bereavements, drugs, alcohol, and benefits."* [GP 5]

Adopting a social model of health can be difficult for GPs however, and some may opt not to focus on patients' social or economic circumstances.

> *"…because they [GPs] perceive that they can't really do much to change it, they probably, for understandable reasons, choose to keep that stuff in the background and choose to deal with the stuff that they can deal with."* [GP 6]

Moreover, patients may not choose to volunteer information about their financial circumstances during consultations, and so these issues may not be raised if GPs do not ask patients direct questions.

> *"I think there's a lot of shame and stigma around money often it's only when they're directly asked about it will people talk about it, and even then I get a sense that people are keeping that stuff buried. I think it's quite a shameful thing to tell someone they work with that they don't have money."* [GP 6]

Some GPs emphasised how their role is to provide medical support. As such, much of the workload that is generated by patients' financial problems was argued to be outside of the role of the GP. This in turn was viewed by some GPs as being an inefficient use of their training and expertise.

> *"We are the sponge of the NHS … we fill all the gaps and so contractually, yes, a lot of the stuff we do is non-contract work. Morally we do it because if we don't do it no one else is going to do it … It's an inefficient use of our expensive time because we do cost money, doing stuff that a money adviser could do."* [GP 4]

Referring patients to money advice services

Rather than dealing directly with patients' financial problems, all study participants saw the role of primary care staff as being to direct patients toward money advice agencies who would be able to provide specialised support. One health improvement worker for example described how they have been trying to:

> *"[encourage] staff to understand that they're not expected to have any expertise in this; trying to make it as simple as we can and encouraging them to make the referrals."* [Health Improvement 1]

GPs described how they currently use a mixture of both signposting and making direct referrals for patients to see money advice staff.

> *"I think we will always be the first point of contact … We are their advocates and it's very difficult for a lot of our population to actually have the knowledge base and the information … And I think we will always have to accept the role of 'Oh right, yes, this is a problem, this is who you need to see' and signposting and being very clear about it and having good links."* [GP 4]

Other GPs described referring patients directly on to money advice services.

> *"The service I use most is the NHS money advice, because it's easy to refer to: it's just putting a sticker on and sending it off…"* [GP 3]

There were several issues identified that may prevent GPs from making these referrals however. For example, one GP stressed the importance of having a clear and simple referral pathway.

> *"So there's [money advice agency]. We can email them … we've got the template on our computer there … and we've pre-filled the template with our practice data to try and make it quicker … but our Links Practitioner*[d] *helps with that, because there was a problem about emailing. Somebody didn't have an NHS.net email, and I think [health improvement] is aware of that, so there's these kind of blips in the system. Now, with a Links Practitioner, we're kind of getting some of those things ironed out, but if you can imagine: I run late in surgeries anyway, having that at the end of the day and filling in, and, "Where was that?" "Who did I send that to?" it's very difficult."* [GP 5]

Another GP – who does not routinely refer patients to advice services – described the referral process as being "cumbersome" and suggested that taking time to locate and complete the necessary form during surgery time has the potential to disrupt consultations.

> *"…if you've got someone that's got money problems, they're often anxious and you're mindful of the dynamic of the consultation and you want to remain empathetic and engaged."* [GP 4]

For this GP, signposting patients onto money advice services is preferable to making referrals, as it is a simpler process that may also promote further engagement with services.

[d] The National Links Worker Programme is a Scottish Government-funded project that aims to explore how general practices can support people to live well in their communities. Community Links Practitioners work with general practices to help people access community assets and resources. See: http://links.alliance-scotland.org.uk/

> *"… a self-referral … It's got two things. One of them is that it's straightforward, it's simple. It also gives people the challenge of actually engaging themselves… If they can't even do that, they're not going to engage with the help that they've been given. So self-referral… from our point of view, works better."* [GP 4]

Patients who are signposted to advice services and consequently make a self-referral will not be included in referral figures, meaning that the referral data likely underestimates the number of clients who access advice services through primary care. This is particularly evident in open access drop-in services.

> *"…we are underselling ourselves because it [referral data] is not capturing the open access and I know that lots of people are signposted … and a lot of GPs will send people round, because it works for GPs."* [Health Improvement 2]

Another barrier to GPs making referrals to advice services may be a lack of awareness regarding the referral systems that have been developed within the city. As one GP explained:

> *"I believe they have a referral form but I've never seen one … they might even be in our software somewhere, but we've not really ever been aware of them."* [GP 1]

Health improvement staff have been working to identify and address these issues in order to make referral processes as simple as possible.

> *"…the whole purpose of this… is the urgency with which you get somebody to the help that they need; so you have to… make it as easy and accessible as possible. So a lot of energy in this part of the process has been around trying to get that set up."* [Health Improvement 1]

Much of this work has focused on redesigning and simplifying referral forms, and in developing IT systems to support referrals. For example, one health improvement worker described how the money advice referral form has now been placed on the desktop computer of all GP practices in some areas of the city. Health improvement staff also described how adding money advice referral forms to SCI Gateway[e] may be a helpful prompt for GPs to ask patients about their financial concerns, as well as making it easier for GPs to make referrals to advice services.

[e] SCI (Scottish Care Information) Gateway is a national IT system that integrates primary and secondary health care systems.

GPs also discussed how other members of the practice staff – such as practice nurses and reception staff – could play a role in supporting patients with financial problems, through either signposting or making referrals to money advice services. One advantage of adopting such a model is that it would remove some of the workload from GPs.

> *"…because we are now struggling with appointment time and we have so many ill patients, that as much as we can signpost before they reach us, the better."* [GP 3]

The extent to which staff will be able to undertake such work will be dependent on their knowledge of advice services however, which may be limited in some practices.

> *"I don't think our practice receptionists know enough about it. The practice nurse does, and she is certainly advising the people to go to Citizens Advice or [money advice agency]."* [GP 2]

> *"They [reception staff] have a role. Whether they do it or not is variable. I think it all depends on local knowledge. I don't think they are overall guilty of not using the full breadth of the services that are available to us because they're not at the tip of our fingertips. The stuff that you use every day, you just go, 'Ah, it's that', 'the number for this is that' and you often just work within that sphere."* [GP 4]

The importance of readily accessible information was cited as being important for all practice staff, including GPs.

> *"…the information that I use and the most useful is laminated and it's on the board in front of me. Literally all the numbers are there and that's how we still work … if it's not literally on your fingertips it's almost useless. It just doesn't get used. And then by not using it, it becomes redundant."* [GP 4]

In particular, one GP noted how cards that provide the minimum amount of information for patients can be helpful in this sense.

> *"…the thing we find really helpful in our practice is cards with information, that's badged, that's clear, that's trustworthy. One example I would give is that over the years the Sandyford – who are a sexual health service that are citywide – have got really onto that, and they've got a logo that stands out, they've got a minimum amount of information for people with low literacy skills, which is what is needed in the context I work in and in any Deep End practice we know that from the evidence is something that just says right*

here's the phone number, here's the office hours, here's where to go if you're needing advice about XYZ." [GP 6]

Health improvement teams across the city are promoting advice services within general practices, although it may be that alternative methods may be more effective or more likely to have an impact within general practices.

"…we have circulated stuff. We've done newsletters, we've done core briefs. We circulate information I would say fairly regularly. I don't know if it's just a case of it's a volume thing for GPs, and their staff in terms of just not getting through it all, or scanning or, or it's just on the periphery for them. It's hard to know." [Health Improvement 3]

3. Improving partnership working between primary care and other organisations

Preparing supporting information for appeals and benefits applications

Improving partnership working between advice services and primary care may help to lessen the pressures placed on GPs by requests for information to support appeals or benefits applications. Some GPs reported that it would be helpful to receive guidance from advice workers on the types of information that would be most helpful to support patients' cases. One GP described how they have already attempted to develop a template of sorts to support this type of work with the help of a colleague from Social Work:

"I went to speak to [Social Work colleague]. But he couldn't take it forward unless my patient was appealing through him … [but] he was also very knowledgeable about the rules and I thought, "You're the sort of person that you could tell me" – "Can you say this?" and I can say, "Yes, that's the truth, and I can write it," … so I didn't get anywhere with it, which was a great pity." [GP 5]

Another GP described receiving a report from a previous patient's appeal, which outlined why the appeal had been successful. This GP has referred to this information when preparing subsequent letters for patients, in order to maximise the likelihood that the appeal would be successful:

"…when I'm doing another appeal … I use the words which they accepted before to say 'This person has difficulty in social situations' and 'This person can't …'. And I've got tick boxes of my own so I know which bits you get your

points for and which bits you don't. I've had to do that with working it out myself and somebody maybe could have told me." [GP 2]

These examples illustrate how some GPs improvised strategies to help them respond to requests for medical information. The potential for strengthened partnership working was also recognised by commissioners and health improvement staff, who likewise recognised the challenges of doing so.

"…we think there is enough capacity there in the information and advice sector. It is being smarter around how we work together and how we join up … but that is the hardest job to do." [Commissioner 3]

"…what can the sector advice worker do to support the client, but also to advise the GP, so that we're getting successes and taking the pressure away – at least so that the piece of work the GPs are actually doing is actually going to be meaningful, and the effort that they put in is actually going to be useful, at the end of the day." [Commissioner 2]

One example of where there could be greater links made between primary care and other organisations was raised by a FIP Commissioner, who noted that Links Workers could be better connected to social housing landlords:

"…even with the Link Worker post, they don't take in housing which is a missed opportunity, we think, because if you are talking about a Link Worker role attached to the practice, you can refer to your landlord as well as the money and advice sector which would help join things up for us too. We feel that there can be a lot of strength in partnership. I think we are just at the beginning of that." [Commissioner 3]

There are some potential difficulties between trying to create better partnership working between advice agencies and primary care however. For example, although targeted requests for specific forms of information may help GPs to provide letters of support for patients, there are some areas where GPs may not be able to provide evidence, such as patients' daily functioning.

"Money advice often send [us] letters asking us for information on things that we cannot give: things like, "Can this person cook a meal?" "Can they do this?" "Can they do that?" and we can't answer those questions… we can't possibly say what the patient's function is like over a longer distance, over a day, over cooking their dinner or making a cup of tea. So there is a wee bit of unrealistic expectations, we feel, from money advice because they're looking

for the things obviously that will trigger the patient getting benefit, and a lot of those we can't answer." [GP 1]

This raises the issue of whether GPs are always the most appropriate professionals to seek evidence from, or whether advice services could link into other social or health services.

> *"I do appreciate that having to provide letters… is quite an ask. GPs are not always the people who need to be asked… sometimes your contact is not with your GP at all: it's with your consultant, it's with a psychiatrist, and they're not being asked – it all goes back to the GP. The GP's not seeing you so all he really knows is 'that condition and that medication', that's all. There's a bit of, are they always the right people, or should that load be shared a bit with other professionals who are providing ongoing support?"* [Health Improvement 1]

Moreover, at a strategic level, there may be scope to broaden the range of services that are involved in financial inclusion work in the city:

> *"…We see it [primary care] as a kind of a front door for health services … but there are other areas that we want to try and connect in to as well. So, if you think about some of the mental health teams, the many addictions teams, some of the other work, it's not just all about what comes through the door in primary care."* [Commissioner 1]

Providing feedback to GPs on the outcomes of advice referrals

Improving communication between GPs and advice services may be one method of encouraging referrals within primary care. Some GPs described receiving positive feedback from patients following advice, although this may only be apparent if the GP follows up directly with the patient.

> *"I think of one patient who got money paid back for quite a long time and she was extremely grateful, and that helps me then to engage with them, and look how else I can then bring them forward, or support them, or engage with health issues again."* [GP 3]

> *"..they'll [patients] often not tell me spontaneously. I will say, "What about, you were worried about this?" "Yes, I'm starting to work through that," so, yes, I know that they're [money advice services] very helpful."* [GP 5]

Another GP on the other hand described how the only feedback that they receive is from patients who are dissatisfied with advice services:

> *"We probably get more of the complaints but that is, I would think, because the people whose problems get sorted out don't necessarily come back and tell us that."* [GP 1]

The lack of feedback from advice services on the outcomes of referrals may discourage GPs from making future referrals. One GP for example described how referrals to NHS-funded advice services do not appear to result in any positive outcomes for patients.

> *"…this referral system has not worked for me, to my knowledge… it's been a dead loss for us, as far as I'm aware … patients never hear from them. We will ring them [advice service] up and say 'What's happened?' and they'll say 'Oh we tried to phone somebody a couple of times now.' If I then phone the patient and say 'They've tried to get you' my patients will say 'No, no I never got it.' So there's some breakdown in communication somewhere, but I don't know if people don't answer their phones because they don't know who it's going to be, or I don't know if letters just go awry but the communication between them… And we never hear anything back from anybody saying 'Oh that worked out.' Ever."* [GP 2]

This highlights how valuable feedback from advice services may be to ensure GPs continue to refer onwards. In particular, it would be helpful for GPs to know how the referral was acted upon, and whether the patient was seen by a money advice worker.

> *"…we need to get feedback, even just to say 'I'm dealing with this.' It doesn't have to be a long letter, it doesn't have to explain all the ins and outs because we don't want to know it. Or this person's going to appeal and in due course we'll be looking for something from you."* [GP 2]

GPs may lose confidence in advice services if they are not provided such feedback, which could in turn discourage future referrals:

> *"I wouldn't say I don't use it [NHS money advice services], but you don't get the [referral] number from me that you could be getting, and the reason for that is, I've got no faith in it."* [GP 2]

Health improvement teams are currently working on delivering feedback to GPs on the results of referrals. Importantly however, it will only be possible to provide feedback on referrals as opposed to patients who are signposted toward money advice services.

Building trust between primary care and advice services

Health improvement staff and service commissioners discussed the importance of building trust between general practices and advice services, and it was recognised that GPs are unlikely to refer patients on to services that they do not know or fully trust. This reflects an issue with how these services are promoted and branded within primary care, which could partly be addressed by communicating clearly to GPs which advice services are being funded by the Financial Inclusion Partnership.

> *"…there does seem to still be confusion with GPs with who to trust, who to refer to, and I think that's something that this partnership actually does need to address … One of the GPs last year said that because she's familiar with the brand 'CAB', she felt they were trusted – she could refer to them – but she didn't know about [advice services] although she'd been given a leaflet – but she didn't know if she could trust them."* [Commissioner 2]

Building trust between staff can be difficult however. Another health improvement lead for example emphasised the importance of softer communication skills among advice staff working in health centres, and how these help to foster partnership working with GPs.

> *"I don't think … that there is [always] that consistency in terms of the relationship building and softer communication skills that are probably needed. Particularly for GP practices, because I think they are quite impenetrable at times. I think you do need a good set of skills to make that work."* [Health Improvement 3]

Furthermore, health improvement staff could play a role in helping to foster these relationships between advice services and general practices.

> *"…we need the [advice service] staff to be talking to all the staff, whether we use our own health improvement staff to be a bit of a conduit … I think they almost need that kind of nurturing and introduction, a bit more support probably from our team to make that happen."* [Health Improvement 3]

4. Challenges and opportunities to delivering advice services in Glasgow

Co-location of advice workers within primary care

All of the participants were asked for their views on a model of advice service delivery in which advice services are co-located in primary care, and advice staff are integrated members of the practice team. This approach allows advice staff access to patients' medical records in order to provide medical evidence for appeals and benefits applications.

GPs were largely supportive of co-location of advice services and primary care, although some points were raised in relation to advice staff being able to access medical records. In particular, one GP questioned whether patients are always aware of what information is held on their medical record, while another suggested that any access to medical records would have to be filtered.

> *"…as long as consent's given, I don't have any concerns about advisors having access to [patients' medical] records. I suppose a slight caveat with that is that patients don't always know what's on their record."* [GP 6]

> *"I think that sort of thing in reality is probably fine, but in principle is fraught with difficulties… there's big issues about sharing GP information. This wouldn't be unfettered access to all medical records, I suspect that this would be access to certain information."* [GP 4]

The FIP commissioners and health improvement staff also discussed the feasibility of implementing aspects of the NHS Lothian model across Glasgow, but cited the number of general practices in the city as a reason why this particular model would not be transferable.

> *"I think there's only something like 80, 90 full-time equivalent staff throughout the whole sector – advice centre staff – plus volunteers, so it's just not scalable for 160 general practices."* [Commissioner 2]

Moreover, if such a model were to be pursued in Glasgow, it would require funds to be diverted from other areas of financial inclusion that successfully reach populations that general practice may not.

> *"…if you did that, which would take more than… we currently commit, you wouldn't be doing Healthier Wealthier Children because usually those families don't come through from GP practices, they come through from maternity services and other services. You would be concentrating everything on that*

> *GP approach and I'm not sure that is the best way to work. I think they are an important element but they are not the only element of the NHS so, and the scale of Glasgow makes it very difficult."* [Commissioner 1]

Rather than place advice workers in specific general practices, the strategy in Glasgow has been to deliver advice services in health centres that host several practices. The main advantage of this approach is that it provides a wide spread of advice resources, although it lacks the integration that would be achieved by attaching advisors to specific practices.

> *"…I have only got a small amount of money… that is why we have gone with the health centres because you get the biggest buys for your money."* [Health Improvement 2]

> *"…what you could probably end up with is something not too dissimilar to what we have now, which is that for one afternoon a week or a couple of days a week you have an advisor that's servicing all the practices in that health centre… in Glasgow, apart from in South Glasgow, most of our GPs are in health centres and the health centres are massive… then of course it wouldn't feel like it belonged just to that one practice, it would be shared, and then you lose some of that connectivity."* [Commissioner 1]

Moreover, one health improvement lead also noted that some practices are not within health centres, and are located in relatively isolated parts of the city. Focusing on health centres may therefore make it more difficult for these practices to engage with advice services.

Funding the provision of advice services in Glasgow

Each of the FIP commissioners cited financial inclusion as being a priority, but also described how the funding of advice services continues to be an issue. Much of the funding that has been contributed from the NHS for example is non-recurring which raises challenges over how this work will be supported in the future. Furthermore, the Wheatley Group have only committed one year's funding to the FIP, with future funding being contingent on the outcomes of an evaluation of the partnership. One FIP Commissioner also described how the level of funding from Glasgow City Council has remained constant since 2014 and has been guaranteed for the next three years, but also explained how the demand for advice services in the city is expected to grow over time, particularly as a result of welfare reforms.

> *"…Universal Credit is probably the big one that everybody's been waiting for, whereby we could end up seeing more demand on advice services, and we need to find ways of delivering more for the same amount of money…"* [Commissioner 2]

Resources may also be further stretched as efforts are made to reach more vulnerable populations who currently do not engage with money advice services.

> *"…they [money advice services] need to move away a little bit from just being whoever comes through the door first, which is the way they have tended to work because… there's a lot of people with a lot of need [that] will not come to your door... The equality data isn't always great in terms of showing that they are reaching all parts of the population so that's a key challenge moving forward."* [Commissioner 1]

In particular, the FIP has identified seven priority groups for advice provision within the city. These are: people under the age of 25; victims of domestic abuse; individuals experiencing homelessness; mental health service users; people from black and minority ethnic communities; in-work poverty; and financial capability. Future work for the FIP will involve looking at the needs of these groups and any potential barriers to them accessing services at the moment, with a focus on developing new models of service delivery.

> *"I think we now have a great opportunity to look at the services from a client perspective and make sure that it is fit for purpose because there are outreaches that people don't turn up at. The drop-ins work okay. There are referrals that people don't engage in. There is signposting that doesn't happen. These are big, big warning signs for me which means this sector needs to operate differently."* [Commissioner 3]

While the budgets of all partners are constrained, there are additional funding opportunities that could be used to support this work, such as the European Social Fund (ESF).

> *"…what we're currently working on is the chance to try and bring in ESF funding into the city – one of the strands of European Social Funding money is poverty and social inclusion money, which we're going through the application process for at the moment… and if we're successful in getting ESF money in that would help us target the most complex people, and that was one of the challenges we wanted to take on, because we know we're not doing enough for them."* [Commissioner 2]

In addition to seeking extra funds, the commissioners also described how advice services could be delivered differently in order to support a greater number of clients. One approach to this is the modernisation of the advice sector in Glasgow, which is currently set up to primarily deliver face-to-face support. A particular change will involve providing more forms of advice and information through various different channels that allow advisors to spend more time assisting clients who have more complex needs.

> *"…at the moment, probably, a lot of the advice sector is geared towards giving face-to-face – so I think in the future we need to do more triaging around who can self-serve – which customers can actually do things for themselves and what other ways can we get information to them – so can we do things more online for them so that we're left with the people who are the most complex getting face-to-face service? …that's probably one of the best things that we can do in terms of dealing with the greater number of people."* [Commissioner 2]

There are also opportunities to improve the delivery of face-to-face advice services. Within some areas of the city for example, advice services in health centres are moving away from open access drop-in services, in recognition that some clients who attempt to access these services do not have positive experiences. For example, one health improvement lead described how some patients arrive at these sessions only to be turned away and asked to attend another time. Therefore, an appointments-based system has been tested in some health centres, where clients are triaged into appointments via telephone contact in the first instance. This allows advice services to prioritise emergency cases, and ensure that clients who most need help are seen quickly.

More generally, there are also challenges associated with how each of the organisations works together in partnership. The housing commissioner suggested that there is currently enough capacity within the advice sector in Glasgow, and that the main challenge is how to better co-ordinate the activities across these groups:

> *"We feel that there can be a lot of strength in partnership. I think we are just at the beginning of that. There wasn't much achieved in the last three years around those partnerships and sharing information and being closer together because, controversially, we think there is enough capacity there in the information and advice sector. It is being smarter around how we work together and how we join up. That is the hardest, it sounds very simple, but that is the hardest job to do…"* [Commissioner 3]

Finally, there may be scope to extend the range of partners working on financial inclusion at a strategic level in the city.

> *"…what is interesting is that it's only housing, health and council finance services that are round the table because we've put money in, but actually there's lots of other partners who could have a much bigger role in all of this… that is under developed because they never put any money in or you know, it's almost like you've got to put your money in to have a stake at the table. The reality is, we were round the table before we ever put our money in, and we probably wouldn't have put our money in if we hadn't been round that table first, building that relationship. So there is a bit of thinking more broadly about some of the partnership members that you would want to really take financial advice services forward…"* [Commissioner 1]

Discussion

The aim of this study was to explore how welfare reforms are affecting Deep End GP practices in Glasgow, and how GPs are responding to these issues. In particular, we were interested in how GPs work with advice services, and how this partnership working could be strengthened to ensure that patients receive timely and effective advice and support. The main themes identified in this study were the pressures placed on primary care as a result of patients' financial and welfare concerns, the role of GPs and primary care, how partnership links could be strengthened with advice services, and the challenges associated with delivering advice services in Glasgow City.

Primary care pressures

GPs described how welfare reforms and benefits issues are having a negative effect on the health and wellbeing of patients. This picture is consistent with previous reports from GPs at the Deep End[1], and with findings from a national survey of GPs, where 68% of respondents reported that their patients' health had been harmed by reductions in benefits[9]. This study's findings are also consistent with previous qualitative research conducted in Glasgow, which highlights how issues such as benefits sanctions and undergoing Work Capability Assessments are causing considerable hardship and distress among those affected[10].

GPs further described how benefits issues generate considerable workloads for general practices, particularly when GPs are asked to provide medical information to support patients who are appealing DWP decisions. Within this small sample of GPs there was variation in the response to these requests, with some providing patients with letters of support for free and others charging a fee. One GP also explained how they are no longer able to provide these letters because the volume of requests has become so large that it was beginning to detract from their medical work.

Again, this echoes the wider experiences of GPs; in a national survey of GPs, 94% of respondents reported that their workload has increased as a result of their patients' financial difficulties[9]. Much of this additional work comes from completing Employment Support Allowance (ESA) and Personal Independence Payment (PIP) forms, which were estimated to take up to 47 and 97 minutes to complete, respectively[4]. These administrative issues will only become more pressing in the future, as more individuals in cities like Glasgow migrate from Disability Living Allowance (DLA) to PIP. This presents a significant challenge, as of August 2015 there were 30,130 working-age recipients of DLA in the city, aged 16-64[21]. This process will generate a substantial administrative workload for general practices, and

may also increase the demand for appeals evidence should patients receive adverse decisions during their reassessments.

Crucially, the burden of financial losses as a result of the welfare reforms in Scotland are concentrated in deprived areas where Deep End practices are operating[17]. As a result, these reforms will generate greater workloads in Deep End practices compared with more affluent practices. This additional work is on top of the higher levels of health and social problems that Deep End GPs are already tasked with managing[18-21]. Furthermore, the distribution of GPs is flat across Scotland, and general practices operating in deprived areas do not receive additional funding to match the greater level of clinical need[20,22]. This is an example of the inverse care law[f], which limits the extent to which GPs will be able to respond adequately to patients' benefits issues and financial problems.

Supporting advice referrals

As increasing pressure is placed on primary care, it is clear that any referral pathway from general practices to advice services must be straightforward, non-disruptive to consultations and require no additional work from GPs. Although local health improvement teams in Glasgow have invested considerable efforts into establishing such a system it appears more could still be done, as the GPs interviewed here described quite different experiences of making referrals. Where one GP described the referral process as being simple, another felt that it was cumbersome and a third was not aware of any referral form to advice services. There were also differences in how GPs preferred to guide patients toward advice services, which involved using a mixture of making referrals and signposting. Furthermore, while it was acknowledged that other staff members in general practice, such as receptionists and practice nurses, could play a role in referring patients to advice services, GPs noted that these staff may not possess the information necessary to do so. Similarly, one of the FIP commissioners highlighted that GPs may be confused as to which advice services can be trusted and therefore, which they felt they could refer patients to.

One suggested means of simplifying referrals was to include advice referral forms on the SCI Gateway national IT system. This issue has been raised previously, and a local GP subcommittee recently concluded that such a template would increase workloads and introduce an additional step to accessing advices services. Self-referral approaches, similar to those adopted by NHS physiotherapy and smoking cessation services, and staff signposting were considered more effective by this

[f] The inverse care law was suggested in 1971 by Julian Tudor Hart in a paper for *The Lancet.* It describes a perverse relationship between health care need and actual use. In other words, those who most need medical care are least likely to receive it. Conversely, those with least need tend to use health services more, and more effectively. See reference 18.

subcommittee. However, an important issue to consider in this regard is whether moving towards self-referral and signposting could introduce inequalities in accessing advice services. For example, patients with co-morbid physical and mental health problems and psychosocial problems, such as literacy challenges[g], may be less likely to approach these services by themselves.

Improving partnership working

There is considerable scope to improve partnership working between primary care and other organisations. Some GPs described how it would be helpful to receive guidance from advice services on which forms of evidence would be most effective in triggering a successful appeal for patients. There was recognition that GPs may not always be best placed to provide information on how a condition affects a patient's daily functioning and that others, such as Community Addiction Teams providing secondary care, may be better placed to provide comment. On the other hand, there are some forms of information that GPs are well placed to provide, such as information on those patients with longstanding mental health conditions who are being primarily managed by general practice.

Providing GPs with information on referral outcomes may help in building their confidence in advice services and encouraging them to make referrals in the future. In particular, GPs could be given salient feedback such as whether advice agencies were able to contact patients, whether patients had taken up the referral, and on any financial gains made as a result of the referral. The form that this feedback takes is important however; at a recent partnership event, a Deep End GP commented that the most helpful feedback on outcomes should be brief[2]. Such audit information is currently collected by local health improvement teams, who provide some feedback to practices on the outcomes of referrals.

In addition to collecting information on the numbers of referrals being made to advice services, it is also important to consider the extent to which this activity is meeting the level of need. This could be achieved by estimating the numbers of individuals who would benefit from advice services but who have not been referred to these services. For example, in the context of Healthier Wealthier Children, health improvement teams in Glasgow City have previously used local birth rate and child poverty data to estimate the numbers of money advice referrals that health visitors would be expected to make over time. Comparing these data against the numbers of referrals that were actually made provides some sense of how well the service

[g] The Scottish Survey of Adult Literacies (2009) found that 26.7% of the population may face occasional challenges and constrained opportunities due to their literacies difficulties, but will generally cope with their day-to-day lives[24].

matches the levels of need. Without capturing data on the estimated numbers that are not accessing advice services, it will be difficult to evaluate how effectively the system is operating or how it could be improved.

Challenges and opportunities

In principle, GPs were largely supportive of advice services being located within general practices, similar to the integrated model of co-location that operates in NHS Lothian. The FIP commissioners and health improvement staff suggested that under the current level of resources it might not be possible to scale up the integrated Lothian model across the 148 general practices in Glasgow City, of which 76 are Deep End practices. Due to the scale of the challenges, to date the adopted approach in Glasgow has been to deliver advice services in health centres that host several general practices. This has the advantage of providing a wider spread of advice service coverage across the city, but it may result in a loss of connectivity between advice service staff and the practices within health centres. Health improvement staff could support advice service workers in this regard, in order to foster relationships with GPs and encourage joint working between advice services and general practices.

There may be a need to test if an embedded approach to providing advice service coverage across Glasgow's Deep End practices is achievable or not. The experience of service commissioners in Edinburgh suggests that a practice with a population of 10,000 patients can be served by an advice worker embedded in the practice for two days per week[2]. While there are a greater number of Deep End practices in Glasgow compared with Edinburgh, the Glasgow practices are typically smaller and the combined list size of the 76 Glasgow practices is approximately 320,000 patients. This provides an indication of how much resource would be required to provide advice coverage across Glasgow's Deep End practices.

The continued funding of advice services was identified as an issue by each of the FIP commissioners. In recent years for example, the NHS has funded the provision of advice services in Glasgow through the Keep Well programme, which was introduced in 2010[h]. Primarily designed to provide health checks to individuals aged between 40 and 64 living in areas of high deprivation, Keep Well also offered interventions designed to address social issues, such as employability and advice services. The programme has since been discontinued, with funding being tapered off with an aim to stop in 2017. These funding challenges will become especially pertinent over the next few years as further welfare reforms, such as the expansion of Universal Credit take effect, and the demand for advice services grows.

[h] For more information see NHS Health Scotland's website page on the Keep Well programme: http://www.healthscotland.com/keep-well.aspx

Resources are also likely to be stretched further as the FIP partners work toward better serving priority groups, such as under-25s and people experiencing mental health problems. Additional funding sources such as the European Social Fund are being explored to address these challenges. Moreover, the modernisation of advice services could also help them deal more effectively with increasing workload demands.

A minority Scottish Government led by the Scottish Nationalist Party (SNP) was elected following the May 2016 parliamentary election. Recognising that Scotland's most deprived communities need additional support, the SNP manifesto pledged to recruit at least 250 Community Links Workers to work in GP surgeries and direct people to local services and support. These new workers are a potential resource that could be used to help address access to advice, and also to support advice services to work more effectively within general practices.

Future changes to social security in Scotland

A range of UK social security powers are due to be devolved to the Scottish Parliament. With these new powers, the Scottish Parliament will have autonomy over a number of benefits for carers and people with long-term illnesses and disabilities, including DLA and PIP. Given the substantial health component to these benefits, any changes that are made will likely have repercussions for general practices, and Deep End practices in particular. Therefore, there will likely be opportunities in the future for general practices, and particularly Deep End practices, to influence the development of Scotland's new social security agency, which will oversee the delivery of devolved benefits and which aims to emphasise the principles of dignity and respect and to support a fairer approach to social security that tackles inequalities. These important welfare changes may also present opportunities to address the funding challenges faced by Deep End practices, to ensure that they are best able to support patients engaging with social security systems.

Future work

The GCPH is continuing to work with the GPs at the Deep End and Glasgow's FIP to explore how advice services can connect with general practices to ensure that patients receive timely and effective financial support. Two FIP partners – the Wheatley Group and NHSGGC – along with the GCPH, the Deep End project, the University of Glasgow, are supporting a funded demonstration project. This project involves locating an advice worker once a week in two Deep End general practices in north east Glasgow. This project builds on the learning that has been generated from partners' work to date[2]. The project brings together GPs, practice staff, funders, patients and advice services to trial innovative methods of delivering real-time

support to some of the most low income households in Glasgow. Key approaches include co-location of services, addressing organisational barriers and empowering partners to work differently, with an emphasis on learning from real life experiences. The demonstration project is also exploring whether links can also be made between local job centres and GP practices to improve outcomes, such as putting money in people's pockets and providing access to services to some of the most vulnerable and excluded groups in Glasgow. This demonstration project provides an opportunity for trialling methods of joint working among the FIP, and is generating further learning on how to better integrate the delivery of advice services in primary care. Early data show promising outcomes for patients involved in the demonstration project.

While the focus of this work has been on primary care, it is important to remember there are other sectors that also have routine contact with individuals who would benefit from advice services. Future work should explore which sectors beyond health services, that advice services can be connected with, in order to maximise the number of individuals who receive financial support when it is needed. As advice services cannot be feasibly co-located within every service, there is a need to identify which services should be given priority for integrated advice services and how these services can be connected most effectively. Widening advice provision to other sectors may also help to lessen the pressures faced by GPs, as patients are more likely to receive assistance before the point at which they access primary care.

Conclusion

Welfare reforms and financial problems are detrimental to patients' health, and generate additional workloads within primary care. Moreover, there is a risk that the pressures on primary care will become greater in the future as welfare reforms continue to be rolled out across Glasgow, such as the migration from DLA to PIP. This is in addition to the already high concentration of social and health problems that Deep End practices manage, and the fact that practices in deprived areas receive less funding that the Scottish average.

While the GPs interviewed in this study described quite different experiences of referring patients to advice services, there is scope to consider streamlining and simplifying existing referral systems. Partnership working between general practices and advice services could also be strengthened. For example, providing GPs with feedback on referral outcomes may help to build trust in advice services and encourage additional referrals. Audit information on the numbers of individuals who have not been referred to advice services would also be helpful in evaluating how well the system is meeting the level of need. Additionally, there are models of good practice which could be built on, and further tests of change, such as the pilot currently being conducted by the NHS and the Wheatley Group in Glasgow City, should be carried out to provide potentially replicable models.

Important challenges do exist in relation to the current NHS funding of advice services in Glasgow. However, we are witnessing emerging opportunities in Scotland with the devolution of benefits that have a substantial health component, establishment of a new social security agency, and commitment to recruit a sizeable workforce of Community Links Workers. The changes to the GP contract are another opportunity to address the nature of this demand in general practice, and the way in which general practice is resourced in proportion to need. These important changes could be a platform of opportunities that help strengthen ongoing efforts to address inequalities among primary care and advice services.

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Appendix 1. Service commissioner interview topic guide.

Commissioner topic guide	
Background	• Could you briefly describe your current role in the financial inclusion partnership? o What resources have you contributed to the partnership? What services do these provide? • Given the current climate of budget constraints, welfare reform, in-work poverty etc., what do you think are the big challenges over the next 3 years for financial inclusion partnership delivery?

Current practice	• As you may know, Glasgow City is estimated to be hit by the biggest losses through welfare reform of any local authority in Scotland. In particular, people with health conditions stand to lose the most through changes to IB and DLA/PIP. Given these challenges, what role do you think that your organisation can play in helping people to access money advice?
	  o What role do you think that the other partners in the financial inclusion partnership can play in helping people to access money advice?
	• We know that a lot of people who are affected by welfare reform, benefits issues and other money worries are currently in contact with their GP, and that benefits issues and money worries are especially concentrated in general practices that serve the most deprived communities. On the other hand, we also know that referral rates from GP practices to money advice services has been low to date.
	  o Do you have any ideas on we could improve referral rates from GP practices to money advice services?
	  ▪ Are there any successful models of referral processes from other areas that you're aware of that might be helpful?
	• From the Deep End reports, we know that GPs working in deprived areas face an increase workload due to the more

	complex health needs of their patients, in addition to the additional work generated by dealing with patients' benefits issues and money worries. e.g. in addition to signposting patients to money advice, GPs are also asked to help with appeals, write letters of support etc. o Do you think that the model of partnership working could be reconfigured in some way to alleviate some of the pressures that general practices face? o Are there any other groups who could be targeted to pick up some of this work? e.g. Social Work, mental health services, addictions. • (*Describe Lothian model of placing advice workers within the practice*) how feasible would it be to work toward a model like this in Glasgow? • (*Show financial inclusion partnership model diagram*). What role do you think these structures have to play in strengthening links between primary care and money advice services to ensure that we're reaching some of the most vulnerable in Glasgow who use this service?

Appendix 2. Health improvement staff topic guide.

Health improvement topic guide	
Background	• Could you broadly describe the role that you play in relation to the financial inclusion strategy, at both a local and city wide level? o Are there any particular themes or activities that you are working on at the moment?
Current practice	• I'd like to think about the recent referral patterns from general practice staff (*show referral numbers data*) • What do you think are the most important factors underlying the relatively low numbers of referrals that have come from general practice staff to date? • Do you think that any of these issues are especially pertinent to Deep End practices, or are there any other issues that you think Deep End practices might uniquely face? • I'd like to hear your views on advice services that receive NHS funding, in particular, where and how they are delivered. To what extent do you think that the current model of delivery is working effectively? o Does this model need to be revised? If so, how? • Can you give any examples of good practice, or successful partnership working between advice services and general practices in your area? •
Future work	*(Recap suggested reasons as to why referrals from general practices have been low.)* • How do we address these challenges? What changes to existing delivery are required to improve links between general practice and advice services? o Could any of these suggestions to improve partnership working be of particular help to Deep End practices? o Is there anything additional that could be done to promote financial inclusion in Deep End practices? • Glasgow's financial inclusion contract has recently been revised. Specific groups and themes have been identified as priorities over the next three years: under 25s, domestic violence, BME,

	mental wellbeing, in-work poverty, housing and homelessness, financial capability. What are your views on the current and future role of general practices in supporting the of these priority groups in particular? • *Follow up priority groups identified by participant* – how could general practices be supported to play a role in addressing the needs of these priority groups? • It is recognised that Deep End practices face particular challenges, such as patients with complex needs, working in areas where benefits issues are concentrated and feeling stretched for various reasons. How could links be established or developed between these practices and others supporting the financial inclusion priority groups? What additional support would be required? • (*Describe Lothian model of placing advice workers within the practice*) how feasible would it be to work toward a model like this in Glasgow?

Appendix 3. GP topic guide.

GP topic guide	
Background	• What are some of the most common money worries that patients present with when you're holding surgeries?

Current practice	• What do you think your role as a GP is in supporting patients with money/ welfare problems?
	  o What is the role of other staff working in the practice – other GPs, practice nurses, receptionists, etc.
	• Are you aware of the money advice services operating in this area?
	  o Do you have any experience of working directly with money advice services/ aware of any joint working between the practice more generally and money advice services?
	• Have you helped patients to access money or welfare advice services? How?
	  o Do you have any sense of how helpful these services are for patients? *Have you ever heard back from a patient that you referred?*
	• What other kinds of things do you currently do to help patients with money/welfare issues?
	  o Helping patients to apply for benefits and reassessments (DLA to PIP).
	  o Helping with appeals
	  o Anything else? (e.g. *foodbank referrals, help with welfare fund applications, advocacy etc.*).
	• (*reiterate money worries and activities undertaken by GP*). How do these issues and the resulting workload that they cause impact on how you work with patients?
	• How do these issues and the workload collectively impact on the running of your practice and surgeries?
	• Thinking about the work that you're already doing in response to your patients' money worries, do you think that any of these activities are outside your remit as a GP?

	• If yes, who would be better placed to take these on?
Future work	• Deprivation and money worries place additional workload on GPs, but there are no additional resources provided to meet this greater need (*repeat some issues mentioned by participant*). o In this context, what could be done to help GPs to refer patients on to money advice services? ▪ (*leaflets, paper/online referrals, training and awareness raising, protected learning*). o Applying for benefits or reassessments? o Helping with appeals? • What do you think the ideal model of working between primary care and money advice services would look like? o What could be done to help strengthen the relationships between money advice and primary care to achieve this? • The financial inclusion partnership for the next three years has identified seven priority groups (*show list of groups*) do you think that general practice has any current or future role in supporting these groups? • (*Describe Lothian model of placing advice workers within the practice*) how feasible would it be to work toward a model like this in Glasgow?