The 'go to' organisation for local government improvement in Scotland

Welfare Advice and Health Partnerships 'Test and Learn' Programme

What We Have Learned So Far

August 2024

Scottish Government
Riaghaltas na h-Alba
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improvement service

Executive Summary

Welfare Advice and Health Partnerships (WAHPs) provide access to welfare rights and money advice services in GP Practices. This involves a Welfare Rights Advisor, providing regulated and accredited advice services, becoming a member of the Practice Team with consensual access to medical records.

Scottish Government provided funding for two years to nine local authorities and Health and Social Care Partnerships to establish WAHPs in 150 GP Practices in areas of Scotland that were experiencing social and economic deprivation.

The Improvement Service was asked to evaluate the effectiveness of this 'test and learn' model of service delivery. To achieve this a mixed methods approach was used.

The evaluation found that :

- 89% of individuals accessing advice in their GP surgery had not previously sought advice
- Over 16,000 individuals used the service and made financial gains of £23 million
- 23% of the total financial gain was as a result of awards of Adult Disability Payment
- 38% sought advice because they were unable to work for health reasons
- 22% needed help with council tax debt
- Over 50% of individuals had a household income of less than £20,000 and 27% had a household income of less than £10,000
- 98 % of staff in participating GP Practices thought that the approach offered multiple benefits to both staff and patients
- 75% sought advice in their GP Practice because it was suggested by practice staff
- Individuals reported improved mental health wellbeing and reduced stress as a result of getting advice in their GP Practice
- Almost 50% of individuals had a disability or long term health condition

Advice providers, GPs and individuals all viewed the provision of welfare rights advice in GP surgeries positively.

“It’s a marvelous service. It’s made a huge difference to my mental wellbeing.” (Patient)

“Where staff should be is where communities need advice - in GP practices.” (Advice Provider)

“In an ideal world this would be implemented in all GP Practices. No changes to essential elements are required, just further roll out.” (Local Authority)

“We all know that socio-economic stressors will often manifest as physical symptoms - if this saves even one GP appointment per week its working as it should.” (GP)

Contents

Introduction

Welfare Advice and Health Partnerships (WAHP) integrate local authority, or third sector, welfare rights and money advice services into primary care settings. This is done by the inclusion of a dedicated Welfare Rights Advisor (WRA) who has consensual access to medical records, as a member of a GP Practice Team.

By providing regulated and accredited advice services in a non-stigmatised setting, which usually involves referral by a trusted member of the medical, or an allied, profession WAHPs are able to offer a delivery model which supports earlier intervention and engages individuals who would be unlikely to use 'traditional' advice services. There is supporting evidence that demonstrates the multiple benefits this approach to service delivery offers to funders, providers of both health and advice services and individual patients/ service users.

To explore in more detail the benefits offered by this model of service delivery, and to identify the feasibility of delivering the approach on a national basis, Scottish Government funded a two year 'test and learn' programme.

The Welfare Advice and Health Partnerships 'Test and Learn' Programme

(1) Background

150 GP Practices were originally identified as being eligible to take part in the Welfare Advice and Health Partnerships 'Test and Learn' Programme (the Programme) on the basis of both levels of deprivation (assessed using the Scottish Indices of Multiple Deprivation data) and size. This exercise was carried out by Public Health Scotland. Of the 150 GP Practices that were identified, 50 already had established WAHPs and received continuation funding from April to October 2021 to enable them to take part in the programme without any break in service delivery. These GP Practices were located in the areas covered by Inverclyde, Dundee and Glasgow local authorities. The two-year programme started in October 2021 and ended in December 2023. During this time period a staggered approach to start dates was required to allow sufficient time to secure agreement from the GP Practices, recruit staff and establish governance arrangements.

In July 2022, funding was announced to support the expansion of the programme into a further 30 GP Practices in rural and island areas. The Improvement Service (IS) mapped both spatial and SIMD data and identified a long list of 50 eligible GP Practices from which 30 agreed to participate. Findings from the evaluation related to these GP practices are not included in this report. A final report containing a more detailed analysis at local authority level and considering any difference in approach between rural and urban areas will be produced late Autumn 2024.

(2) Approach

The programme consisted of providing access to a dedicated WRA in each of the eligible GP Practices for around a day a week. The advisors were managed by either a local authority or third sector advice agency.

The funding provided by Scottish Government to support this was distributed through local authorities or Health and Social Care Partnerships (HSCPs) on the basis of a grant agreement which included set reporting requirements. Regular meetings took place between lead officers in local authorities and HSCPs and the Improvement Service (IS) to review progress and provided an opportunity for both parties to raise any concerns.

To enable WRAs to enter GP Practices as members of the team, the IS supported the establishment of locally based WAHPs which reflected the needs and preferred approach of each area. This resulted in minor variations in both the membership and operation of these partnerships in individual areas.

As most of the participating GP Practices operated as independent contractors it was necessary to secure agreement from the outset with each potential participant. The form of the agreement again varied from area to area. The contribution from wider health services, as will be considered later, could be both a barrier and an enabler.

In relation to both establishing WAHPs and engaging with GP Practices there is no single approach that will suit all but there are some key principles that can offer guidance. Details of these can be found on a dedicated web page hosted by the IS.

The concept of WAHPs was introduced some years before the pandemic, at which point, access to services was primarily face to face in the GP practice or in the patient's home. Changes in the way GP services are now accessed has necessitated changes in the way practice-based advice is offered. After the pandemic, virtual access routes increased in prevalence and although such routes have steadily reduced in the last year three years, over a quarter of all appointments in GP Surgeries take place at a distance. The approach now taken is that the advisor will provide services in the same way as other members of the practice team i.e. - by phone, home visits and face to face in the GP practice.

(3) Participating Local Authorities/HSCPs

The following local authorities/ HSCPs took part in the original programme.

- Dundee City Council
- East Ayrshire Council
- Edinburgh HSCP
- Glasgow HSCP
- Inverclyde HSCP
- North Ayrshire Council
- North Lanarkshire Council
- Renfrewshire Council
- West Dunbartonshire Council

Despite originally agreeing to participate, two GP Practices in Fife and two in Renfrewshire were unable to commit to the programme. In Fife, whilst the GP Practices wished to continue participating, the service provider was unable to support the programme. In Renfrewshire, of the four eligible GP Practices which had agreed to participate, two subsequently indicated that they did not have capacity to include the service at this stage. Several meetings were held to highlight the benefits of the service and to explore how the issues might be addressed but ultimately these were unsuccessful. After nine months, at regular review meetings, it became clear that in three GP Practices (two in Glasgow and one of the two remaining in Renfrewshire) referrals to the WRA were either non-existent or at a very low level. Following discussions, it was agreed that resources would be re-allocated to ensure that the service was offered to, and used by, those in need. Given that the programme was time limited, doing this on a geographical basis was considered to be the most effective way of quickly establishing new WAHPs. In identifying new potential GP Practices that could be speedily included in the programme both advice provider capacity and level of GP engagement were carefully considered. There were several other GP Practices in Glasgow in which referral rates were lower than expected. Improvement plans were put in place by Glasgow HSCP to address this with a degree of success.

Given that c93% of all eligible GP Practices maintained participation in the programme there can be a degree of confidence that the service is perceived to offer value to primary care services.

Evaluation

(1) Health Benefits

Two separate reports have been produced on the health benefits that are delivered by the programme.

(i) Briefing paper

This sets out supporting evidence of the effectiveness and experiences of welfare advice services co-located in health settings. A systematic review[1] reported that by addressing the social determinants of health, there are both direct and indirect improvements to patients' health and well-being. The review also found that, in addition to significantly improving patient's financial situation and financial security, access to welfare advice services co-located in health settings also improved patients' knowledge about financial issues, the law and welfare rights.

By being able to access welfare advice in a healthcare setting, patients felt a greater sense of confidentiality and trust in the welfare rights advisor. The review suggested that health services and healthcare professionals often have unique access to vulnerable individuals which can assist in identifying the need for advice among their practice population, thereby mitigating poverty and reducing health inequalities.

The findings of the systematic review are similar to those in this evaluation.

(ii) Findings from a survey of GP Practices

This was carried out in 2023 and can be accessed on the Improvement Service website. 98% of staff from those GP Practices who responded to the survey thought that delivering access to advice in their practice offered multiple benefits both to staff and patients. Staff were able to discuss issues related to benefits, that they would not previously have discussed, because they were able to confidently make referrals to a trained and knowledgeable professional.

Patients could get advice that they would otherwise have been unlikely to access in a safe, confidential and non-stigmatising space.

There is compelling evidence of the time saved by staff to focus on clinical issues. A little under a quarter of all respondents said that having an embedded WRA

1 Reece S, Sheldon TA, Dickerson J, Pickett KE - Soc Sci Med. (2022). *A review of the effectiveness and experiences of welfare advice services co-located in health settings: A critical narrative systematic review.*

in their GP Practice was likely to save them between 30 minutes and an hour a week which equates to about three and a quarter days a year. The time this frees up can be used more effectively on addressing individuals' clinical issues.

In addition, potential health benefits from an individual perspective were considered as part of the Customer Journey Mapping process which is set out on page 25.

In the course of interviews, the majority of patients reported, that following support from an advisor, they experienced improvements in their levels of anxiety, depression, insomnia, and stress, plus a reduction in the number of panic attacks they had previously experienced.

> *"I hadn't been sleeping before I saw the adviser as a result of stress and worry. As soon as I walked out of the appointment, I felt a massive relief. That night was the best sleep I'd had in ages because the adviser explained everything to me and helped with all the claims I needed."*
>
> *"I suffer from fibromyalgia, arthritis, stress, and anxiety. Stress makes the symptoms of my fibromyalgia and arthritis worse, and I had been getting flare ups because of the worry about my situation. After the appointment with the advisor, I felt so relaxed my symptoms got better as I wasn't so stressed anymore. It was a massive relief."*

Anecdotally a number of patients reported no longer having suicidal thoughts.

> *"I think about my life more positively. I was suicidal but not anymore.'"*

(2) Methodology

The evaluation has collected both quantitative and qualitative data.

All advice providers were required to return both types of information for each GP Practice using a set template. This had a dual purpose. Firstly, to confirm the extent to which the service was being provided so that any issues could be quickly discussed and addressed and, secondly to evidence the impact of

the programme. Quantitative data was collected to identify who was seeking advice and why, the route through which advice was delivered and any resultant financial gains. In the period covered, 16,367 individuals have accessed advice services in their GP practice and in excess of 30,000 cases have been opened. The total number of cases is likely to be much higher, but this has not been consistently recorded.

It should be noted that one individual may be entitled to numerous benefits. For example, a successful claim for Attendance Allowance may lead to entitlement to Council Tax Reduction and Pension Credit. Establishing entitlement to a benefit can take a considerable amount of work. Although the patient may have been assisted to make all the claims that were identified as a result of the advice intervention, it may be recorded as one individual rather than three separate 'matters' or types of support. As a result, the number of cases recorded may not fully reflect the complexity of the work undertaken. Similarly, an individual may be assisted with a range of issues such as claiming benefits, dealing with problem debts and resolving housing problems. This may be recorded as one individual or three separate cases depending on the advice providers recording system. This is further illustrated in the case studies section.

It was agreed that an iterative approach to evaluation would be taken, and following the first set of data returns, discussions took place with advice leads to try to refine the recording template and resolve any outstanding issues. As the data in these initial returns was not consistently reported, and in some cases was incomplete, the results from the first quarter do not feature in the evaluation findings. This means that there is likely to be a level of underreporting. To help with the analysis of the large data sets involved an analytical support tool, power-bi, was used.

The majority of advice providers were using one or the other of two case management reporting systems (CMRS) - AdvicePro or CASTLE. Several meetings took place with representatives from Advice UK and Citizens Advice Scotland, who have responsibility respectively for each system, along with advice providers. The purpose of the meetings was to ensure that the data in the required template was collected consistently, and the reporting requirements could be achieved with minimal effort. Despite the time and resource spent on doing this there were ongoing issues with the quality of some of the data that was provided. Ultimately this was resolved, and Advice UK was particularly helpful and responsive.

As well as the quarterly data returns, advice providers also produced an annual case study for each GP Practice and a very brief overview report. Templates were provided to assist with this and to ensure that there was a degree of consistency in the approach taken to reporting.

To try to identify the benefits from the patient or client perspective in depth customer journey interviews were carried out. These considered the client or patient views on the accessibility and responsiveness of the advice service and also tried to identify the impacts in relation to individual health. Whilst preliminary results have been included in this report, further interviews are planned, and the final results will be included in the subsequent report.

To support both service delivery and the evaluation process, regular meetings were held with advice leads. In addition, four open sessions were arranged to bring advice leads together at which they could share challenges and examples of effective practice.

A more detailed report of the methodological approach adopted, and the materials used, and accompanying guidance notes provided is available on request.

(3) Findings

The findings draw on both quantitative and qualitative data. Each is considered separately. The quantitative data is drawn from the quarterly monitoring report and details the number of participants in relation to key metrics. It should be noted that 'other' and 'not recorded' have been excluded when calculating the percentages depicted in the charts on subsequent pages. The metrics are:

- Previous access to advice services
- Demographic information
- Inward referral source
- Reason for seeking advice in the GP Practice
- Drivers for seeking assistance
- Channel through which advice is accessed
- Type of debt
- Financial gains

The qualitative data is drawn from the customer journey maps and the case studies provided for each GP Practice.

There are further sections that consider the following:

- Outward Referral Routes
- Benefits applied for and awarded
- Barriers and Enablers

Quantitative Data

(i) Previous access to advice

One of the most striking features of this method of offering access to welfare rights and money advice is the extent to which it is used by individuals who have not previously sought advice. c89% of all individuals accessing advice services in their GP Surgery had not previously sought advice.

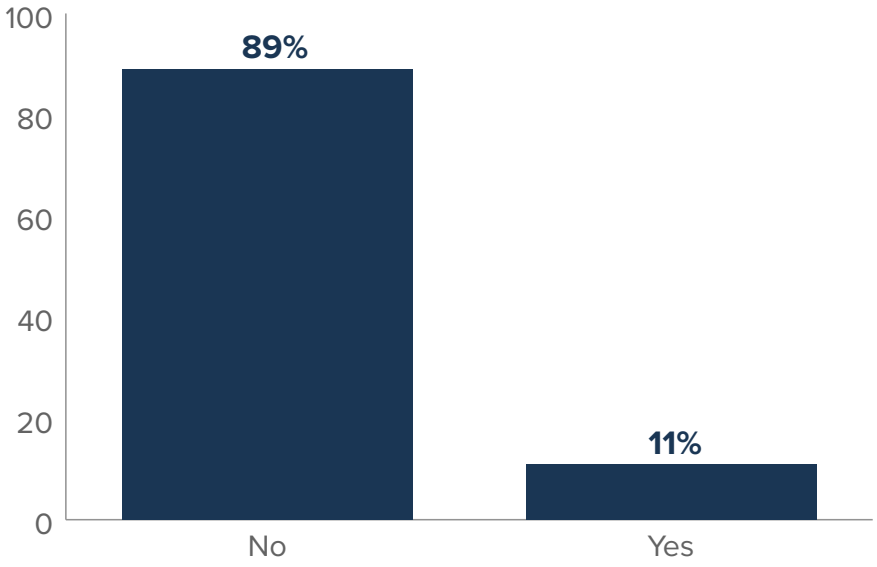


Figure One. % of individuals who had not previously sought advice services

When looking at the effect of demographic factors there was a high level of consistency across all groups. There were two exceptions. Slightly lower numbers of individuals in the following groups were first time seekers of advice services - 73% Caribbean or Black individuals and 78% of individuals who were homeless or in temporary accommodation. However, it should be noted that the number of individuals with these demographic characteristics was small. Large families with several children were more likely not to have previously sought advice in comparison to single parent families with several children.

(ii) Ethnicity

White individuals are by far the largest group seeking advice, however proportionally the numbers are almost 10% lower than in the wider population in which 96% are white.[2]

2 Ethnicity | Scotland's Census (scotlandscensus.gov.uk)

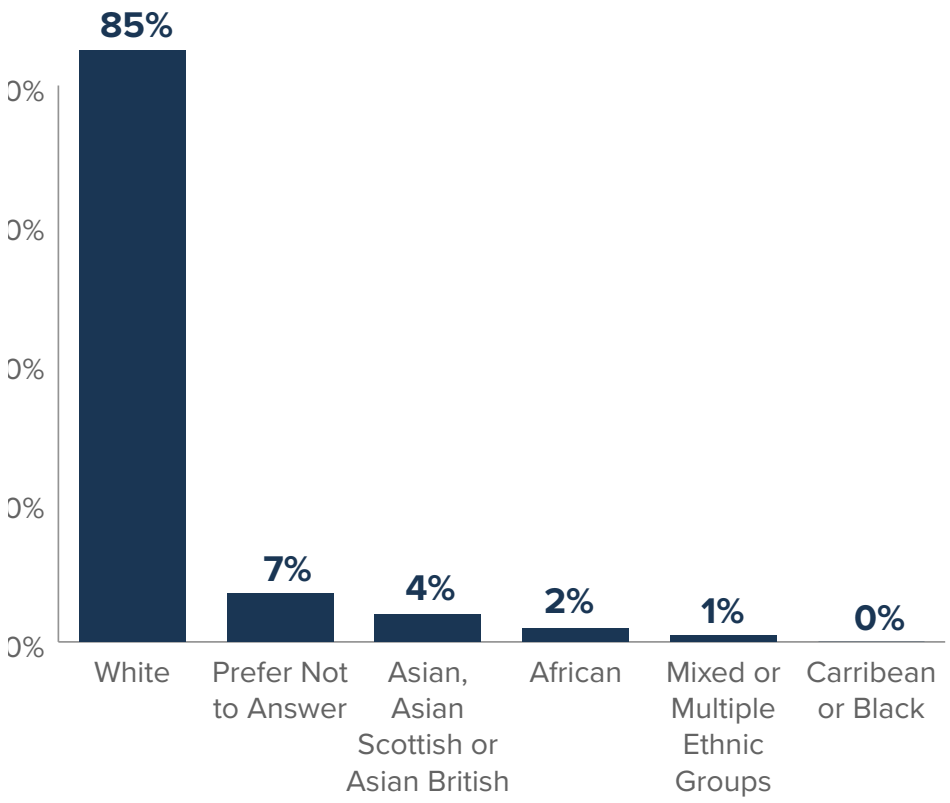


Figure Two. % of individuals seeking advice by ethnicity

(iii) Household Composition

Single adult households were the largest group accessing advice through their GP. A little under a quarter of individuals accessing the service are families with children. However, this number is likely to underestimate the actual number as in Glasgow HSCP the Healthier, Wealthier Children initiative (HWC) aims to contribute to reducing child poverty by helping families with money worries. The project targets pregnant women and families with young children experiencing, or at risk of, child poverty, as costs increase, and employment patterns change around the birth of a child. Accordingly, referrals in Glasgow, which accounts for over half of the participating practices, are most likely to be made through this route.

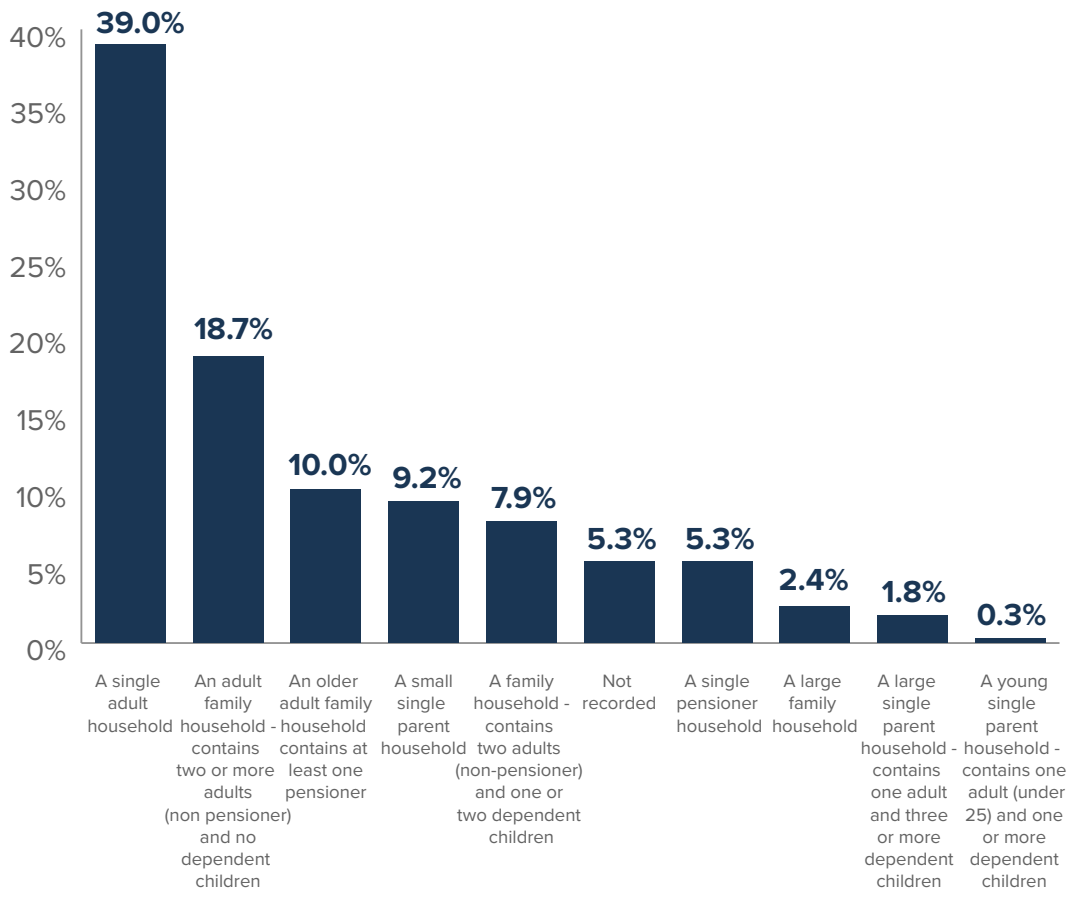


Figure Three. % of individuals seeking advice by household composition

(iv) Disability or Long-Term Condition

Almost half of individuals seeking advice have a disability or long-term condition. Given that advice is being sought in a primary care setting this is not unexpected.

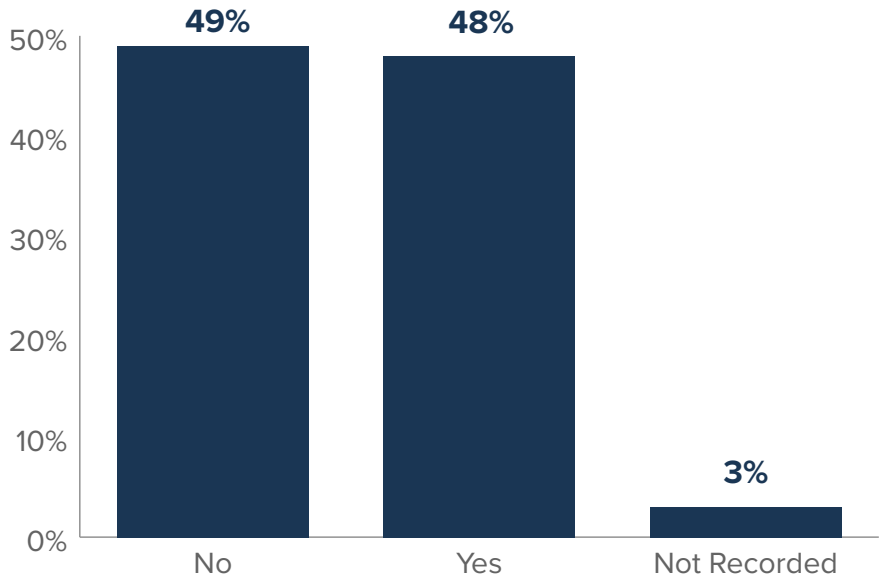


Figure Four. % of individuals seeking advice with a disability or long-term condition

(v) Economic Status

Over half of individuals seeking advice are economically inactive as a result of ill health. The number is slightly higher than those who are disabled or long term sick as it also includes those unable to work as a result of shorter-term sickness. A little under a sixth are either in work or are retired.

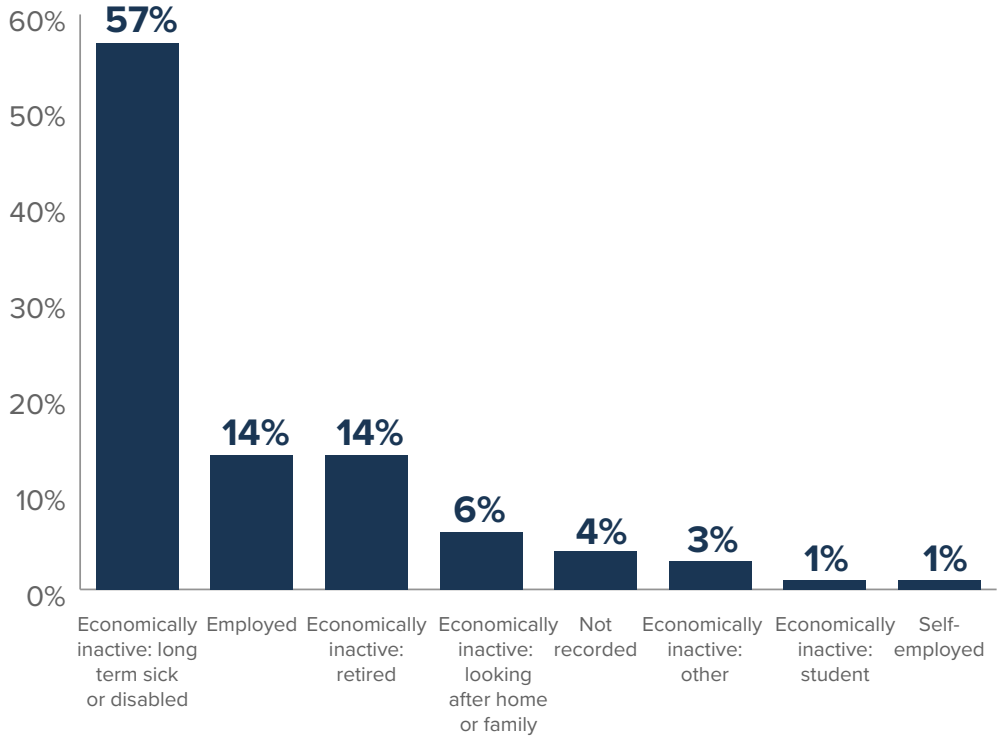


Figure Five. % of individuals seeking advice by economic status

(vi) Housing Status

When individuals whose housing status was not recorded are excluded, almost two thirds of individuals seeking advice lived in rented accommodation with six out of seven having a social landlord. Individuals who did not have secure accommodation made up less than 5% of service users. The challenges in accessing GP services without a permanent address may have contributed to this lower uptake.

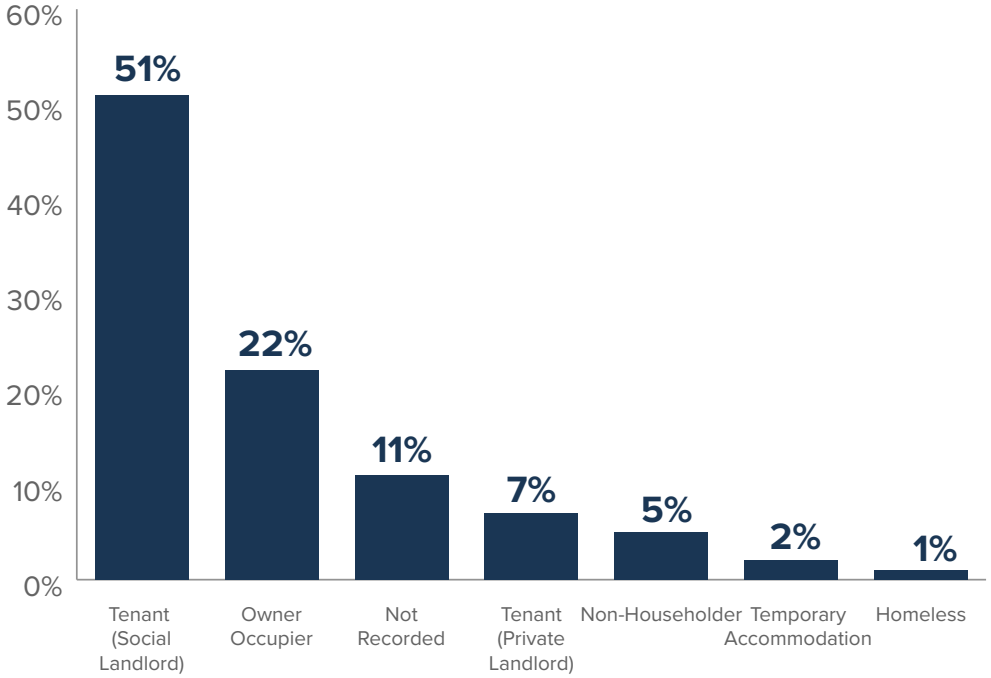


Figure Six. % of individuals seeking advice by housing status

(vii) Household income

Almost three -quarters of all individuals who sought advice had a household income of less than £20,000 per annum and a little over a third had a household income of less than £10,000. This illustrates how it is individuals in the poorest households who are accessing advice in this way.

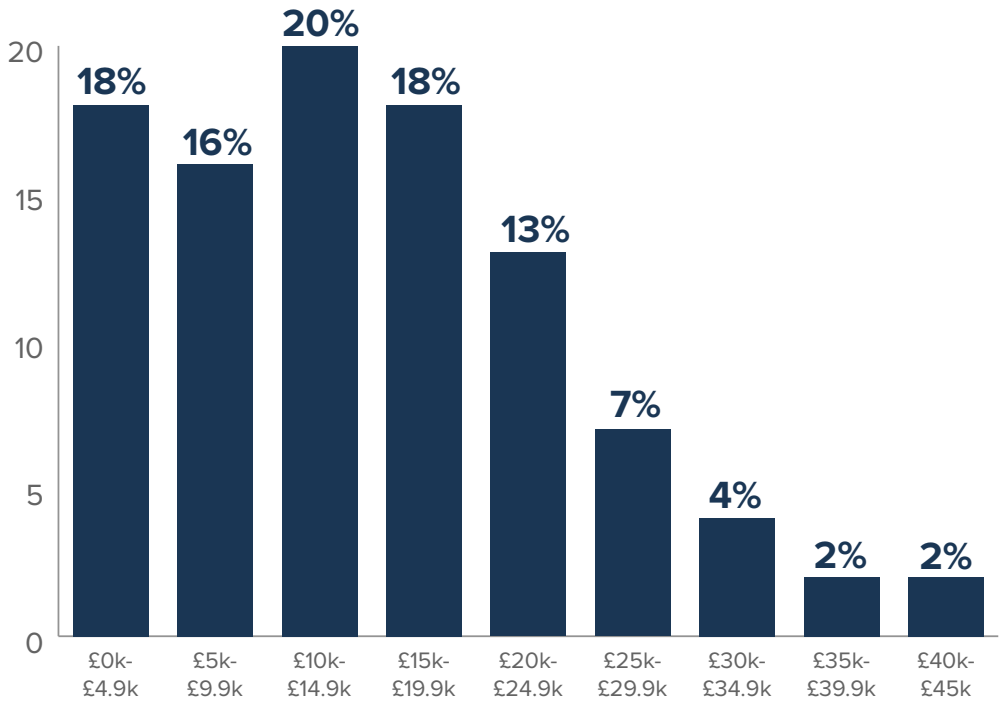


Figure Seven. % of individuals seeking advice by household income

(viii) Referral Source

A little under half of all referrals were made by Community Link Workers (CLW), whilst under a third were made by GPs with a further fifth being made by reception staff. It is clear that CLWs have a crucial role to play in making referrals for advice and hence the relationship between both CLW and WRA will be considered further in a future section of this report.

It should be noted that the referral source reported in the survey that was sent to GP Practices and in the interviews with individuals do not align completely with these findings. This is most likely to be as a result of the smaller sample sizes involved and variations in relation to both the geographical area and, in the case of the survey sent to GP Practices, the role of the respondents.

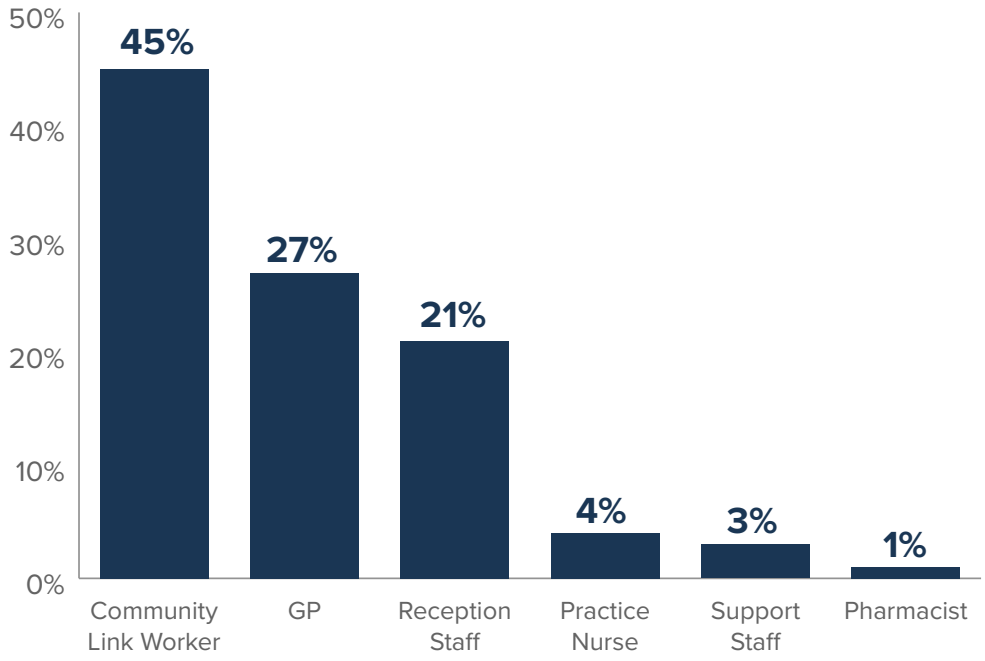


Figure Eight. % of referrals by GP Practice staff

(ix) Reason for seeking advice in GP Practice

Individuals were asked what had prompted them to seek access to advice in their GP Practice. Almost three quarters had done so because it was suggested by GP Practice staff, whilst a sixth stated that the primary driver was that they felt they would be treated on a confidential basis and their privacy would be respected. This highlights the key role GP Practice staff can play in encouraging and supporting individuals to get help with welfare rights and money advice.

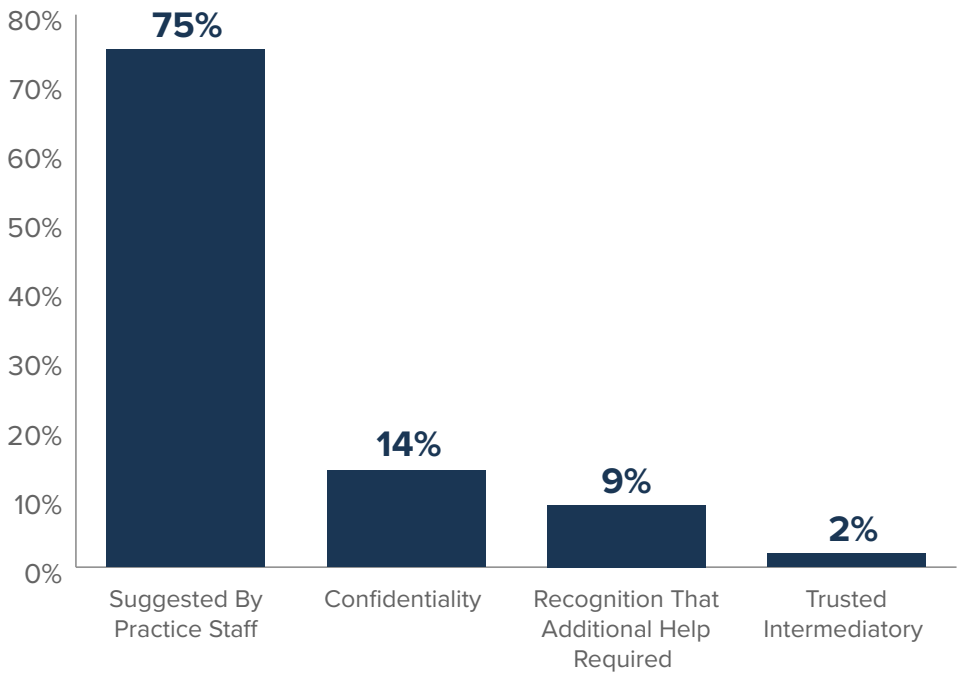


Figure Nine. % reporting what influenced them to seek advice in the GP Practice

(x) Main reason for needing advice services

Individuals were asked to identify the main reason that had made them accept that getting welfare rights or money advice would be beneficial. For over a third an inability to work for health reasons was the main driver. Another fifth stated that they needed help to claim benefits.

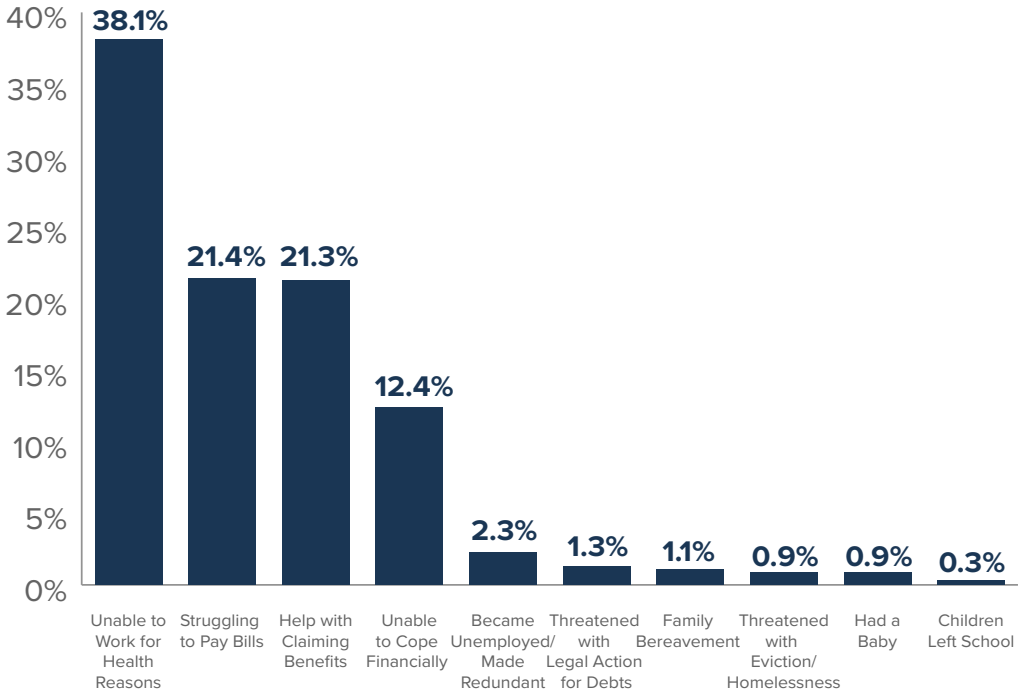


Figure Ten. % reporting the reason for needing advice

(xi) Appointment Type

A little over half of appointments took place by phone whilst a little under half were on a face-to-face basis. There were variations in individual areas which broadly reflected how access to other services in the GP Practice was provided. Many individuals required several appointments and follow up appointments were offered by phone. In some areas an initial 'triage' interview to identify, in general terms, the type of advice required was done by phone.

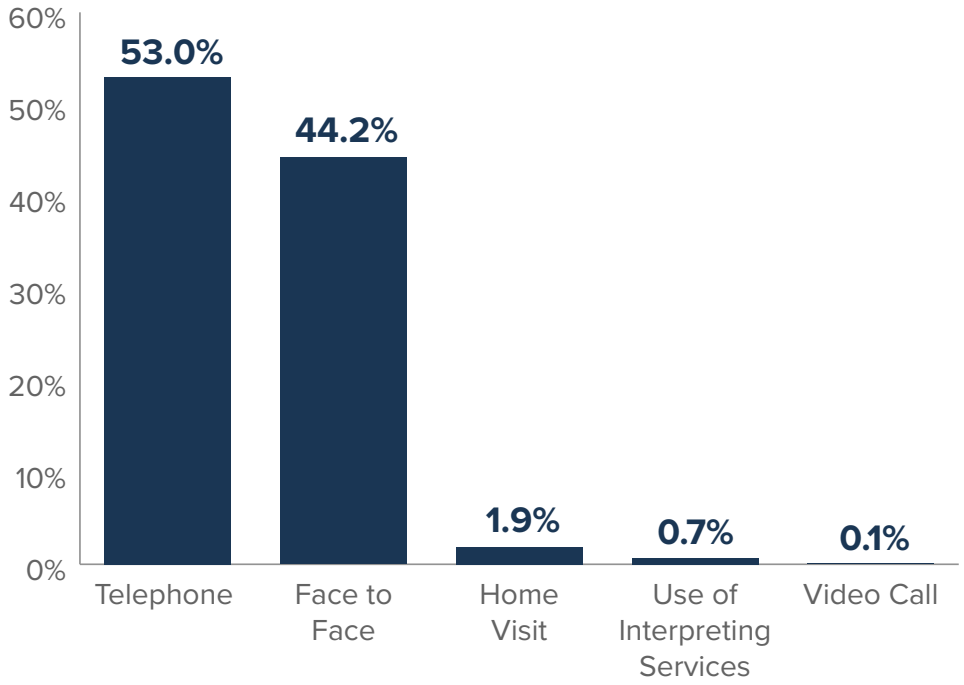


Figure Eleven. % reporting the type of appointment through which advice was provided

(xii) Type of Debt

The most common debt types, reported by around a fifth of individuals, were council tax arrears and credit, store and charge card debts. Rent arrears and utility debts were reported by less than 10% of individuals.

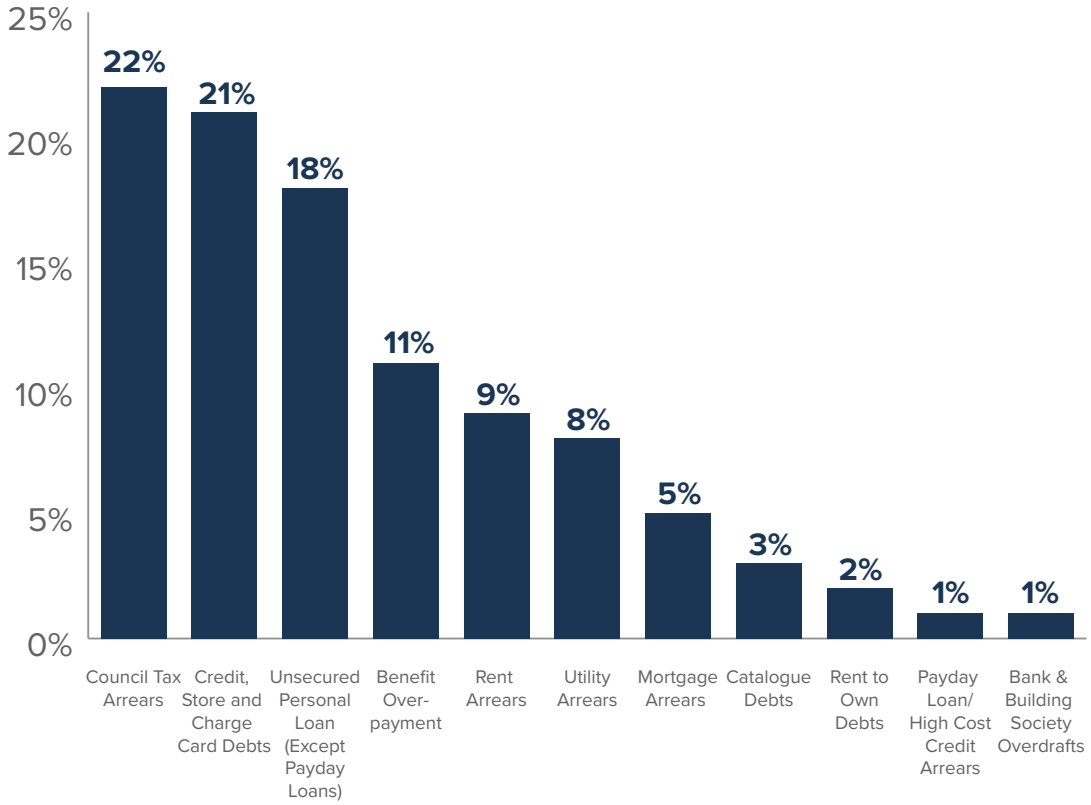


Figure Twelve. % of debt type

(xiii) Financial Gains

As a result of the investment by Scottish Government during the two-year period of the 'test and learn' programme individuals service users have made financial gains of around £23 million. Whilst attempts have been made to link financial gain to benefit type and both the demographic characteristics of individuals and household income, due to the recording processes used by some advice providers, this has not always been possible. As a result, the total figures do not match. It should also be noted that there is likely to be a time delay between advice been provided and benefits awarded. Depending on the complexity of the case this can take several months.

Financial gains arise most commonly as a result of Adult Disability Payment (ADP), which when recording started was referred to as Adult Disability Assistance (Working Age), closely followed by Universal Credit (UC). These two benefit types account for c45% of all financial gains. Personal Independence Payments (PIP) are responsible for c14% of financial gains and Attendance Allowance for c8%.

The 9% of financial gain that is not accounted for in the figure below is made up of various benefits/grants each of which contributes less than 2% to the total.

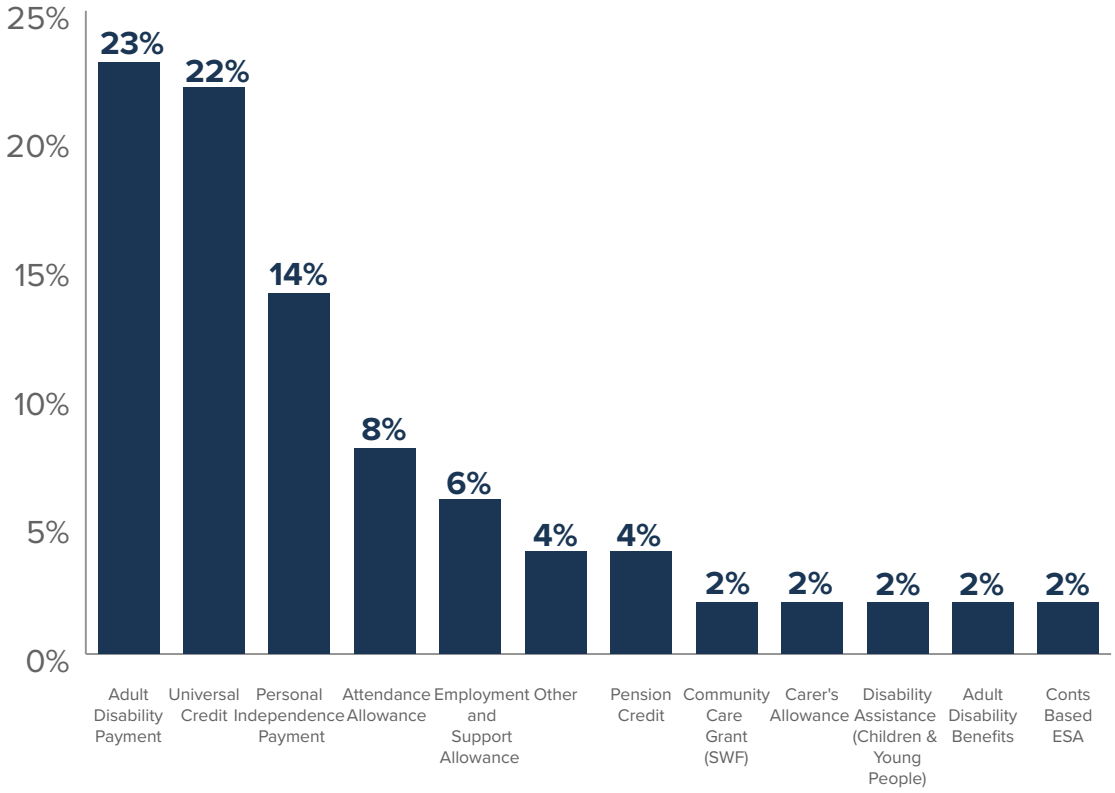


Figure Thirteen. % of Financial Gain by type of benefit/grant

In two of the key demographic groups there are variations which should be noted. These are described below.

Ethnicity

In African groups awards of UC accounted for 32% of gains and ADP for 27%

In Caribbean or Black Groups again UC contributed 32% of recorded gains, PIP was 16%, Carer's Allowance was 13% and ADP was12%.

In mixed or multiple groups, the benefit individuals gained most from was UC (28%) with PIP and ADP each accounting for 15%.

As has been stated already the numbers of individuals claiming in each of these groups is comparatively small. Nevertheless, it would appear that there is a distinction in the type of benefit being supported to claim with an increased emphasis on UC.

Financial gains in White and Asian groups align with the overall totals set out above. This is not surprising in relation to individuals who describe themselves as White, as they make up the overwhelming majority of clients, but it is worth noting in relation to individuals who describe themselves as Asian.

Household Composition

In **single adult households** ADPs contributed a third of financial gains whilst UC was around a fifth. PIP contributed c15% and Employment and Support Allowance 7%.

In **adult family households** it was UC that contributed a little over a third, ADPs accounted for 28% and PIP was responsible for 12%. The numbers benefiting from Employment and Support Allowance were broadly similar in both cases.

There is evidence in both **single adult** and **family households** where a child is under 16 of financial gains resulting from Employment and Support Allowance.

In both **older family** and **pensioner households** Attendance Allowance accounted for c41% of financial gains, followed by Pension Credit at 15% and 20% respectively. Whilst in older family households ADPs contributed to financial gain by 11%, in single pensioner households the next most frequently reported gain related to housing benefit at 7%.

In **small single parent households** UC was responsible for 27% of financial gains with ADPs and PIP contributing 17% and 12% respectively. Employment and Support Allowance contributed 5% and the Scottish Child Payment (under 6) contributed 3%. The figures in **large single parent households** were broadly similar to those recorded for small single parent households except in relation to the Scottish Child Payment and Disability Assistance (Children and Young People) which each contributed 9% towards financial gain.

In **family households** 53% of gains resulted from awards of UC whilst ADPs and PIP accounted for 15% and 9% respectively.

In **young single parent households** UC made up 31% of financial gains, ADPs were responsible for 25% and PIP for 20%. Interestingly the Scottish Child Payment (under 6) contributed to financial gains in 7% of cases.

In households in which there are children under 18 support from the WRA in the practice is more frequently related to securing UC as opposed to ADPs. There is also increased financial gain as a result of the Scottish Child Payment (under 6) - particularly for young single parent households.

Household Income

Again, the most common benefits resulting in financial gains for individuals in households of all income levels were ADP and UC. There is one exception as, not unexpectedly, claims for UC did not contribute to the limited financial gains recorded for individuals living in higher income households. A similar pattern was identified in relation to financial gains from Attendance Allowance, which were

less likely to be experienced by individuals living in households with higher and lower levels of income. PIP and ADP contributed fairly consistently to financial gains across all levels of household income. The financial gains resulting from Employment and Support Allowance followed a similar pattern.

Qualitative Data

Qualitative data was collected from two sources. The one-to-one interviews that were carried out through the customer journey mapping process and the case studies submitted in relation to each of the individual GP Practices.

(i) Customer Journey Mapping

Introduction

Customer journey mapping of service users was conducted to determine their experience of the appointment and advice process as well as any self-perceived health benefits. This was carried out using a structured questionnaire and participants were offered the choice of being interviewed by phone, in-person or on a video call. The majority (90%) of the 28 people engaged chose to be interviewed by phone. Interviews were conducted across five local authority areas (East Ayrshire, Glasgow, Inverclyde, North Ayrshire and North Lanarkshire).

Participant Demographics

There were approximately the same number of respondents who described themselves as male as female.

Most were aged 60-64 years of age (36%) or 45-59 (36%), with the rest aged 65-70 (18%), 71+ (7%) and 35-44 (4%).

The predominant household types were single adult household (36%) and adult family household (32%), with smaller proportions in a family household (11%), older adult household (11%), small single parent household (7%) and large family household (4%).

Almost half of respondents indicated that they were in a household where someone is disabled. Over three quarters said they were economically inactive, with the highest proportion being long-term sick or disabled. Of those individuals who were economically active, there was a higher portion in employment (14%) than who were unemployed (7%).

Findings

(1) Combined journey map

The combined map summarises the main point at each stage of the journey, showing broad results at each stage, from respondents' initial reasons in seeking advice, through finding out about welfare rights/money advice support, being

referred to an advisor, their experience of the appointment process and getting advice, to their feelings after seeing an advisor and any changes in their health.

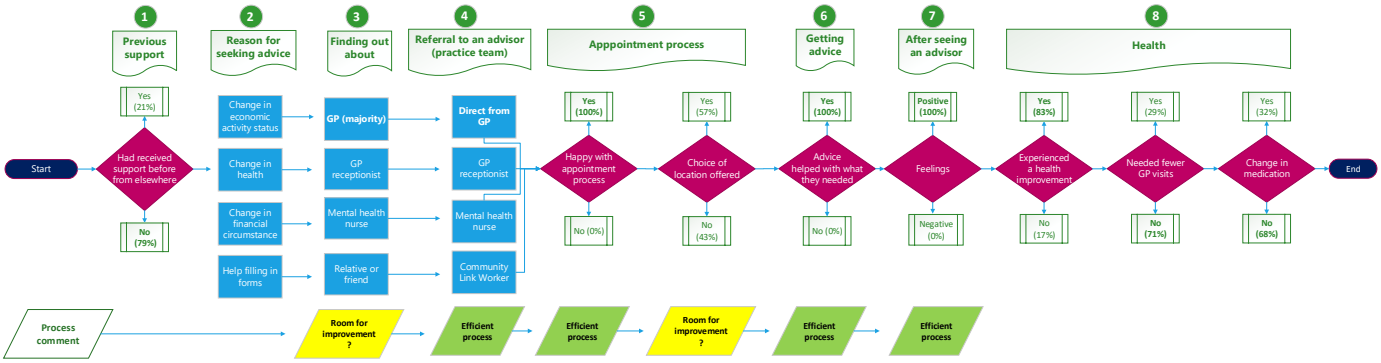


Figure Fourteen. Customer Journey Map

A larger version of this map can be found in Appendix One.

(2) Summary of responses by stage:

1. Most of the respondents had not received welfare rights or money advice support before from elsewhere.
2. The main reasons that respondents had for seeking advice was a change in their health, a change in circumstances resulting in an adverse financial impact (for instance becoming unemployed), or for help to fill out forms.
3. Most found out about the service from their GP or through someone else in the practice.
4. The referral to an advisor was mainly directly from the GP, sometimes through the GP practice reception and occasionally through another member of the practice team.
5. All were happy with the appointment method. Just over half were offered a choice about where the appointment took place - a potential area for improvement.
6. All reported that the advice they received helped meet their needs.
7. Equally, all reported positive feelings after seeing an advisor.
8. While over three in four said they had experienced an improvement in their health after being in receipt of advice and support, this was usually qualified as being an improvement in their well-being or quality of life.

(3) Reason for seeking advice

The main reasons for seeking welfare rights or money advice were suggestions from practice staff, particularly GPs, a change in employment or financial

circumstances, specific needs related to completing disability or benefits applications and occasionally getting general financial support and information.

(4) Finding out about the service

Respondents found out they could see a WRA in their GP practice through various sources. The main way individuals learned about the availability of advice services was through their GP, followed by other healthcare staff in the practice, such as a mental health nurse, or a combination of these. To a lesser extent information was provided through a CLW or by external connections such as relatives and friends.

(5) Referrals and appointments with advisors

The main source of referral to a welfare rights or money advice advisor was from the GP, or less frequently from someone else in the practice team, either at reception or a nurse.

Overall, the views expressed about the appointment process were overwhelmingly positive, with many respondents expressing happiness, satisfaction, and delight with both the method and results. There was only one slightly neutral comment regarding the desire for an earlier appointment, but this did not include dissatisfaction with the process itself.

> *"Honestly, I'm delighted. It's changed things immeasurably. It meant so much, was unable to afford food beforehand. The advisor pushed in the right ways."*

(6) Choice of location

For around two in three respondents, there was no choice of location offered for the appointment, with the default being the GP practice. However, in some cases home visits occurred which were welcomed by those who were able to choose that option.

(7) Keeping in touch

If more than one appointment was needed, advisors kept in contact mainly by phone and text messages, but some respondents also mentioned the use of email and other messaging (such as WhatsApp).

(8) Experience of getting advice

All respondents said that they got the help that they needed and that they felt positive after seeing a WRA. Emotions expressed included feelings of relief, satisfaction, support, and understanding. Key phrases include *"weight lifted off*

shoulders," "massive relief," "life changing," "eternally grateful," and *"hugely relieved."* There were no negative or neutral sentiments expressed, suggesting that the advisors had a profoundly positive impact on the individuals they assisted.

One person said that they felt

> ***"Supported, great, nice to feel you're being helped rather than trying to just say the right things. Being able to speak openly with ease. Like dealing with a friend, have never experienced anything like it. For it to be available in the accessible health centre is absolutely fantastic."***

Most said that they wouldn't want to change anything about the process, with a small number indicating that getting an appointment more quickly would have been beneficial.

(9) Health Benefits

Respondents indicated that the advice and support primarily improved mental health, well-being, and reduced stress, even if for many physical health remained unchanged. The overarching theme is that the increased financial stability that resulted from the support contributed to reduced stress and anxiety, improved overall quality of life, and, in some cases, resulted in indirect improvements in physical health.

Almost all indicated that they had experienced at least one of following conditions before they had received advice through their GP practice: anxiety, depression, panic attacks, insomnia and, stress, with anxiety and stress being the main ones mentioned. When asked to reflect on whether they had experienced a change in these conditions following receipt of advice the most common self-reported change was a reduction in anxiety and stress.

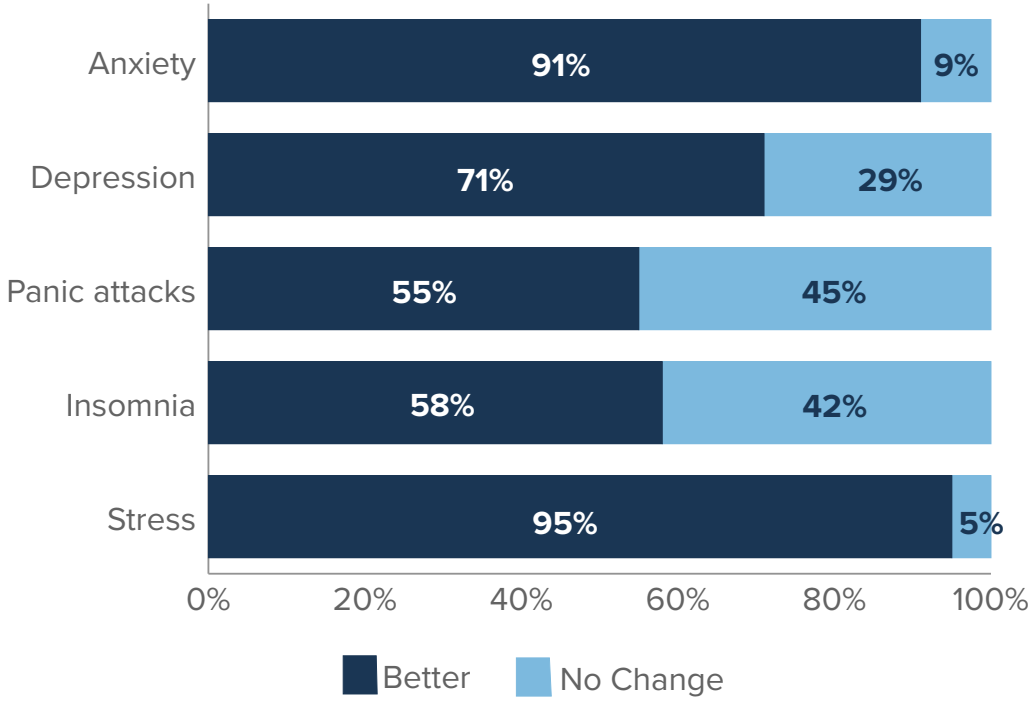


Figure Fifteen. Self-reported changes in health after accessing advice in their GP Practice

Just over one in four reported needing fewer GP visits after receiving advice, with some noting that their pre-existing physical conditions had not changed or had worsened. Some indicated that there had been a change in their medication since receiving advice, but this was not necessarily related.

(10) Making advice available in all GP Practices

All respondents indicated that access to welfare rights/ money advice should be made available in all GP practices. They gave various reasons as to why integrating welfare rights/money advice within GP practices was seen as beneficial including: accessibility and convenience; trust and comfort; comprehensive and effective support and positive personal impacts.

Several were strongly supportive, while some expressed the view that it could help others in similar situations, who are either unaware of the types of benefits and support they could apply for or did not know where to turn to for help. Others mentioned that going to the GP Practice for advice was comfortable, familiar and safe, while a few considered that the service should be advertised or promoted to raise awareness.

> *"Being able to access the advice in a place you know and with the knowledge that you can access more advice is very helpful."*
>
> *"One place people can get to easily- everybody knows where it is, and it is local. I feel safer going to my doctors. People don't know why you are there. No judgements. I feel more relaxed."*
>
> *"Quite surprised to find it was there, but very grateful for it. For someone with a working background, not knowing about the support available and now being able to offer help to friends, directing them and further enquiries. Reducing stigma."*

Additional Comments

There was genuine gratitude and appreciation expressed by many and some wanted their advisor recognised for the help they had provided. Some noted that they would share details of the service with others and would strongly recommend it, citing positive impacts not just for them but their wider family as well. Others reiterated their support for making the service more widely available, while a few mentioned their relief and reduced levels of stress.

> *"The advisor who helped me was extremely helpful, very professional and I appreciate the help I received all the way down the line."*
>
> *"Worrying about money was making my anxiety worse but the knowledge of the advisor and help to fill in the forms was amazing. He explained everything so that I could understand it and took me through it all step by step."*
>
> *"This service needs to be shouted from the rooftops and available to everyone. I cannot fault the service and it should be rolled out to every practice."*
>
> *"I think there should be TV adverts so that more people know about it."*
>
> *"It's a marvelous service. It's made a huge difference to my mental wellbeing."*

Conclusions

Respondents indicated that:

- they were all happy with the appointment process
- all received the advice that they needed
- all felt positive after seeing a welfare rights/ money advisor
- most experienced a reduction in stress and anxiety
- the service should be available in all GP Practices

(ii) Case Studies

The case study examples below illustrate the benefits of accessing advice in a GP Surgery. A selection has been provided to demonstrate the impact on a range of individuals with different backgrounds. A guide to the abbreviations used is included in Appendix Two.

Case Study: Attendance Allowance and Pension Credit

Synopsis

Patient was referred to x as she is a patient at y. The patient was struggling to manage financially due to a very low income; this was affecting the patient's physical and mental well-being. The patient initially came to me to have a benefit check completed and through this I identified that the patient had an entitlement to attendance allowance, and if this was to be awarded it would lead to a pension credit award and an award of council tax reduction. While awaiting the outcome of the patient's application I was able to arrange to have food parcels delivered to the patient to help her manage in the short time. The combination of these benefits would significantly increase the patient's household income, and in turn make it easier for her to manage her health conditions.

Who was helped?

The patient is a 91-year-old woman who lives alone in a property that she owns. The patient suffers from extremely limited mobility and needs to use taxis to go anywhere as she is no longer able to manage on public transport. The patient's financial situation meant that when I first met her, she was very socially isolated and was struggling with her mental health due to this.

How was the individual helped?

The patient was initially referred to us by a member of the practice staff. The patient was helped financially due to the awards of attendance allowance, pension credit and council tax reduction being made. This meant that the patient's monthly income doubled and gave her enough of a disposable income that not only could she manage all of her basic living costs, but she was able to get out and about within her local community again. The client reported that not only was her mental health better as she was no longer stuck at home all the time, thanks to the awards that were put in place she was also eating better and feeling more physically fit due to this. The patient had been able to re-join various groups that she had been a member of previously and she was able to meet up with friends and live her life again.

Any benefits or challenges?

This case is a classic example of the benefits of having a co-located adviser. Not only was the patient able to access help with her finances almost immediately upon referral, but we were also able to ensure that the client was able to manage in the short term by providing food parcels. The process of applying for any disability benefit can be very slow but the ability to provide medical evidence at the first point of contact when we submit the forms does significantly speed up this process. This client received her first payment within 10 weeks of being referred to us, and the follow up benefits that the client was entitled to were in place within a further month of that.

Case Study: Becoming Primary carers of grandchildren long term – unexpectedly

Synopsis

Mr and Mrs A - 57yr and 59yrs both with health conditions became responsible for long term care of grandchildren aged 6yrs and 7yrs. Mr A has given up work to care for children and Mrs A is off sick from employment. The 7yr old is currently going through school assessment - suspected Autism.

Who was helped?

Mr and Mrs A benefited from successful outcomes in UC, NS ESA, CTR, and are currently awaiting outcomes for 2 x ADP applications, SCP for both grandchildren as well as Free School Meals, Clothing Grant applications and Child Benefit.

How was the individual helped?

Mr and Mrs A were referred by CLW. Support, reassurance, and guidance were provided through regular telephone discussions at times suitable to Mr and Mrs A, information was gathered from EMIS (for Mrs A only) in relation to her health, and relevant benefit claims were identified and lodged. The EMIS system within the surgery was key to ensuring accurate details of health conditions/illness/disabilities were recorded for Mrs A's applications. Advice and information provided on NS ESA and UC and Scottish Options, ADP, CTR, SCP, CB, Clothing Grant, and Free School Meals, how and when to apply and what information would be required to support applications. Made aware of WCA process for UC and NS ESA. CDP for 7yr old – considered once supports in school established and all facts known. Nine claims to benefits and two supersessions identified. Weekly gains to date £326.60/w and arrears of £1773.84

Any benefits or challenges?

Can be challenging when supporting and assisting a couple or family unit due to the limitation and restrictions of the GP Medical Systems and GDPR, in that only the details of the individual person being referred can be accessed. If other individuals within the household could be viewed/accessed in the same way it would mean applications potentially could include more detailed, accurate up to date health information making the process more robust and inclusive. At present WRAs are only permitted to access the records of the individual who is being referred which is adhered to.

Case Study: Supporting the Traveller Community

Synopsis

Income maximisation following referral from reception staff.

Who was helped?

Single parent with one child.

How was the individual helped?

Client was referred by reception to adviser. Client has poor literacy skills and needs intense support to navigate the benefits system after partner left and deterioration in mental health resulted in client being unable to continue being self-employed. Assisted with three-way call to make UC claim as client unable to make or manage online claim. Requested fit note from GP during appointment to accompany UC claim. Made Scottish Child payment claim online for client, adult disability claim, Council Tax Reduction, Free School Meals & Clothing Grant. Client would not have managed these claims without the support of adviser and highlighted she wouldn't have reached out for help. Some claims are still outstanding, but client has expressed thanks as each claim has been awarded. She has built up trust in adviser and feels supported. Client presented with no benefits and is now in receipt of £428.61/w

Any benefits or challenges?

A benefit of being in practice is that you can easily see in the system the health conditions, this makes you more mindful that the client may not be great at engaging, more effort is made around engagement and continuing to pursue engagement through whatever way is best for that client. A challenge that comes with dealing with poor mental health patients is being able to keep the momentum up in terms of progressing claims as their mental health impacts on engagement levels.

Case Study: Supporting Single Parent Family

Synopsis

Maximising the family unit's income.

Who was helped?

Single parent with two dependent children.

How was the individual helped?

Referral received from Practice Manager; client had just given up work due to poor mental health. Supported to maximise income. Assisted with reporting COC to UC to start unfit for work process, requested med cert from GP for client, Claim for ADP, Claim for Scottish Child Payment, Claim for Free School Meals & Clothing Grant – Also received Bridging payments at Christmas and claim for Council Tax Reduction. With ADP being successful we identified oldest daughter as Young Carer and claim for Young Carers Grant made. Income maximised by £249.33/w arrears of benefit £1711.82 and one of payment to daughter of £326.65.

Any benefits or challenges?

Being within practice, advisor can add note on EMIS to request med cert for client for benefit purposes – this saves further calls to practice by client.

Case Study: Homelessness

Synopsis

Patient resigned from full time employment due to mental health issues. Patient was unfamiliar with her options with regards to her finances/welfare and would benefit from advice. Patient living in homeless accommodation and in the process of moving to a new build Local Authority property.

Who was helped?

A 22-year-old woman with a history of depression and anxiety.

How was the individual helped?

Patients GP referred to WRA. The GP also referred patient to a mental health specialist and provided a medical certificate to support benefit applications. The WRA assisted to complete relevant benefit claims. Advice provided on access to Employability Services once patient was ready to return to work.

Any benefits or challenges?

Patient advised rehousing and the advice and support provided gave her a lift in how she was feeling/coping.

Case Study: Full Benefit Overview

Synopsis

The patient was referred to x as ill health had prompted them to take time off work. During the initial appointment it became clear that the patient had been suffering with poor health for a number of years prior to this latest downturn. A full benefit check was carried out on behalf of the patient where it was identified that there were many areas where they were not claiming their full entitlement. Identified a shortfall in their rent, and a Discretionary Housing Payment application was completed. Council Tax reduction was applied for, and requested to be backdated to the period when the patient was forced to reduce her hours and only receiving SSP. This would also help with the arrears that had been accrued during this time. Due to the patient's health, ADP was identified as she struggles with motivation and needs constant encouragement and support from her partner. Patient was also advised to submit her FIT notes to her Universal Credit claim to begin the process of being assessed for work. The patient and partner had some outstanding arrears and would require some help with dealing with these at this time.

Who was helped?

The patient is a 26-year-old woman who lives with her partner, and has a new-born baby, around five months old. The patient suffers with her mental health and tried to return to work after her maternity leave but has been unable to continue. Combined with her partner losing her job, this has caused them to have serious financial difficulties.

How was the individual helped?

The patient is working with practice staff and was referred to us for help as her current circumstances were adding to their health struggles. The patient had already been referred to food banks by practice staff as well as a baby clothes package (Togs for Tots). Due to the patient not due another Universal Credit payment for another week, they were reliant on friends and family at this stage. I requested a supermarket gift card from the Scottish Government Crisis fund that had been distributed to our organisation for support such as this. The patient and her partner felt immediately relieved that applications had been submitted and they were getting help to deal with their finances at this time.

Any benefits or challenges?

The patient will benefit from access to supporting medical evidence that will assist in both the ADP claim, and her Work Capability Assessment. The patient has also benefitted by being directly referred to myself via her practice nurse. This was key to getting the patient the support and help that she needed as she has trouble communicating and asking for help due to her mental health struggles. This enabled me to begin applications as soon as possible and ensure that the patient had the resources in place to provide for her family and alleviate some of the stress that her financial difficulties were causing her.

Outward Referral Routes

It was understood from the outset that there were likely to be occasions when the WRA located in the GP Practice might have to make an outward referral for an individual. This might be for specialist advice, additional support or indeed for some other reason. Advice providers were asked to share details of such referrals in their quarterly reports but reporting, which used an open text box, was variable. It is likely that other outward referrals will have been made which have not been recorded.

During the two-year period of the programme 973 referrals were made to 163 agencies, organisations or services across the six local authority areas for which data was available. Of these the largest volume of referrals occurred in Glasgow (64%), followed by East Ayrshire (17%) and Edinburgh (10%)

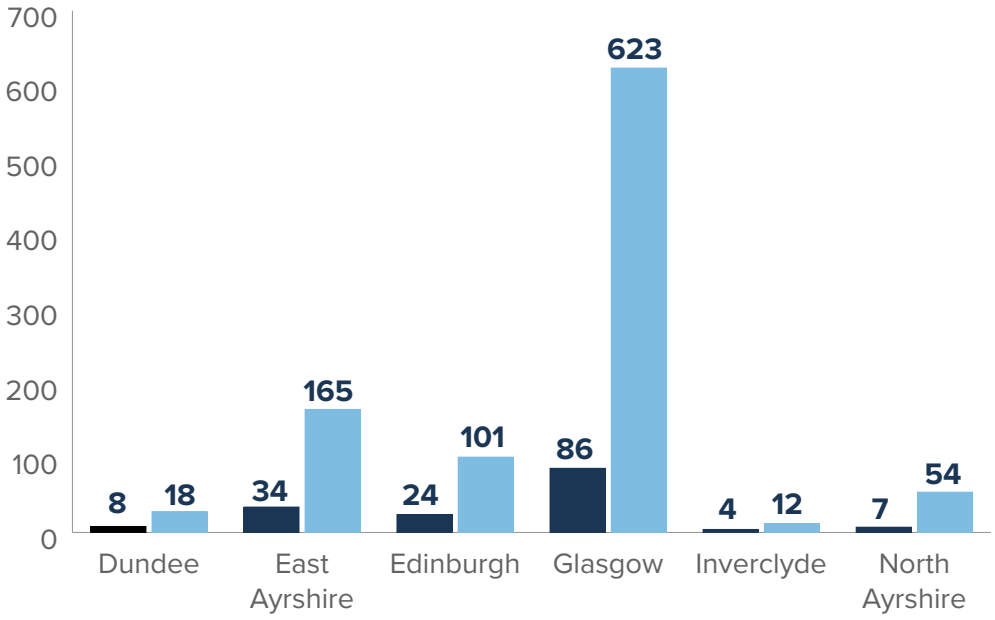


Figure Sixteen. Number of Agencies/Organisations to which an outward referral is made and total number of outward referrals.

Referrals were wide ranging and included both large national organisations and smaller local charities. The most common type of referral (22%) was for energy advice/support. Organisations providing this type of support included Home Energy Scotland, LEAP (which helps support people at risk of going into fuel poverty), the Fuel Bank in Glasgow, the Lemon Aid project in East Ayrshire and utility companies.

There was also a significant proportion of referrals to local authority services (17%) including help from financial inclusion and in-court advice services, as well as for assistance with social care and housing advice.

There are wide variations both between and within geographical areas. Much depends on the availability of local services and the knowledge and experience of the WRA.

Other referrals included the Citizens Advice Bureau network (7%), food banks (7%) and CLWs (5%).The majority of the later took place in Glasgow.

Of the total number of referrals at a national level, 4% were made to DWP and 2% to both Social Security Scotland and Shelter. It should be noted that referrals cannot be made to Social Security Scotland so this should not have been recorded as a referral.

Relationship with Community Link Workers (CLWs)

It is important to clearly distinguish the respective roles of CLWs and WRAs. Whilst both work within general practice and provide non-clinical support and assistance to patients. The WRA is a specialist role focussing on providing patients with social welfare legal advice, whereas the CLW is a generalist role supporting patients to identify issues affecting their health and well-being and linking them to services that can assist.

Role of CLWs

CLWs provide a person-centred approach in response to the needs and interests of GP practice patients supporting them to identify issues that affect their ability to live well. The CLWs work collaboratively with patients supporting them to identify issues that they would like to address and linking them with the appropriate services that can assist.

CLWs are also referred to as social prescribers and community connectors but for the purposes of this report they are referred to as CLWs.

Role of WRAs

WRAs provide patients with regulated and accredited Social Welfare Legal Advice on income maximisation, welfare benefits/social security, debt resolution, housing and employability as well as representation at tribunals. Theirs is a specialist role, working within the UK and Scottish Social Welfare Legal Framework, which requires ongoing training and support as new legislation is introduced by both Governments.

WAHP advisers are WRAs who are embedded within general practice and provide specialist advice and assistance to a practice population.

The roles of CLWs and WAHP advisers are essentially complementary. WAHP advisers often see people in crisis due to lack of money, inability to meet basic financial needs and threatened homelessness. Once these immediate crises have been dealt with CLWs are better placed to address the medium to long term needs of patients which are the underlying causes of poor health and link them with services that can provide appropriate support. Patients are unlikely to address issues such as poor mental health and social isolation when they are in crisis.

Below are two case studies that explore the relationship between CLWs and WAHP advisers in two Local Authorities (LA) which are participating in the WAHP programme. The case studies are drawn from interviews with the LA leads with responsibility for delivering the WAHP service.

Case Study One

Within this Local Authority CLWs and WHAP advisers are providing services within the same GP practices. Both the CLWs and WAHP advisers are employed directly by the Local Authority, except for one practice where the CLW is employed through a third sector organisation.

The CLWs had been co-located in the practices for some time prior to the introduction of the WAHP service. The local Primary Care Manager (PCM) has responsibility for managing the CLW service and had been instrumental in introducing that service to GP practices: ensuring that they were embedded within the practice teams; agreeing referral protocols; arranging training for the CLWs on practice procedures; and ensuring practice staff had a clear understanding on the scope of the CLW service. The CLWs were therefore well established and had a clear understanding of their role and remit.

When the WAHP service was introduced the PCM was able to provide a similar role to the one that she had provided during the introduction of the CLW service. The PCM again introduced and explained the WAHP service to participating practices and arranged for WAHP advisers to shadow CLWs in individual practices. The CLWs then provided training on GP systems (such as the use of EMIS) and introduced the WAHP advisers to key practice staff. In addition, the PCM ensured that there was a clear distinction between the roles of CLWs and WAHP advisers to reduce any chance of duplication of services.

The WAHP advisers and CLWs worked together to develop a desktop aid for practice staff to explain the roles of both services and provided examples of what would be appropriate referrals to both services. Both teams have therefore been able to establish collaborative working practices from the outset of the WAHP service and continue to work closely together. They have developed a ‘no wrong door’ approach to referrals, meaning that if a patient is referred to one service but has no immediate need for advice or CLW intervention, but would benefit from the assistance of the other, a referral is made directly between them. This avoids any confusion or additional work for other practice staff concerning the referral process. The two teams regularly work on cases together where the patient is being provided with assistance from both services.

The LA respondent who was interviewed confirmed that most of their referrals came from their CLW colleagues, and very few referrals didn’t have an advice element. Interestingly, the CLWs had been referring to the LA advice service prior to the introduction of the WAHP service, but once both services were embedded within the same practices the referral rates increased substantially. This was believed to be because of a better understanding of what advice

services provided for patients, and CLWs being more comfortable about asking questions around money problems, when they knew there was a clear referral path to a known and trusted colleague located within the same practice.

Workers from both services also attend practice meetings so they can highlight the benefits of their work and promote further referral from practice staff.

It was noted that referrals from the CLW who was employed through the third sector organisation were lower than those from their LA colleagues. It was suggested this might be because they worked within a remote practice and were managed by a different organisation which adopted slightly different working practices than the LA.

Overall, the experience in this Local Authority has been highly positive. Both services have been supported by a trusted intermediary in the PCM, have developed a highly collaborative way of working from the outset and value the complementary nature of the two services, which is further supported by them being collocated within individual practices.

Case Study Two

In the second Local Authority the WAHP advisers are employed by the LA and the CLWs are employed exclusively by a third sector organisation (TSO). The CLW service had been operating within GP practices for some time prior to the introduction of the WAHP service.

At the outset of the WAHP service the LA advice manager agreed to meet with the TSO manager to agree the roles of WAHP advisers and CLWs and how they could be integrated within individual practices. Unfortunately, there was a change of manager within the CLW service, and the initial agreements were not progressed. The LA authority contacted the TSO on numerous occasions but received no response. It was thought by the LA that the lack of contact was the result of a number of changes within the TSO which meant that the management responsibility for the CLWs changed on several occasions over time.

The WAHP service was therefore established in the practices with no agreements between the two services. This has meant there are no clear protocols and distinctions between the services. Very few referrals are made from the CLWs to WAHP advisers, and the referrals that are made are a result of individual workers within practices agreeing between themselves on joint working arrangements.

The LA also felt that there was no clear distinction between the services, with CLWs advertising that they provide benefit and money advice. The TSO had initially requested that the LA provide them with training on the benefits system, to which the LA agreed with the proviso that a short training course would not equip CLWs with the adequate expertise to undertake complex advice cases. The training was eventually not taken up and it is understood

that the TSO sought training elsewhere. The LA lead also reported of instances of CLWs handing over advice cases they had started but been unable to complete because of their complexity. It is also a concern that patients may be missing out on entitlements due to CLWs lack of detailed knowledge of the benefits system. A further concern is that the CLWs are not regulated and may not have professional indemnity insurance that advice services are subject to and required to have.

This has led to a situation where there is no clear distinction between the role of CLWs and WAHP advisers. Additionally, there are no clear working protocols or referral processes between the two services. One example given by the LA lead to underline this was a CLW refusing to accept referrals from WAHP advisers because they were not primary care staff. Another example was that when referrals had been made to WAHP advisers, some CLWs refused to accept the same patient back as a referral from WAHP advisers who had identified a need that the CLWs could assist with. The explanation given on these occasions was that when a referral was accepted the patient was solely the responsibility of the service who accepted the referral.

The LA respondent reported having no clear referral pathway and distinction between the services leads to confusion amongst practice staff on which service to refer to.

In addition to numerous changes within the management of the TSO there was also several changes within the local public health team meaning responsibility for engagement with general practice frequently shifted. This has meant there has been no clear focus, oversight and leadership of how the services should be introduced to and integrated within general practice.

Despite the challenges facing the working relationship between the CLWs and WAHP advisers the LA lead advised that over the last six months CLWs have been making appropriate referrals and working relationships are improving. This has been put down to a further change of management and personnel within the CLW team.

Learning points

The differences between the two case studies are stark, however both respondents agreed that there were clear points of learning from their experiences:

- Clear leadership from a trusted intermediary who understands the roles and scope of both services and how they integrate with general practice is essential
- Agreement around collaborative/joint working between WAHP advisers and CLWs from the outset is essential
- An agreed clear distinction between roles of CLWs and WAHP advisers and how they are mutually compatible in assisting patients
- Clear referral pathways and protocols between practice staff, WAHP advisers and CLWs is essential

Barriers and Enablers

To support a potential expansion of WAHPs, it is useful to consider what has worked well and supports implementation, and equally importantly to learn about the challenges and the ways individual areas have tried to overcome these. This information has been gathered in the course of discussions with individual advice leads and during sessions that were held with advice leads and providers from participating authorities. In addition, all advice leads were asked to share a brief overview report that focussed on identifying the key learning in relation to how the approach was being delivered locally. The results of this engagement can be used as the basis for highlighting strategies that are most likely to be effective in any future roll out. It also draws attention to some of the potential problem areas that need to be considered even if immediate resolution may not always be possible. These will be considered in relation to each stage of the implementation of the programme.

(i) Securing agreement from the GP Practice to participate

Timing was a key factor in the delivery of the Programme. Whilst it was discussed and developed pre pandemic it was actually introduced whilst there still outstanding issues as health services coped with recovery. GP Practices experienced capacity issues and even finding time for discussion about the potential introduction of the service was challenging. In some areas setting up introductory meetings took longer than expected. A few GPs were unwilling to agree as they had a misconception that the WRA would increase the workload for reception staff.

Relationships are critical to both make and maintain the connection with the practice. Having a champion to advocate for the service is extremely helpful- “someone from health who really gets it” was suggested makes securing agreement much easier. Who the advocate is is important and having someone who GPs will listen to makes a difference *“If a GP went and told a GP how good the service is it would be easier.”*

(ii) Becoming embedded in the GP Practice Team - including how the service is promoted

Even when agreement in principle was secured advice providers sometimes struggled to maintain contact with GP practices and having a health lead who was familiar with how GP practices operated and had a knowledge and understanding of the best engagement strategies helped. This individual could assist in managing issues as they arose. Having a consistent contact in health who could advocate for the service - “a trusted partner” was important but not when that

individual changed on a regular basis. In one area the health lead changed several times during the implementation process.

Two authorities were invited to present information about the approach to local health committees which provided benefits both in relation to improving understanding of the delivery model and securing agreement for its implementation and also enabled other issues of joint concern to be discussed.

As well as many GP Practices experiencing staffing issues which limited capacity the move towards telephone consultations reduced the numbers of individuals attending GP surgeries. In some practices only individuals with medical emergencies were seen in person. GPs may only be in the practice a few days a week limiting the visibility of advice services and as a consequence reducing referrals. Clinical pressures on the GP service created a barrier to the WAHP service even when located in the same building *"sometimes they're sitting in a room almost as an unknown entity"*.

(iii) Community Link Worker Programme

The expansion of the CLW Programme at the same time meant there was competition for space. Space and room availability remains an ongoing issue - particularly as more and more allied health services are moved into primary care settings. Managers understood the benefits of having a WRA in the GP Practice but had genuine concerns about the issue of space. Even when it was possible to secure a space, it was often only available for a limited period and the advice provider had to try to provide a WRA at a time that suited the GP Practice. It should be noted that advice providers have to manage the demands of continuing to meet other service needs and priorities as well as providing a WRA for a day a week in the GP practice. This limited the opportunities for flexibility.

There was confusion over the respective roles of WRA and CLWs and what each were trained to do. This resulted in some GP Practices questioning why both were needed. Some advice leads produced resources to enable practice staff to understand the different roles of the WRA and CLW resulting in more appropriate referrals. This has already been considered more fully in the section on CLWs.

(iv) Clarity on benefits delivered by the service

It was stated that time needs to be spent explaining what the service is and why it is needed. There need to be clear explanations of how the GP Practice will benefit from the service e.g. a reduction in GP time to provide supporting medical evidence for benefit claims and appeals if this can be done by a WRA with access to medical records.

Some GPs refused to allow the WRA to access medical records – particularly if this required to be done remotely. This was overcome to some extent by allowing

supported access to medical records i.e. the information needed by a WRA would be provided by a member of the Practice team as the WRA didn't have direct access to medical records.

One authority produced a short video outlining how the WRA could support the practice and the services that could be offered to both patients and practice staff. This provided a good reference point as it was easily accessible to all staff and could be used to introduce the service to newly appointed staff.

Providing training for both GPs and practice staff on what welfare rights advice is and why their patients need it proved to be extremely helpful in securing ongoing support. In some areas junior doctors were offered training and/or the opportunity to shadow the WRA.

(v) Data Sharing Agreements

One of the biggest problems was the need to develop data sharing agreements between health and the local authority or HSCP. There were wide variations in the way each GP Practice implemented data sharing agreements. In some practices local agreements could be established with minimal fuss, and in others agreements were already in place for the CLW Programme which could be adapted. It seemed problematic when decisions were taken centrally. *"The NHS Central legal team were difficult and created problems that could have been avoided."*

Whilst model agreements that have been used in other areas help, ultimately this requires consensus from all those involved in the process locally, which can be easier if there is limited involvement with the centre.

"Have to say this was the biggest thing".

(vi) Recruitment

There were issues with recruiting suitable WRAs and often existing staff had to take up the positions which meant backfilling their posts. Various factors contributed to the recruitment issues including:

- A lack of skilled staff
- Short term contracts
- Different pay scales and funding timelines between authorities
- Competing with Social Security Scotland's recruitment drive as they offered more secure contracts and different pay bands.

(vii) Funding

The current funding position in local authorities/HSCPs when budgets are under pressure made supporting WAHPs particularly challenging. Whilst a fixed sum was provided by Scottish Government, which was welcomed, it did not take account of the additional costs were not covered including training, pay increases, line management, support costs with IT etc. The salary and pension costs alone of a WRA are £45,949 per annum.

Referral Processes

A key element in the delivery model is how the appointment for the patient with the WRA is made. There are many different ways that this can be achieved. The only condition in the WAHP model is that a referral to the WRA has to be made by a member of the GP practice team. The different approaches that are used are set out below. There is no right or wrong way of making a referral but what is essential is that it is done as simply and effectively as possible and meets the needs of individuals accessing the service, the WRA and the GP practice.

North Ayrshire

There are ten triage slots for each GP Practice. Anyone within the GP Practice can make a referral. There is an initial telephone discussion and then individuals are seen in a way that best meets their needs e.g. face to face. The WRA manages their own caseload - this can be challenging as numbers vary.

Glasgow

With the exception of one GP Practice, which manages its own appointments, a referral form is used. Anyone in the practice can make a referral before the form is emailed to the advice provider. Each provider has a different process. Some have an initial discussion before an appropriate appointment is offered. This is done by a business support officer and allows the WRA to focus on giving advice. Another has a dedicated inbox and the WRA reads the email and books an appointment. The second of these approaches results in the WRA spending more time on administrative tasks i.e. contacting individuals, triaging and booking appointments.

It is not always the patient who initiates the referral, and this may mean unsuitable appointments can be made that do not address the real issue from the patient's perspective. No unscheduled appointments are offered. The preferred option would be that GP Practices make their own appointments, but GPs may not know how much time to allocate so an introduction to the patient and some basic information is helpful.

GP Practices are advised two days in advance of appointments that are booked in.

Inverclyde

GPs and others email the service directly with client details. Triage takes place and the individual is booked in. GPs are not willing to fill in a form but will send

a message using EMIS. Advice Pro is the CMRS and information about the individual can be recorded in advance. There is also the facility to use digital signatures.

North Lanarkshire

Reception staff in surgery have access to a diary and book appointments. This ensures that there is clear and transparent communication. All but one surgery has a waiting list of about a month. Vision is used to make appointments.

East Ayrshire

A referral form has been created which includes data consents. There are different processes used for almost every GP Practice. Triage takes place and follow up appointments are offered using slots in the GP Practice. There is the facility to use notes in EMIS and a template has been created.

Dundee

There are two service providers, local authority and third sector. In the local authority referral processes vary - in about 50% of GP Practices an appointment is made by reception staff or GPs directly. Each GP Practice has a number of set appointment slots each week.

In others, individuals call the duty line, and all callers are asked which GP Practice they are a member of. Appointments are then made. Appointments are made using Vision. (This is not following the agreed model and has been discussed).

In the third sector provider there is a standardised process and members of staff will book individuals in directly if an appointment is available. Some individuals come straight to the third sector provider, especially if they are a previous client. Again, a routine question is asked. A three-way call takes place between the individual seeking advice, the triage worker and reception staff in the GP Practice. 25% of individuals make contact in this way. (This is not following the agreed model and has been discussed).

West Dunbartonshire

Each practice takes a different approach. One GP Practice books appointments using EMIS, another gives the advisor a list of patients and asks them to book appointments whilst the third makes referrals to the main site.

Conclusion

This report provides evidence of the effectiveness of WAHPs by using both quantitative and qualitative data.

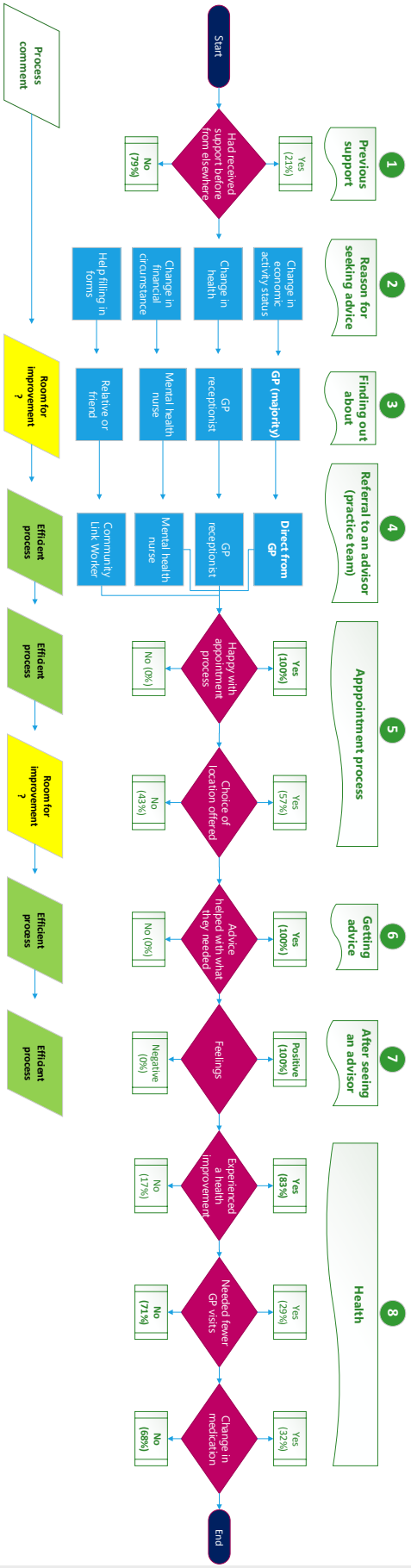
Advice providers, GPs and patients have, from their own individual perspectives, shared their positive experiences of being able to access welfare rights advice in GP surgeries.

Whilst recognising the benefits of this approach to service delivery there have been challenges and these have been identified and the ways in which they have been addressed shared.

Advice leads and providers were asked to share what they considered to be the most important message about WAHPs. A selection is set out below.

> *"It's not good the support I've got from the practices, it's great."*
>
> *"Previously GPs would not refer into a mainstream service – now they see the value of advice."*
>
> *"To recognise the impact of the work within the WAHP and provide permanent funding to LAs to roll it out to all GP Practices in an area."*
>
> *"The WAHP service model has been proven to work and needs to be fully funded to ensure support can be provided to local residents across Scotland."*
>
> *"The model is excellent but the uncertainty on funding and staffing and lack of recognition derails it."*
>
> *"The WAHP Provision should be of equal value as CLW to enable a holistic service."*
>
> *"This is an essential service increasing capacity would enable all practices to be included."*
>
> *"The service offers value for money."*
>
> *"Where staff should be is where communities need advice - in GP practices."*
>
> *"In an ideal world this would be implemented in all GP Practices. No changes to essential elements are required, just further roll out."*

Appendix One: Customer Journey Map



Appendix Two: Abbreviations guide to case studies

ADP	Adult Disability Payment
CB	Child Benefit
CDP	Child Disability Payment
COC	Change of circumstances
CTR	Council Tax Reduction
EMIS system	An NHS programme that supports improved patient care by sharing information held within GP practice IT systems for use across health and social care.
ESA	Employment and Support Allowance
FIT note	A fit note is issued by certain healthcare professionals. It provides evidence of the advice patients have been given about their fitness to work.
GDPR	General Data Protection Regulation
NS ESA	New Style Employment and Support Allowance
SCP	Scottish Child Payment
SSP	Statutory Sick Pay
UC	Universal Credit
WCA	Work Capability Assessment
WRA	Welfare Rights Advisor

Other welfare/benefit abbreviations

AA	Attendance Allowance
CA	Carer's Allowance
CAA	Constant Attendance Allowance
DLA	Disability Living Allowance
IB	Incapacity Benefit
LCWRA	Limited Capability for Work-related Activity
PIP	Personal Independence Payment
SDA	Severe Disablement Allowance
SDP	Severe Disability Premium
SMI	Severe Mental Impairment

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