Nick Hopkins Consulting

Evaluation of 'Tackling Money Worries'

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Content

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Executive Summary

This evaluation report explores the following questions in relation to Maryhill & Possilpark CAB's Tackling Money Worries Project, a primary care linked advice project in Glasgow's Possilpark, one of the most disadvantaged communities in the city:

- Has the service been managed effectively?
- Has the service been effective in meeting the needs of the people it has targeted, and has it had a positive impact on their lives?
- Has the partnership between the CAB and primary care staff that lies at its heart been successful?
- Does this partnership deliver added value to clients sufficient to justify the continuation of the project model?

Summary of the Plan for the Project

The project was initially funded by the Scottish Legal Aid Board, with the allocation of £141,376, for the 18 months to 30th September 2016 which was extended for a further six months. This was to fund two members of staff; a senior advice worker and a money advice worker, with the former providing technical supervision for their colleague.

The project sought to improve the health and wellbeing of clients through a holistic and preventative service aimed at:

- Improving the financial skills and knowledge of low income families thus preventing them from getting into unsustainable debt.
- Supporting such families when they have fallen into unsustainable debt, providing advice to level 2.
- Maximising the income of families.
- Putting families in touch with sources of other support, for example employability advice.

The work was to be based on partnership between Maryhill & Possilpark Citizens Advice Bureau and the six GP practices in Possilpark, and the project sought to deliver a number of partnership outcomes:

- Fostering stronger bonds between primary care staff and advice services, ensuring that the former acted as a gateway to the latter.
- Creating better, seamless pathways between the two, with the emphasis on referral not signposting.
- Embedding money and debt advice in the practices through co-location or attachment.

Health visitors were expected to be the main source of referrals to the project, with effort focused on building relationships with them to generate those referrals.

The proposal set out that advice staff would be co-located with GP practices. This was aimed at ensuring that people did not drop out between referral to the project and actually accessing it. Some out of hours support up to 8pm was planned, with home visits also offered if required. Childcare costs would be met for those otherwise unable to make use of the project. A variety of channels for the delivery of advice would be used; including phone, face to face, text and e mail, according to the wishes of clients.

Group sessions were to delivered as part of the focus on prevention, within the health centre, but also targeting nurseries and schools.
The project aimed to target families with children under 8, particularly those on low incomes, expectant families, families with a child with a disability, and kinship carers.

The proposal suggested that 75% of the 1,950 families on the register at Possilpark Health Centre would be supported through one to one or group sessions. 120 clients would be reached through 10 group sessions over the course of the project, and 20 families per week would receive intensive support.

Project Delivery

- The first referrals to the project began in March 2015.
- The start of the project was delayed by difficulties relating to recruitment of the senior advice worker. Recruitment was only achieved after the changing of the role to project co-ordinator.
- There were significant early practical issues around co-location and multiple referral points. IT issues persisted into the Autumn of 2015.
- As relationships were built with staff at the health centre, in particular the GOs, the project broadened its focus to include clients without children.
- The first workshops were delivered in Summer 2015.
- Pressure on space meant that project staff had to leave the health visitors room in late Sumer 2015.
- In April 2016, after significant investment of time, involving meetings with, and the development of 'contracts' for, each practice, a pilot was set up allowing project staff to access client medical records to help with applications for disability benefits and reduce the burden of such applications on GPs.
- Staffing issues in 2016 included significant sick leave for one of the initial advisers, and the moving on and replacement of both initial staff members.

Project Statistics

Levels of Client Engagement

- The project has dealt with 366 clients, a reasonable number over its 21 months, although referrals were too low initially.
- The initial target for the project was too high, and the project has dealt with fewer people than comparator projects elsewhere in Scotland.
- The capacity exists to increase the number of project referrals further.
- The significant variation in referrals across time reflects both gaps on staffing due to changes and spikes in engagement work by staff.
- Managing the project workload would be difficult if referrals were coming in as fast as they might be.
- The project has seen reasonably steady caseload growth.

Sources of Referral

- There has been a significant shift in the source of referrals since the first 12 months of the project, with 55% now coming from GPs and 42% from health visitors. This reflects significant engagement work being done with GPs.
- There are potentially untapped sources of referrals amongst the Early Years Service and voluntary organisations.

Client Demographics

- 76% of clients are female, partly reflecting the focus of the project on parents with young children.
- This may also suggest that this project has not been as successful at reaching men as hoped, and perhaps that health-linked projects are not always the most effective way of reaching male clients.
- There is a spread of clients across the working age group, reflecting the dual focus of the project.
- About 1 in 4 clients have a disability, a number which is lower than might be expected, and which possibly reflects a recording issue for people with mental health problems/ long-term conditions.
- Only a quarter of clients whose family size is recorded have three or more children; people with small families can still be at high risk of financial problems.
- The predominance of clients living in social rented housing is a reminder of the financial status of many social renters, and that substantial existing efforts by local housing associations to meet their tenants' need for advice still leave some demand unmet. It also suggests that duplication of service can be overstated as a concern, and multiple points of access to advice services are necessary.
- Three quarters of clients are single, reflecting both the focus of the project, which inevitably engages with large numbers of single parents, and the pressures that operate on single adult households.
- The project client base seems to reflect the increasingly ethnically diverse nature of the Possilpark community, and the project seems to engage with a significant number of migrants with particular needs. Project statistics suggest that it is not engaging as many people from Eastern Europe as might be expected.

Client Financial Exclusion

- The client base is very much more financially excluded than the broader UK/ Scottish population, and significantly more financially excluded in terms of accessing mainstream products than the broader UK/ Scottish population living on low incomes.
- Project statistics suggest that the majority of clients have no current contact with mainstream or subprime providers of financial services, although this picture was not clearly born out by interviews.

Client Issues and Outcomes

- The project has predominantly dealt with benefits issues, with debt issues not far behind.
- The incomplete statistics available from the project suggest that where financial capability issues are dealt with, they are dealt with as secondary issues.
- The incompleteness of the statistics means that we cannot identify how much work has been done on dealing with the financial exclusion issues identified above.
- The project has delivered significant client financial gains of nearly £330,000, over 21 months although the true and final figures are likely to be higher.

Client Feedback.

14 clients were interviewed in a semi structured format, 13 of those interviews being carried out over the phone. Recruitment for the interviews was challenging, and interviewees often did not engage with the consultant despite agreeing times with him on one or more occasions. This difficulty reflected the vulnerability of the client base.

Routes into the Service:

- Referrals arise naturally from client interaction with health visitors and GPs.
- Other health professionals, including surgery receptionists, have also been making referrals, although these are not seemingly recorded as such, suggesting that awareness of the service is spread wide amongst health teams.
- Word of mouth also has a role in promoting self referral, or priming people to seek help.
- Some clients will find their way to this service through referral, despite previous struggles to access CAB services.
- There are barriers to self referral even for people aware of the CAB's existence:
    - Prior knowledge of the CAB service, even when gained professionally, does not necessarily translate into seeking help, particularly if clients have inaccurate beliefs their entitlement to benefits.
    - People may be aware that the CAB exists but have little or no understanding of the work that it undertakes.
- Lack of awareness of entitlement to benefits remains a major barrier to people seeking support; some people do not realise that there is anything they need support with.
- Feedback suggests that some people from migrant communities are not accessing specialist support from organisations like the Scottish Refugee Council in the way that might be hoped. It is also possible that the project is not referring to them in the way that might be expected.
- Other actors in the support/ advice system, such as welfare rights officers with social landlords, are not necessarily engaged with clients in the way that might be hoped.
- The service is getting to people who otherwise would not have accessed support and advice, or at best would have accessed it later in the development of their problems.

Clients Problems Faced

- The vast majority of clients were facing problems claiming their benefit entitlement.
- Issues were experienced associated with change of circumstances, including childbirth, bereavement and medical retiral.
- Benefit issues experienced could be complex, and difficult for clients to explain.
- Difficulties accessing the benefit system, or their lack of entitlement to benefits in the case of clients from migrant communities, could mean some clients living without state financial support.
- Benefit issues could trigger risk of homelessness, debt, or unsustainable financial situations.
- Clients reported falling behind on priority debts, including clients who were from migrant communities not entitled to state support.
- Some clients had also fallen into consumer debt, in one case as a result of the breaking down of a household appliance; events can overwhelm people with little financial resilience.
- Previous debts can compound the problems clients face.

- Loans from families are an important source of support in dealing with debt, but are not unproblematic themselves, and are generally not sufficiently large to deal with broader problems faced.
- Some clients felt that their financial situation was out of control, others that they had acquired the skills to deal with the problems they faced.
- Those problems may have been more limited partly because of their possession of these skills.
- Financial problems can be a source of intense stress to clients.
- Stress can be triggered by debt, worries about loss of particular goods and services, worries about loss of independence, or by the experience of claiming benefits itself.
- Stress related to worries about their financial situation may compound clients' other worries, or simply be additional to them.
- Clients may also experience anger or frustration as a result of their financial situation.
- The worry and the practical problems occasioned by financial problems can put the health of clients and their families at risk.

Support Provided

- Clients receive a variety of support in relation to benefit issues:
    - Comprehensive benefit checks.
    - Assistance with filling out forms/ completing forms on their behalf.
    - Explanation of the system/ situation in which they find themselves.
    - Chasing up progress from an unresponsive system.
    - Assistance to access grants and funds from outside the statutory system.
    - Appeals against decisions.
- Benefit checks may start on the basis of discussing one benefit related issue, and conclude with looking at several more.
- For some clients, more light touch support may be all that is required.
- Explanation of the benefit system may be particularly important for clients from migrant communities.
- Debt advice begins with a taking stock of clients' situations.
- Advisers had also phoned creditors on clients' behalf and one was being taken through the bankruptcy process.
- Advice on money management generally followed problem resolution, although initial conversations on money management were being had even before that point and more detailed conversations were often planned later.
- Often clients had felt that they did not need advice on money management, or that this aspect of the service was only a small element of the support provided, in the manner of a quick health check that they felt confident, capable and were on the right track.
- Advice might be as simple as pointing people in the direction of cheaper food/ fuel bills.
- Some clients require direction for support to deal with destitution/ access humanitarian aid.
- Clients may see the support they receive as 'fixing things' or even 'sorting their life out.

Additionality of the Service

- There is clear direct evidence from client feedback that the service is additional, in that it helps them resolve problems that they feel they would not have been able to deal with themselves.
- Those who had been provided with support on benefit issues report that:

    - They would not have been able to deal with the complexity and length of benefit forms themselves.
    - They would have lacked the knowledge, skills and stamina to have completed them themselves.
    - They would have lacked the persistence to deal with an unresponsive system.
- Clients who had been experiencing emotional difficulties at the time of accessing support were particularly clear they would not have been able to deal with the challenges they were facing.
- Clients often lacked access to other support.
- Some clients felt that they would have suffered significant harm without support, either being placed in a unsustainable financial situation, or seeing their housing situation put at risk.
- Even without being at risk of such harm, clients felt that they would have been 'stuck' without help.

Impact of the Service

- The service has a significant practical impact on the lives of its clients.
- For some clients, this is about enabling them to meet basic household needs, including the purchase of baby milk formula, or at least enabling them, to meet such needs more cheaply.
- Other clients were now able to meet specific additional expenses, for example food and accommodation bills associated with a child's hospital treatment.
- Clients also saw an impact on their ability to pay basic household bills, including energy bills.
- Clients had received humanitarian support in relation to specific events such as Christmas time, or were better placed to meet the costs of such events.
- Back payments on benefits can be used to make large purchases for example of furniture.
- Maintaining access to a Motablity car, and thereby to independence was a key outcome for some clients.
- For some clients, outcomes included less pressure and greater flexibility over spending, whether on better food, on children including on leisure activities, or on leisure activities for themselves.
- Clients cannot always completely take themselves out of financial difficulties as a result of the support received.
- Clients have mixed views as to whether they are truly financially resilient as a result of the service.
- Some continued to see aspects of their resilience in terms of access to benefits, others flet that they had made appropriate provision to deal with financial challenges, others felt that they would struggle to access finance if they needed to replace household goods. The latter point suggests that messages about affordable loan products have not been absorbed or that alternative loan products do not meet their needs.
- The resolution of financial problems has had a positive psychological impact for many clients.
- For some, that resulted simply from being able to support their children properly, for others from no longer being hassled by creditors.
- The service had given some clients the space to breathe and take a step away from pressure on them before starting to rebuild their finances.
- Some clients who felt they had been the victim of discrimination still felt huge frustration at the situation they had found themselves in, the service cannot completely resolve that.

- Some clients reported changing their financial behaviour, sometimes quite significantly.
- This could be as a consequence of the advice and help on money management offered by the service, and/or the determination to avoid a repeat of existing problems once they had been resolved.
- This feeling of greater control could in itself reduce stress.
- For some clients, empowerment will be about seeking help from the CAB at the right time if problems arise in the future, not about being able to resolve those problems directly themselves.

Quality of Service and Recommendations for the Future

- Clients are very positive about the service, both generally, and when highlighting specific aspects of it.
- They see staff as being understanding, professional, reliable, expert and knowledgeable.
- Clients felt they had been dealt with great empathy at moments of real stress.
- They also felt listened to and not judged.
- Two clients had slightly more negative experiences. One felt that the service could do better at remaining in contact with them whilst their case was being worked on, another had found another service provided by the CAB that they had previously accessed to be disorganised.
- The service was compared favourably to other sources of support.
- The service passes two acid tests; clients would recommend it to others, and would use it again themselves.
- There are few recommendations from clients for improving the service, but there is some suggestion it could be more effective at staying in contact with clients, and clients imply that more publicity more generally for CAB services would be helpful in terms of getting to people sooner.

Feedback from Partners and Project Staff.

13 interviews and 1 focus group were conducted with project partners; including both health visitors and GPs, the Health Improvement Team at NHS Greater Glasgow and Clyde, project staff and CAB managers.

These explored their views on the:

- Issues affecting clients.
- Project set up.
- Partner relationships and referrals
- Service model and pilot project.
- The impact of the service and its additionality.

Issues Affecting Clients

- The financial pressures reported as being faced by families with young children confirm that the project selected its core target group appropriately.
- Financial worries have significant impacts on the health and wellbeing of patients, both their mental health, and their physical health.
- Issues around debt and benefit take up may also have an impact on child development through reducing household income.
- Welfare reform is seen by partners as a key driver of the financial problems facing their patients.
- This can be through generating general uncertainty about entitlement, exacerbated by media coverage, or through creating specific fears about loss of entitlement, for example in the case of the transition between disability related benefits, or through practical problems including suspension of payments.

- Sanctions can leave people facing situations of extreme hardship, and have a severe impact on their mental and physical health.
- Particular pressures may be experienced by parents who are also dealing with drug and alcohol problems, or who are from migrant communities or in the asylum process.
- There is a debate about the extent to which the issues facing young parents and other clients relate to money management.
    - Some suggest that a lack of household management skills such as cooking play an important part in causing financial difficulties.
    - Others suggest that most clients who are not facing addiction issues are competent money managers, but just face a different set of financial 'choices' from those who are better off.
    - Lack of cash is seen as the major issue for most clients' money management.
- There is agreement that sudden financial shocks, pressures on expenditure that can in theory be planned for such as Christmas, and the natural desire of parents to ensure their children don't miss out, are all risk factors for turning highly stretched household budgets into something unmanageable.
- Patients referred to the project may also struggle to access affordable credit.
- Those accessing credit may not take the need to pay it back seriously enough, or may have their own particular ideas about household essentials.

Project Set Up

- The project was able to some extent to build on pre-existing relationships between the health visiting team and Maryhill & Possilpark CAB, based on their work together under the Healthier Wealthier Children project, although the time gap between that project and this had fractured that relationship somewhat.
- The project faced significant organisational challenges during set up.
- There is consensus that many of these issues took too long to resolve, particularly given that the practices involved were part of the Deep End movement, although it was acknowledged that most of the pressing practical issues had now been dealt with.
- The causes of delays in recruitment, not concluded until the end of the project's second quarter, are not clear.
- NHS bureaucracy and inflexibility, whether or not justified, and pressures on accommodation at the health centre were identified as the key causes of delays to resolving issues around accommodation, access to IT and some of the practical challenges around referral.
- It was suggested that a project steering group or the earlier appointment of a project co-ordinator might have been able to resolve these issues sooner, and that it was unfortunate that lack of certainty about accessing funding had curtailed prior preparation work.
- Partners and project staff were, however, clear, that delays were also the simple result of the project breaking new ground, there had been no pre-existing route map to creation of something that would function effectively.

Partner Relationships and Referral.

- The project cannot function without effective working relationships between project staff and primary care staff. Without trust, there would be no referrals, without referrals there would be no project.
- That building of relationships requires effort.
- Interaction between project and primary care staff is key to having that trust.
- However, there are barriers to informal interaction between advice staff and GPs, mainly the few opportunities they have to engage with other, and barriers

to formal interaction given the huge agenda facing GPs and consequent pressure on time to meet.

- Interaction with health visitors has been more intensive, although project staff are no longer sharing accommodation with health visitors due to pressure of space has reduced the extent to which it happens.
- Despite that, the project workers have become well integrated with primary care workers, although staff changes will necessitate further work to rebuild links.
- There have generally been good working relationships between Maryhill & Possilpark CAB and the Health Improvement Team which have been critical to project staff's ability to create the necessary links with primary care staff.
- The groups targeted by the project have expanded to include adults with health conditions as well as families with young children.
- This has been a reasonable response to the demand for the advice on money issues that has been channelled through GPs. Whilst continuing to meet the needs of families with young children, the project has determined developing their relationship with GPs was more strategically important than seeking to build links with other organisations who work with families with young children.
- Primary care staff identify patients in potential need of advice on money issues both through deliberately seeking to discover whether they are in such need, and over the natural development of their engagement.
- GPs may often refer people with mental health problems when their exploration of the causes of those problems identifies money difficulties as one of the issues. However, the number of referrals like this may be limited by the time constraints they face on consultations.
- Health visitors are in the homes of young families in a way that few other professionals are. They use that presence to identify visual clues that patients might be struggling financially, as well as asking parents direct questions about financial circumstances.
- There are variations in the extent to which different health visitors make referrals to the project, and encouraging health visitors to make referrals remains an ongoing challenge.
- Barriers to increased referrals may include health visitors facing time constraints, but it may also be the case that there are some attitudinal barriers to referral amongst a few, and that a few pay lip service to the idea of referral.
- It is possible that greater use of standard questions by health visitors with patients, and greater focus on referrals in work plans and meetings, might generate a greater number of referrals.
- Practically, referrals may be made through paper, email and phone channels.
- The number of channels reflects the need for flexibility so that primary care staff can refer in a way that makes sense to them.
- There is, however, a considerable amount of effort required to make these different referral channels work effectively and ensure prompt response.

Service Model.

- The majority of the project's work is standard welfare rights and debt advice.
- There has been less work than was predicted in the funding bid on financial capability and financial inclusion in the sense of providing support with budgeting and to access financial products:
    - Only half of the clients are reported to need financial capability and financial inclusion support.
    - Many clients are not open to a discussion of money issues, or do not believe they need advice on budgeting.
- However, all debt clients do receive basic messages about the importance of paying back money borrowed.

- The balance between problem resolution and capacity building is seen as reasonable and as being determined by the balance of client wishes and needs.
- On referral, in house and externally, on issues as varied as immigration, mental health and smoking cessation is a key part of the project.
- Resolving clients' issues typically takes a number of meetings, not least for trust to develop and clients to open up about the issues that they face.
- Some tensions do require management, in particular the tensions between empowerment and control, between meeting the needs of existing and the needs of new clients, and between moving people on and providing them with all the support they need.
- There are time pressures on the service when referrals are high, challenging in a context in which so many clients need intensive support.
- There are specific groups which can be difficult to engage or remain in contact with, particularly people with mental health problems and people experiencing domestic violence.
- Group sessions have been delivered effectively by project staff, though some challenges have been experienced in delivering to mothers when children are present, and because of the short time slots available.
- There is an appetite to do more group sessions, engaging with a wider range of partners as a way of raising the profile of the service as well as of communicating key messages to service users.
- A pilot project has been run involving advice workers accessing clients' patient records and using the information to submit supporting reports as part of clients' disability benefit assessments.
- This has been working effectively, despite some teething issues.
- Pressure on GPs to deal with benefit applications appears to have reduced as a result of the pilot.
- The process of setting up the pilot involved considerable work, but there were fewer barriers than might have been expected from GPs, with any concerns about confidentiality talked through, and overcome by GPs' pressing need to deal with a source of considerable pressure on them.
- It is essential that project staff communicate clearly with GPs about the project and the people it is engaging, so that there can be full appreciation on all sides of what it is achieving.

The Impact of the Service and its Additionality.

- The service is seen as successful in raising patients' incomes, dealing with debt and preventing them from experiencing destitution. Its impact can be as basic as helping a young mother afford nappies.
- This practical impact has a positive impact on patients' mental health and well being, amongst mothers of young children as much as adults with long standing depression and anxiety.
- There may be some reduction in the number of appointments that some clients seek from GPs.
- Primary care staff report that the project has changed their practice, increasing the likelihood that they will raise financial issues with clients because they know they now have a way of dealing with those issues.
- The project is also seen as having the potential to be an exemplar project influencing practice more widely.
- Prior to the project's existence primary care staff would provide adhoc and limited support to their patients in relation to the completion of benefit application forms, and/ or signpost them to the CAB or other services.
- This situation was seen as an inadequate way of dealing with the issue, increasing the risk that people would not make it to advice services, because it

placed the onus for taking action more on to patients, some of whom were vulnerable.
- The co-location of identified workers with health staff is at the heart of the project.
- This basic model is seen as having given people the opportunity to access a service in a familiar and nearby location in which they feel comfortable and non stigmatised, delivered by a person whose name they know and in whom they can develop trust over time.
- The referral processes themselves are seen as smooth, and as tailored to the specific demands of individual practices, and the tight relationship between advice and primary care staff as meaning that non engagement can be followed up.
- The service has become an essential part of the support to which primary care staff can link their patients, and it would be a huge frustration to them if it were lost. Its loss would represent yet another gap in the range of support services available to patients.
- Its loss would be seen as a very retrograde step, which would risk hurting the vulnerable, and risk fewer people accessing appropriate advice and information.

Conclusions

Has the delivery of the service been managed effectively?
The delivery of the service has faced a number of significant practical challenges. Recruitment to the posts was slow, neither of the initial staff are now in post, and there were issues that took a long time to resolve around accommodation, access to IT, e mail addresses and storage.

These issues did appear to have affected the project's initial ability to deliver its objectives, and were a distraction in its early stages. There have been barriers to the creation of the sorts of mechanisms, such as a project steering group, which might have been able to resolve them.

However, the service has, despite there being a something of a forerunner version, been breaking new ground. Furthermore, it has successfully introduced a new way of working through its pilot project on patient record access that has required complex discussions.

It looks therefore as if the difficulties in service delivery have largely been about the challenges inherent in working up a partnership between primary care and advice staff, challenges that can be reflected on and dealt with more quickly in any replication of the service.

Has the service been effective in meeting the needs of people in need of adviceand has it had a positive impact on their lives?
There is strong evidence that the service has been effective in meeting the needs of people in need of advice.

There have been two significant changes to the project that was initially envisaged; the project has more focus on problem resolution than supporting people to change their long term behaviour, and it has taken referrals of adults with health conditions as well as of parents with young children.

However, these changes have been a response to demand, to the needs of clients, and the balance of need for advice observed by GPs amongst their patients.

The project has shown the flexibility to respond appropriately, and to prioritise the need to develop effective working relationships with GP practices by encouraging referrals. In the first case their experience also reflects that of similar projects which have found that clients need to resolve pressing financial problems before focusing on changing their behaviour in the long term.

The interviews with clients make clear the extent to which the service has succeeded in reaching people facing significant financial issues, something confirmed by primary care staff reporting on the problems facing their patients. Project statistics are clear about the extent of financial exclusion amongst clients, a majority appear not to use mainstream or even sub prime financial products.

It is also clear from the interviews that the service has succeeded in making a real difference to the financial situation of clients, through increasing the amount of benefit they are claiming and resolving their debt problems. People's financial behaviour has also been changed. Clients have no doubt that they would not have been able to resolve the situations they faced without the help of the project. However, it is possible that the project has not engaged with the issues of financial exclusion as it might have done.

Changing people's financial situation has often resulted in significant gains to their mental health. Dealing with the situations of destitution facing some clients has meant that they have been able to care more effectively for their children.

In its first 12 months, the project did not reach as many clients as was desirable. That situation has been at least partly dealt with over the latest nine months of the project. The project delivers well for those who are referred, and there is capacity to ensure that it delivers well for an even greater number of people.

Has the partnership between the CAB and primary care staff that lies at its heart been successful?
The initial failure to generate sufficient referrals points to the challenges the project faced in creating effective partnerships with health colleagues.

However:

- The growth in referrals is testament to some improvement in partnership working.
- Some health visitors and GPs report a very positive relationship with the CAB.
- The closeness of those relationships has changed the practice of those primary care staff, they are more likely to identify clients facing financial problems than they were before, and they have a clear route for responding effectively to those problems.
- The pilot project involving advisers having access to patients' records could not have happened without the development of effective working relationships and trust between primary care staff and the project, and the intervention of the Health Improvement Team.
- Those clients who have accessed the service would in most cases not have done so had it not been for the referral through primary care staff.
- Referral rather than signposting reduces the likelihood of clients not engaging with the service once their issues have been dealt with.

The challenge for the service now is to ensure that the warmth of the core project relationship extends across all primary care staff within Possilpark Health Centre, and those warm relationships translate into further increases in referrals and more

consistent identification of need. There will no magic recipe for this, just constant engagement work and feeding back on project progress.

It is clear that the co-location of the service has been a factor in the success it has had. Most importantly, clients have been able to access support in a location close to where they live, in a location in which they feel comfortable, and which is not in any way stigmatised. Joint work with primary care staff has enabled project staff to maintain contact with clients.

Does this partnership deliver added value sufficient to justify the continuation of the project model?
Despite the challenges the project has faced in generating sufficient referrals, the answer to this question must be yes.

Yes, because the service is getting to people who cannot resolve their financial difficulties themselves, who might otherwise not have accessed appropriate support, or might not have stayed engaged with advice, and is impacting positively on both their financial situation and their mental health.

Yes, because the service has begun to shift the practice of primary care staff in a way that will help their patients.

Yes, because the service would be much missed by clients and by primary care staff, and its loss would lead to fewer people accessing support, more pressure on primary care staff, and clients with greater health problems.

Section 1: Introduction

In April 2016, Nick Hopkins Consulting was commissioned to undertake an evaluation of the 'Tackling Money Worries' Project, a holistic money advice project delivered by Maryhill & Possilpark CAB in six GP practices in Possilpark Health Centre.

This evaluation report explores the following questions:

- Has the service been managed effectively?
- Has the service been effective in meeting the needs of the people it has targeted, and has it had a positive impact on their lives?
- Has the partnership between the CAB and primary care staff that lies at its heart been successful?
- Does this partnership deliver added value to clients sufficient to justify the continuation of the project model?

The evaluation is divided into four main sections:

- Section 2: An overview of the project, based on the initial proposal to the Big Lottery and subsequent monitoring reports.
- Section 3: A review of statistics provided by the project.
- Section 4: Feedback from clients, based on 14 telephone interviews.
- Section 5: Feedback from primary care staff, managers within Maryhill and Possilparkand Possilpark CAB, the Health Improvement Team and project staff.
- Section 6: Conclusions, exploring the answers to the questions detailed above.

At the end of each subsection is a list of key points, which also form the larger part of the Executive Summay at the start of this report.

A Note on the Delivery of the Report.
Delivery of this report has been significantly delayed due to two sets of issues, both of which are significant findings in their own right.

Maryhill & Possilpark CAB provided lists of names of clients of the service on three separate occasions, providing over 30 names in total. Despite this, the consultant was only able to carry out 14 interviews with clients. In 9 years carrying out telephone based interviews the consultant has never experienced as many clients not answering the phone to him to arrange an interview, or more commonly, not answering the phone when he called at the arranged interview time, despite as the project continued, the offer of £10 to all interviewees.

There were also significant delays in arranging phone interviews/ focus groups with primary care staff, in particular with GPs. It took numerous attempts at contact by the consultant, and messages passed on through the Health Improvement Team to make appropriate arrangements.

The consultant would not interpret either of these sets of difficulties as reflecting clients' or primary care staff's views of the project, but as more likely to be indicative of the vulnerability of clients, and the time pressures on primary care staff.

Section 2: Summary of the Project

The Bid to the Scottish Legal Aid Board

The bid to the Scottish Legal Aid Board, submitted in June 2014 sets out the key features of the project as it was envisaged at the start of the development process.

Objectives

The project sought to improve the health and wellbeing of clients through a holistic and preventative service aimed at:

- Improving the financial skills and knowledge of low income families thus preventing them from getting into unsustainable debt.
- Supporting such families when they have fallen into unsustainable debt.
- Maximising the income of families.
- Putting families in touch with sources of other support, for example employability advice.
- Developing peer support where local people will be trained and supported to help families with the above.

The order of the key actions was significant; the emphasis of the project was very much to be on prevention and building the capacity of clients.

The project also sought to deliver a number of outcomes in relation to partnership:

- Fostering stronger bonds between primary care staff and advice services, ensuring that the former acted as a gateway to the latter.
- Creating better, seamless pathways between the two, with the emphasis on referral not signposting.
- Embedding money and debt advice in the practices through co-location or attachment.

The project was seen as providing a significant boost to capacity locally. It aimed to be scaleable, replicable and transferable, influencing practice more widely and testing out the effectiveness of an intensive neighbourhood approach to reducing income and health inequalities.

Service Provided

Debt advice was to be provided to Type 2 level; including checking liability/ enforceability of debts, identifying and agreeing options in debt cases, drawing up financial statements, negotiating with and making offers to creditors and assisting with bankruptcy and sequestration.

Advice on financial capability would include supporting clients to develop a better understanding of; budgeting through getting a financial health check; bank accounts backed by work with banks to help clients open bank accounts; key concepts around borrowing and saving; credit unions; the importance of insurance and how to choose appropriate insurance.

The work was to be based on partnership between Maryhill & Possilpark Citizens Advice Bureau with its longstanding record of advice work, and the six GP practices in Possilpark, who would support people from the target groups to access the service.

There was to be a particular focus on linking with health visitors; providing them with training so they could better identify families who might benefit from the service using strategies for raising issues in a tactful way, and backing this by increasing their knowledge of the benefits for families of resolving their financial issues.

The Specialist Children's Service would also be involved to assist access for children with disabilities.

Time was to be allocated for staff to build links with the primary care staff, both providing them with training, with 10 sessions planned for staff across the period of the project, and, with consent, feeding back to those staff about progress with the families they had referred.

Co-location and Channels for Delivery
The proposal set out that advice staff would be co-located with GP practices. This was aimed at ensuring that people did not drop out between referral to the project and actually accessing it.

To further ease access, some out of hours support up to 8pm would be provided, as would home visits if required. Childcare costs would be met for those otherwise unable to make use of the project.

A variety of channels for the delivery of advice would be used; including phone, face to face, text and e mail, according to the wishes of clients.

The emphasis on early intervention was also to be backed by project and health care staff systematically working through GP registers to identify potentially vulnerable clients.

Group sessions were to delivered as part of the focus on prevention, within the health centre, but also targeting nurseries and schools.

Target Group and Project Targets
The project would explicitly target families with children under 8, with the initial statement identifying key groups of families who would be supported:

- Low income families.
- Expectant families.
- Kinship carers.
- Families where disability is present.

The proposal acknowledged specific points of vulnerability around childbirth, the desire to keep up with other families in terms of children's possessions, and the impact of barriers to accessing services such as tiredness, isolation and worries. It also acknowledged the increasingly difficult financial climate in which families were trying to survive.

The proposal suggested that 75% of the 1,950 families on the register would be supported through one to one or group sessions. In terms of group sessions 120 clients would be reached through 10 group sessions over the course of the project.

20 families per week were to be assisted with intensive support, that number including both new and repeat clients.

The geographical area covered would be bounded by the distribution of patients from the six partner practices based in Possilpark, one of the most disadvantaged communities in Glasgow.

The area has higher levels of child poverty, single parenthood, unemployment and economic inactivity, ill health than the Glasgow average, and much higher than the Scottish average.

Strategic Fit.
The project was seen as fitting with a range of wider plans and strategies:

- Glasgow's Single Outcome Agreement commitments to supporting people to become more resilient in the face of a difficult economic context.
- GCC's Strategic Plan commitments on access to financial services such as credit unions, tackle poverty and health inequality.
- GCC's financial inclusion strategy with its themes looking at early intervention and education, targeted support for vulnerable groups, improving accessibility and partnerships and collaboration.

It would also fit with developments within NHS Greater Glasgow and Clyde:

- Building on their Healthier, Wealthier Children model of practice supporting families with children to access advice services, to create a more intensive, targeted neighbourhood approach.
- Being part of Community Oriented Primary Care, the new approach to planning services linking primary care staff and voluntary sector organisations.

Staffing and Management of the Project.
The project proposed to employ two members of staff; a senior advice worker and a money advice worker. Both would be appropriately experienced and qualified, the senior would provide technical supervision for their colleague.

The project was to be overseen by a project board, to whom the project team would report monthly.

Budget
The budget requested from the Scottish Legal Aid Board was £141,376, with a further £5,000 from the Area Development Group, split as follows:

- £38,394 in 2014/15, of which £27,840 in salary costs.
- £71,988 in 2015/16 of which £55,680 in salary costs.
- £35,994 in 2016/17 of which £35,994 £27,840 in salary costs.

Project Delivery Timeline- Key Milestones.

First Quarter: Ending December 2014:

- Recruitment delays experienced.
- Money advice worker recruited in November 2014, and started on January 5th.
- Senior money advice worker not recruited despite internal and external recruitment attempts.

Second Quarter: Ending March 2015

- Referrals to the project began in this quarter.
- A senior member of staff was recruited, with the role changed from senior advice worker to project co-ordinator. They began work on April 1st.
- Project sought to deal with a number of issues associated with co-location; access to lockable cupboards, a room for interviews and access to laptops.

Third Quarter: Ending June 2015

- Partners were identified to host workshops.
- The number of referrals grew, particularly from health visitors.
- Some issues arose around multiple referral points.
- The NHS refused to allow staff to access lockable cupboards and co-location remained a challenge.
- Connections were built with practice nurses.

Fourth Quarter: Ending September 2015

- Discussion began on the project exit plan.
- The money advice worker dropped her hours to 28, with another colleague from the CAB picking up some additional work, being employed for half a day on the project.
- Referrals continue to grow although many were made not according to the initial criteria set by the project.
- 6 financial capability sessions, 'Summer on a Budget' were delivered.
- NHS.net accounts were established for staff, although laptops were still not made available.
- Accommodation issues arose, with pressure on space meaning that staff had to leave the health visitors' room, and the room used on the ground floor for delivery of appointments proving unsuitable.

Fifth Quarter: Ending December 2015

- Discussion began on the possibility of piloting access for advice staff to medical records.
- Visit to Edinburgh to learn about their approach took place.
- HR advice taken on NHS view and honorary contracts with practices covering the sharing of information.
- Staff reported spending more time in the CAB office than expected because of issues about PCs, lack of room, no storage space or supplies.
- Three workshops were delivered on a Christmas theme.
- Referrals grew as GP confidence in the service increased.
- GPs reported a reduction in their workload.

Sixth quarter: Ending March 2016

- The money advice worker had a significant period of sick leave in February 2016, ultimately leaving the project in April 2016.
- Project management passed from the Bureau manager to service development manager.
- GPs and the Health Improvement Team expressed the explicit wish to do more work on PIP.
- Work to allow advisers to access medical records was nearly concluded, with draft contract produced, meetings held with individual practices and individual tailored processes designed.
- Training delivered for CAB staff focused on referring onwards to other organisations.

Seventh Quarter: Ending June 2016

- Honorary contracts between practices were signed off and received by April.
- A new process was established to make contact with clients by text to reduce the level of drop off between referral and engagement.
- The project co-ordinator handed in her notice, leaving in July 2016.
- Her role was taken up by one of the existing workers on the CAB's [other] NHS Project, based on her experience of working with NHS partners.

Section 3: Project Statistics

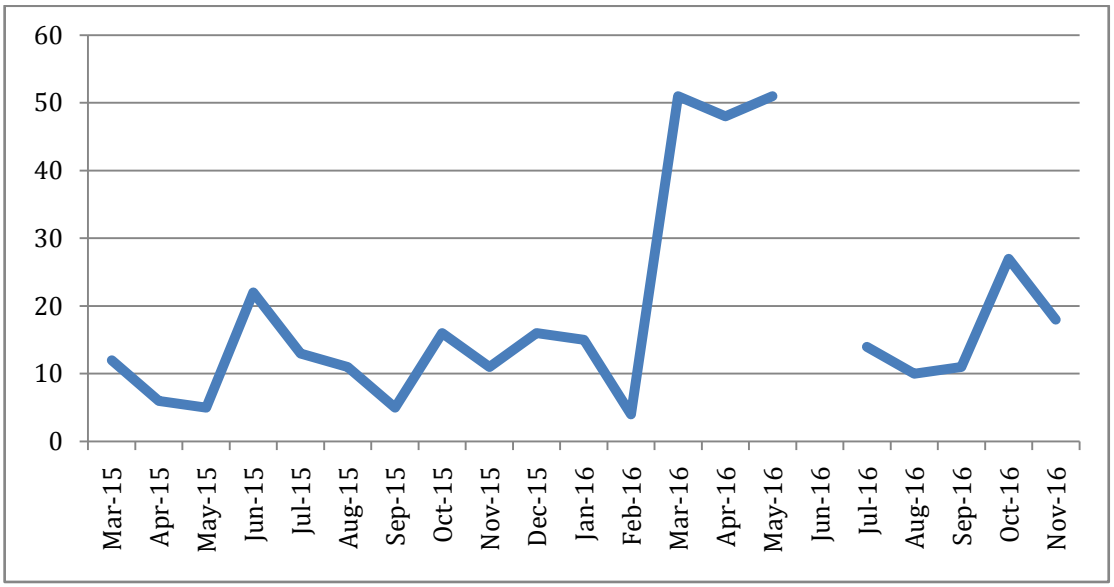
This section looks at some of the key project statistics over the 21 months of its delivery from March 2015 to November 2016. It has been rewritten since the initial version of the report to reflect the acceleration of referrals since the Spring of 2016.

It looks in turn at:

- The number of clients referred and worked with by the project.
- The source of referrals to the project.
- Client demographics.

Section 3.1: Levels of Client Engagement

Number of New Clients Taken on by the Project.



The project engaged with366 clients over the 21 months, an average of 17.4 per month. The average hides the story of the variation month to month, with engagement falling to lows of 5 in May 2015 and September 2015, and 4 in February 2016, and reaching highs of 51 in March and May 2016. There was no engagement with new clients in June 2016 due to a staffing gap.

The total number of people engaged across 20 months is reasonable. However:

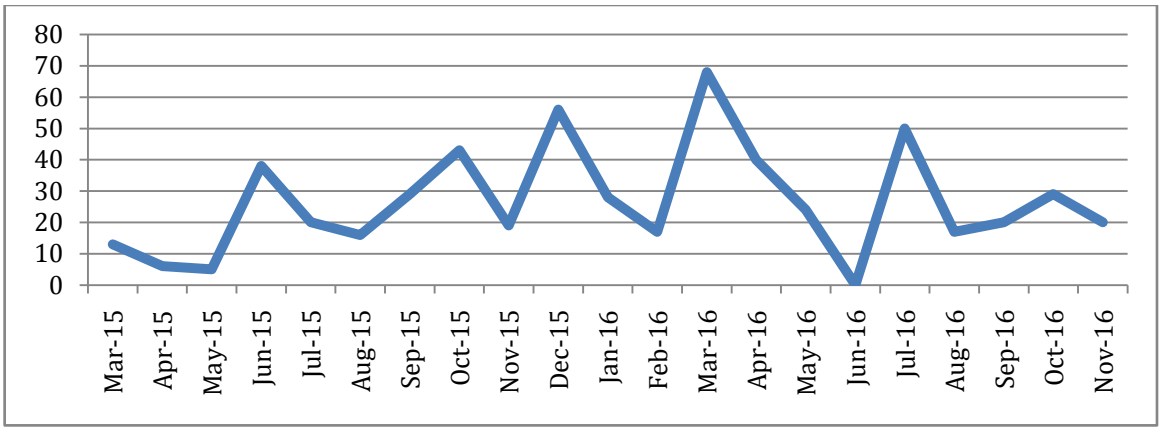
- It is very significantly below the unrealistic target in the SLAB proposal.
- It is also below the number of clients that might be expected to be seen by a benefit specialist during a year, and a little below the number of clients that might be seen by a specialist debt adviser over such a period. This might be expected given the holistic nature of the service.
- The project has seen fewer people than comparator CAB projects evaluated by the consultant such as the BOAT project in Tayside, and the ADAPT project in Angus/ Dundee.

In relation to the pattern of engagement with new clients across time:

- The pattern of engagement has varied greatly month to month, suggesting that for at least some of its period of operation, the project will have been operating with spare capacity.
- The increase in rate of engagement over the Spring of 2016 was probably not sustainable and, in the context of staff turnover, was not sustained.

- The project received around 40% of its total referrals over that three month period, 14% of the time it has been operating.
- Even if the rate of engagement with new clients was purely a function of the occurrence of problems amongst the potential client group engaging with health visitors/ doctors, a degree of variation across time would be expected.
- However, the fluctuations month to month here are at a much higher rate.
- As well as being the result of staff changes, this variation might suggest that:
    - Pushes to increase referrals generate a response from health visitors and doctors, which is then followed by a reduction in referrals as those health professionals fall back into a pattern of not referring.
    - Referrals are still not fully built into the standard practice of health visitors and doctors in the health centre.
- Were the numbers of people referred to the project to regularly reach potential, it might become challenging to manage demand for the project.

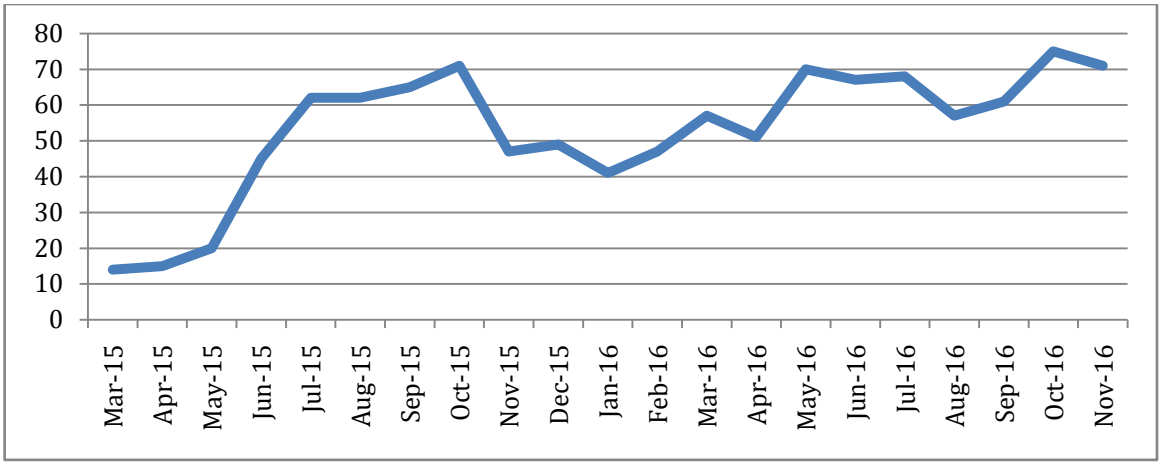
Caseload Management: Unique Clients Supported by the Project



This graph shows the number of unique clients that were seen by project advisers in any given month. It again shows considerable variation, from as few clients as 5 in May 2015 (and 0 in June 2016 at a time of staff changes) to as many as 68 in March 2016.

The figures are again indicative of significant spare capacity at certain points within the project.

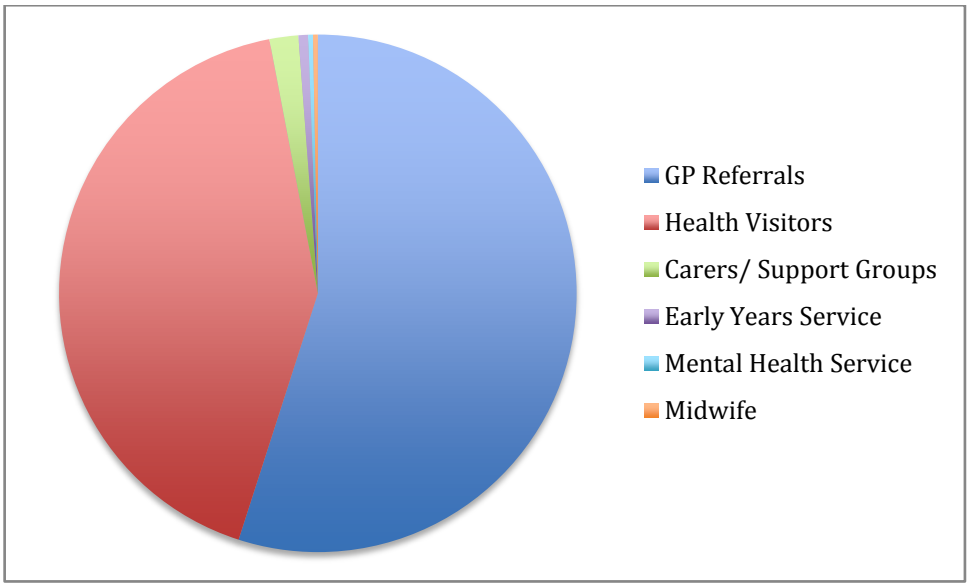
Caseload Management: Clients on Project Caseload



The graph shows a steady growth in project caseload across the period of the project, peaking in October 2016.

Cases remain live, with follow up work required, and results of interventions awaited, even when people are not being seen directly, which explains why the number of live cases exceeds the number of clients seen in any given month.

Section 3.2: Source of Referrals



55% of referrals to the project come from GPs, 42% from Health Visitors, almost a complete reversal of the position in the initial analysis carried out by the consultant using project statistics relating to the first 12 months of the project.

These figures:

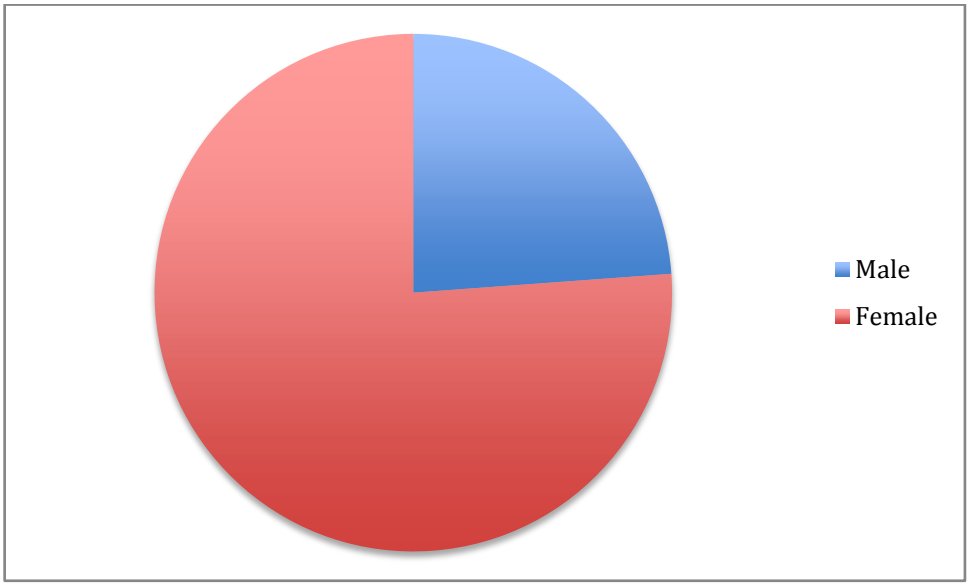
- Highlight the importance of both health visitors and GPs to the project as professional groups very much in touch with the target group.
- Demonstrate the recent progress made in building relationships with GPs to generate referrals.
- Suggest there has been a significant drop off in the level of referrals from health visitors, perhaps associated with project staff no longer being based in their room.

The Early Years Service, and local voluntary groups working with families with young children/ adults with health conditions will all have close relationships with their service users, and might be in a position to increase the small number of referrals they make to the project in the future.

Source of referral was not initially recorded for 33 of the clients.

Section 3.3: Client Demographics

Gender of Clients



The vast majority of clients, 76%, are female.

It would be expected that the number of referrals of women would be higher than those of men, given the targeting of the service at families with young children, and health visitors' primary engagement with mothers.

As noted above, there has been a shift within the project away from a tight focus on families with children, with older patients at the participant practices also being referred by GPs.
The majority of referrals coming from GPs, generally not of families with young children but of older people, often presumably with health problems, are still of women.

Given that men are more likely to claim key disability related benefits such as ESA and PIP, this may reflect the gender balance in GP caseloads, or potentially of GPs experiencing difficulties raising financial issues with male patients.

Gender was not initially recorded in 194 cases.

Age of Service Users.

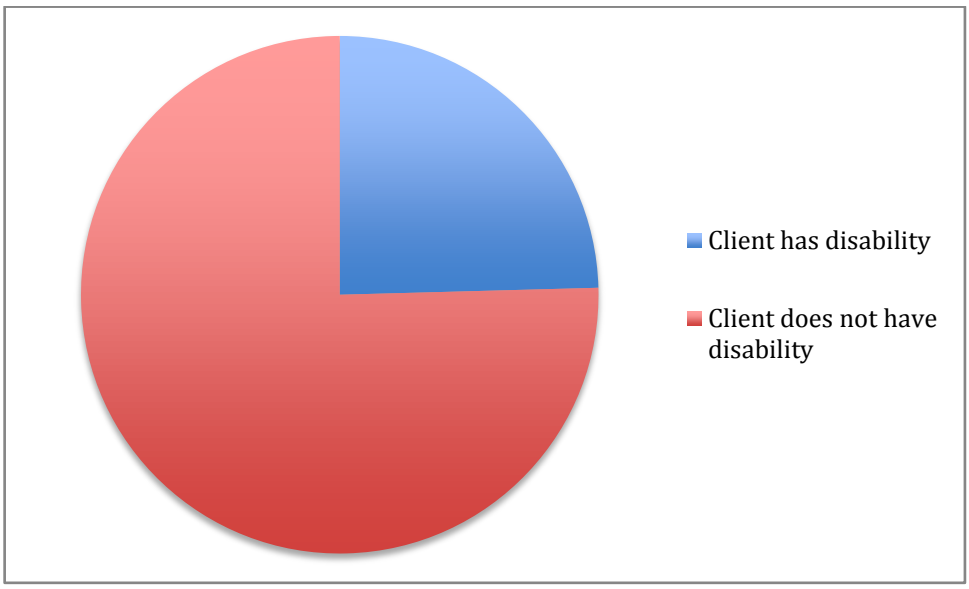
Age	Number of Clients
Under 17	1
17-24	24
25-34	39
35-49	53
50-64	53
65 plus	5

Comparison across age band needs care due to the different size of age bands under which client ages were recorded. Taking account of that, the most common ages for clients were those between 25 and 34, followed by those between 35 and 49 and 50-64. There was a reasonable spread of clients across working age.

This relatively even spread reflects both the targeting of adults with young children, and the expansion of the focus of the project.

Age was not initially recorded for 191 out of 366 clients.

Disability Status of Clients



Three quarters of clients for whom disability status was recorded do not have a disability.

This seems low, given the number of people referred by GPs, even allowing for reasonable health of the majority of the young mothers referred to the project.

It suggests either that:

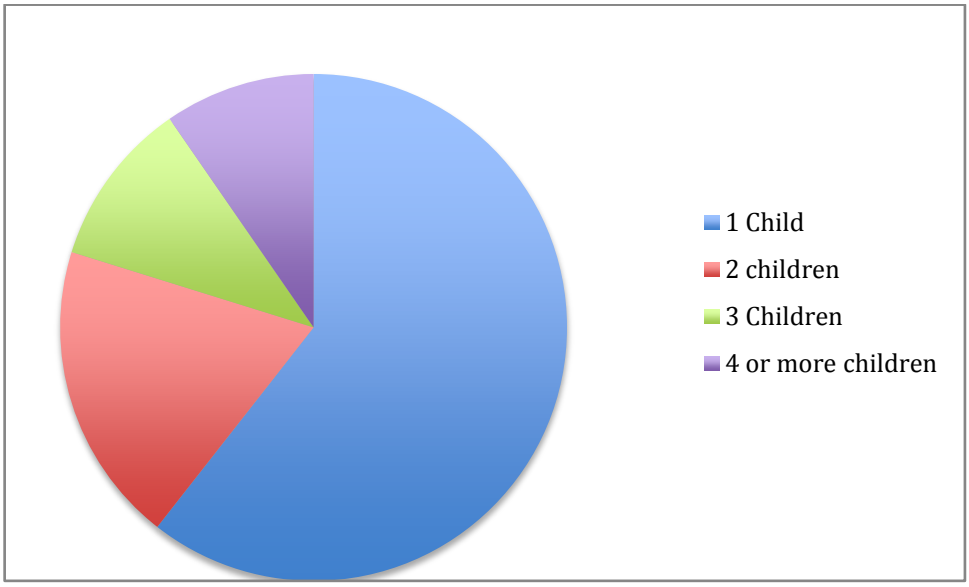
- There may be a recording issue, people with long term conditions, for example with mental health problems, may not have not been recorded as having a disability, despite the financial/ benefit entitlement significance of such conditions, or
- GPs have been referring significant number of people, not because they have significant health problems which they recognise place them at risk of financial problems, but because they have directly identified financial problems for patients who may or may not have significant health issues.

Disability was not initially recorded in 190 cases.

Family Size.

Problems with the way that client family size has been recorded mean that robust statistics on the total client population cannot be generated. 190 clients did not have their number of children recorded at first contact.

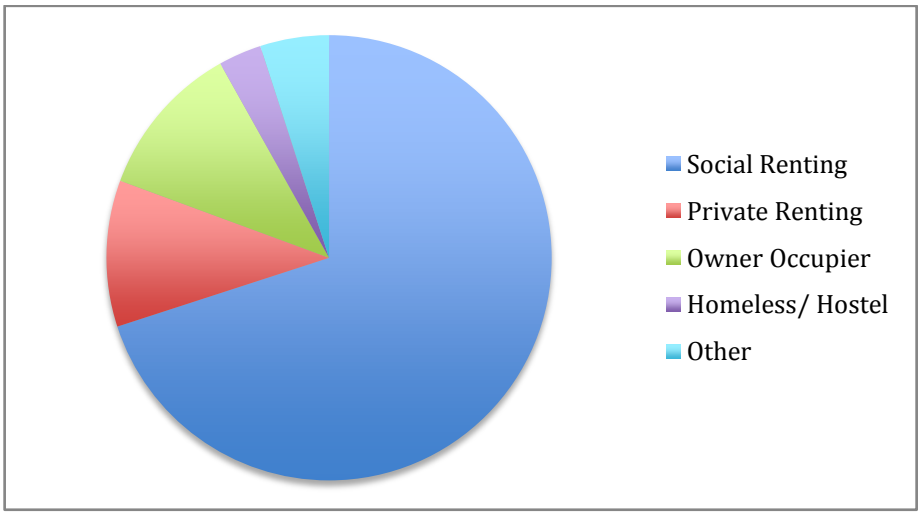
It is possible to look at the spread of the number of children in the household amongst the clients for whom children are recorded as being present.



The chart indicates that only 21% of the clients recorded as having children have three children or more.

Increases in family size do increase the financial pressure on households. However, these figures suggest that such pressure, and the resultant demand for advice, is far from confined to those with larger families.

Clients' Tenure.

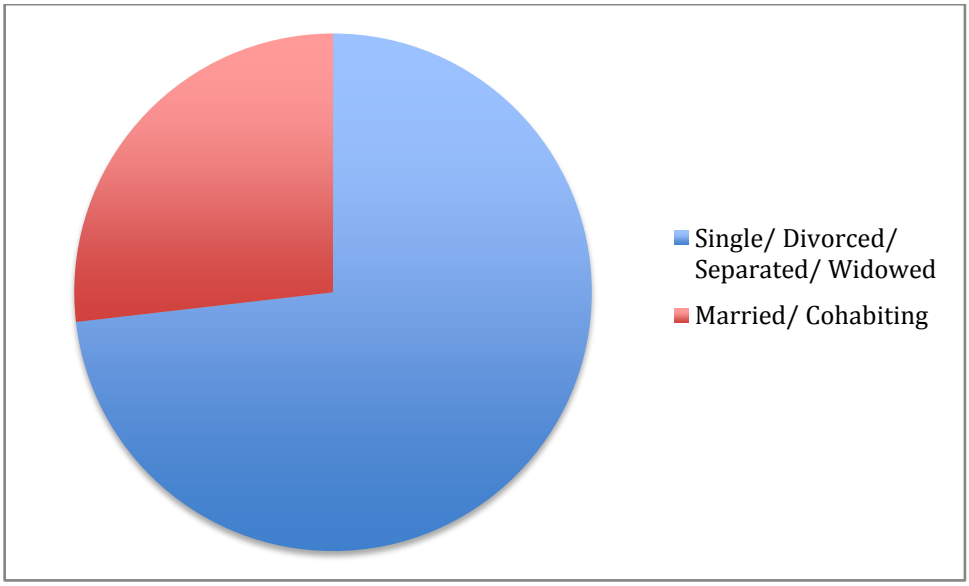


As would be expected, the vast majority of project clients were renting, with 70% renting from social landlords and 11% from private landlords. Only 3% of clients were homeless or living in a hostel, reflecting that the project, through linking with local primary care, will tend to reach those who are generally in more secure housing situations.

The high proportion of social rented tenants amongst clients is noted in the context of local social landlords who have made significant investment in financial inclusion and benefits advice services. These services are clearly not reaching all tenants who might benefit from them. This suggests that there is real value in there being a range of different routes to advice services for potential clients, and that concerns about duplication of service in an area can often be largely misplaced.

Tenure status was not initially recorded for 206 of the clients seen.

Relationship Status.



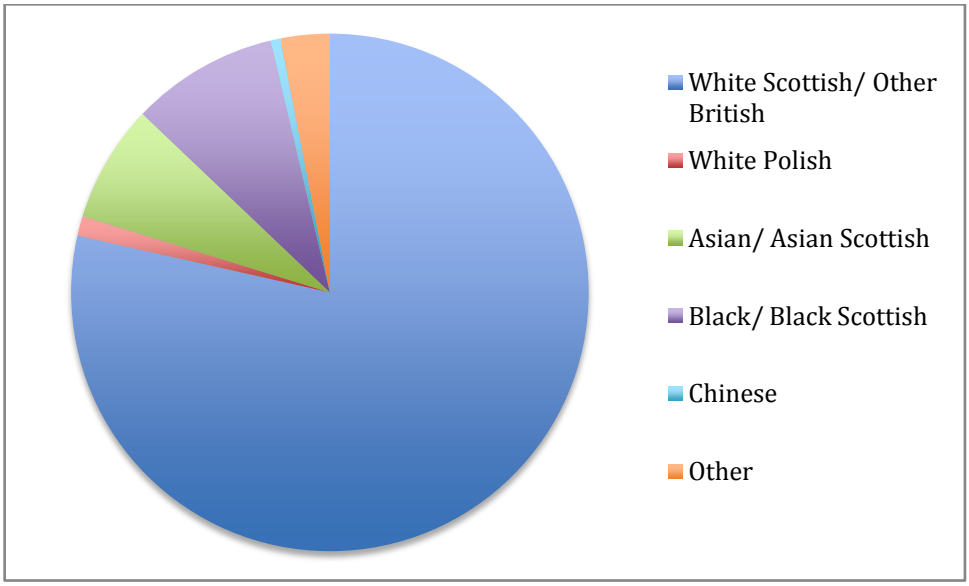
The most striking thing about the relationship status of clients is that only a just over quarter of clients are living with a partner/ husband. This will largely reflect the greater vulnerability of single adult households, particularly single parent households, to poverty, in part as a consequence of difficulties accessing work.

However, the predominance of single people amongst those referred is so great, that it might reflect the practice of those referring to the project, rather than the balance of need amongst potential clients; in particular health visitors, aware of the greater vulnerability of single parents to financial problems might be less likely to refer people who are part of a couple to the service than their level of need might suggest. Alternatively, it might reflect greater intensity of contact between health visitors and single parents.

Relationship status is not initially recorded for 202 of the clients seen.

Ethnic/ National Origin of Clients

The chart below shows the ethnic/ national origin of clients.



Strikingly, that only 79% of clients are from a 'White Scottish/ Other British' background. A decade ago, an advice project in Possilpark would have seen a much higher figure for that category. The Possilpark community is increasingly diverse, and the project is clearly finding some success in serving that diversity.

The significant figure for clients from BME communities may also reflect the specific financial challenges faced by people from migrant communities, not least in terms of access to benefits, and not least for single parents.

The small proportion of clients from Eastern Europe is noticeable. Certainly, the figure is much lower than for financial capability projects evaluated by the consultant in Tayside and Stirling. This may reflect; lower populations of people from Eastern Europe in the Possilpark area; a lower demand for advice from that group; barriers to people from that population being referred; or lower usage of primary care services.

The ethnic origin of clients was not initially recorded for 203 people.

3.4 Client Financial Inclusion Status.

Project workers recorded clients' access to/ use of four key financial products:

- Use of the Provident/ Other Home Credit.
- Possession of a bank account.
- Possession of savings.
- Possession of Home Contents Insurance.

The table below sets out the proportion of clients in each situation, where appropriate setting this against the proportion of the total UK/ Scottish population in that situation, and/ or those on lower incomes/ in social rented housing in that situation.

	Percentage Clients	**Percentage Total Population**	**Percentage Lower Income/ Social Rented Population**
Borrowing from Provident/ Home Credit	4.1%	5.8% (UK adult population)	25% of Scotcash customers
Having a Bank Account	30%	95% (Scotland, they or partner having bank account/ building society account)	
Having Savings	4.5%	75% (Scotland)	20% (UK benefit reliant) 47% (Scotland social rented)
Having Home Contents Insurance	6.2%	60% (UK)	54% (Scotland, social rented)

These figures make clear the extent to which the clients seen by the project are financially excluded:

- They are very significantly more financially excluded than the general UK or Scottish population.
- They are also very much more financially excluded than people on low incomes/ people in social rented housing more generally.

Particularly striking are the figures relating to the very low number of people with bank accounts, an area in which most commentators believe a considerable amount of progress has been made. Such high levels of being unbanked will be particularly significant in the context of the introduction of Universal Credit, claimants of which will need to have their own bank account.

It seems possible from these figures that a majority, at the very least, of clients of the project have no personal connection with formal, mainstream or even non mainstream/ sub prime financial (the Provident figure is lower than expected) products. The project appears to be engaging with the most financially excluded members of the population, even allowing for the uncertainty resulting from relevant statistics not being recorded for 189 clients.

3.5 Client Issues Dealt with/ Outcomes

The project provided data on the:

- Key issues (referred to as matters) that it dealt with.
- The actions undertaken in response.
- The financial outcomes for the project.

Key Matters Dealt With.
The project provided data about the key matters that it dealt with, i.e the main issue with which clients presented, and what appears to be the initial matters. This information is set out in the table below.

	Number of Clients Primary Initial Matter	**Number of Clients- All Initial Matters**
Benefits- Advice and information on entitlement	101	145
Benefits- Dispute	7	11
Non-debt- Housing matter	9	14
Debt- rent arrears	4	8
Debt- Council Tax	3	7
Debt- Doorstep lender/ subprime	8	10
Debt- Benefit overpayment	4	6
Debt- Fuel provider	0	3
Debt- mobile phone	0	2
Debt- Social Fund	0	1
Financial capability	3	5
Energy provider	3	3

For both the clients' primary matter, and the other initial matters categories, a very high number of 'other' matters were recorded; 219 in relation to the primary matters, and 240 in relation to all initial matters.

In the absence of more detail on matters included in the 'other' category, this incompleteness means that the figures must therefore be treated with a degree of caution, but they suggest that:

- Benefit issues are by some distance the predominant issues facing clients.
- Priority debts are more common for clients than non priority debts.
- Few clients present seeking support with financial capability, i.e. money management issues.
- This last point suggests that if financial capability issues are dealt with, this will be done after dealing with other benefit and debt issues, and probably as secondary matters/ as an adjunct to such issues.

Actions Undertaken.
The project records 743 actions undertaken on matters raised at any stage of engagement with the client.

177 of these are recorded as being in the 'other' category. The rest are categorised as set out in the table below/

Action	Number of Actions
On-referral	107
Approach second tier support	49
Nothing to be done/ not proceed	22
Benefits	
Benefit check/ income maximisation	*166*
Advice to make initial claim	*103*
Supported self help	*10*
Assistance on migration from other benefits	*4*
Advice on reassessment	*3*
Referral to specialist benefit adviser	*2*
Debt related	85
Negotiation with creditors	*82*
Application for Council Tax exemption	*3*
Money Advice	14
Self help	*2*
Budget planning	*6*
Social Fund	*2*
Income Maximisation	*4*
Housing	4

The statistics also record the supporting of 13 applications for Crisis Grants and 6 for Community Care Grants from the Scottish Welfare Fund (included within the figure for advice on initial claims), and the issuing of 21 vouchers for the local foodbank.

There are a number of key points in relation to the actions undertaken by the project:

- It makes significant numbers of on referrals and regularly seeks second tier support for more complex cases; it does not work in isolation from others, and acts as a gateway to other services.
- A significant amount of its work is basic income maximisation/ benefit checking work.
- The smaller number of matters where people are given advice to make initial claims suggests that many clients given a benefit check are claiming their due, at least in relation to some part of their benefits.
- The project has been running at a time of a major migration of benefit claimants; from DLA to PIP. It might therefore have been expected that GPs would have been referring across significant numbers of their patients with long term conditions who were facing that migration. However, only 4 people are recorded as being helped with benefit migration.
- This suggests the project is reaching new applicants for benefits, but whether people facing reassessment are missing out on advice that might help them, or getting it from elsewhere, is not certain.

- The amount of work undertaken to negotiate with creditors is significant in comparison to the number of clients presenting with debt as a primary or initial matter.
- The explanation(s) of this is not clear, but might involve debt issues being recognised later in the process of engagement with clients, and/or a small number of clients having a large number of debts.
- Only six people are recorded as receiving help with budget planning. About that number of people who were interviewed reported being helped by an adviser looking at the way they budget. It is improbable that all six of those recorded as receiving budget planning advice were amongst the 14 interviewed.
- This suggests that budget planning work is often being done as an adjunct to benefit advice or debt advice, or may be being recorded as being in the 'other category'.
- There are some clients for whom little or nothing can be done in relation to at least some of the issues that they face.

The statistics as currently available do not of themselves allow much to be said about the extent to which the project tackles the issues of access to mainstream financial products identified above.

Project Financial Outcomes
Client financial gains for the project are recorded as being £325,608. This is an average of £890 per client.

The gains are not split into financial gains relating to benefits and those relating to debt resolution.

The actual figure for client financial gains will be higher; it is not clear how effective the project is at confirming financial gains from clients- experience of conducting the evaluation interviews suggests that contacting clients to confirm gains may be problematic; and some clients will still be waiting on outcomes of benefit applications and negotiations with creditors.

Key Points

Levels of Client Engagement
- The project has dealt with a reasonable number of people over its 21 months, although referrals were too low initially.
- The initial vague target for the project was too high, and the project has dealt with fewer people than comparator projects elsewhere in Scotland.
- The capacity exists to increase the number of project referrals further.
- The significant variation in referrals across time reflects both gaps in staffing and spikes in engagement work by staff.
- Managing the project workload would be difficult if referrals were coming in as fast as they might be.
- The project has seen reasonably steady caseload growth.
- A small number of clients see the project several times, most see the project 2 or 3 times.

Sources of Referral
- There has been a significant shift in the source of referrals since the first 12 months of the project, with 55% now coming from GPs and 42% from health visitors. This reflects significant engagement work being done with GPs.

- There are potentially untapped sources of referrals amongst the Early Years Service and voluntary organisations.

Client Demographics

- 76% of clients are female, partly reflecting the focus of the project on parents with young children.
- This may also suggest that this project has not been as successful at reaching men as hoped, and perhaps that health-linked projects are not always the most effective way of reaching male clients.
- There is a spread of clients across the working age group, reflecting the dual focus of the project.
- About 1 in 4 clients have a disability, a number which is lower than might be expected, which possibly reflects a recording issue for people with mental health problems/ long-term conditions.
- Only a quarter of clients whose family size is recorded have three or more children; people with small families can still be at high risk of financial problems.
- The predominance of clients living in social rented housing is a reminder of the financial status of many social renters, and that substantial existing efforts by local housing associations to meet their tenants' need for advice still leave some demand unmet. It suggests that duplication of service is very often overstated as a concern, and multiple points of access to advice services are necessary.
- Three quarters of clients are single, reflecting both the focus of the project, which inevitably engages with large numbers of single parents, and the financial pressures that operate on single adult households.
- The project client base seems to reflect the increasingly ethnically diverse nature of the Possilpark community, and the project seems to engage with a significant number of migrants with particular needs. Project statistics suggest that it is not engaging as many people from Eastern Europe as might be expected.

Client Financial Exclusion

- The client base is very much more financially excluded than the broader UK/ Scottish population, and significantly more financially excluded than the broader UK/ Scottish population living on low incomes.
- Project statistics suggest that the majority of clients have no current contact with mainstream or subprime providers of financial services, although this picture was not clearly born out by interviews.

Client Issues and Outcomes

- The project has predominantly dealt with benefits issues, with debt issues not far behind.
- The incomplete statistics available from the project suggest that where financial capability issues are dealt with, they are dealt with as secondary issues.
- The incompleteness of the statistics means that we cannot identify how much work has been done on dealing with the financial exclusion issues identified above.
- The project has delivered significant client financial gains of nearly £330,000, in 21 months although the true and final figures are likely to be higher.

Section 4: Client Feedback.

This section looks at client feedback in relation to the service. It explores in turn:

- Clients' routes into the service.
- The range of money related problems being experienced by clients prior to accessing the service, and the impact of those problems on them.
- The support received from project staff.
- Whether they would have been able to resolve the issues without the support they received from the CAB.
- The impact of the support received from project staff.
- People's general views about the service, and their thoughts about its future and their further use of it.

Of the 14 clients interviewed:

- 4 were female, 10 were female.
- 1 male client was being supported predominantly in relation to his wife's situation, 1 female client was being supported in relation to her father's financial situation.
- In terms of age:
    - 1 was aged 18-24.
    - 5 were aged 25-34.
    - 1 was aged 35-44.
    - 5 were aged 45-54
    - 2 were aged 55-64.
- 6 had health problems/ disabilities/ long term conditions themselves, 5 had caring responsibilities for a family member with a long term condition or disability, 3 of whom had a partner or parent in this situation, 2 a child. Four had children who did not have disabilities or health problems.
- 7 were single, 7 were married or had a partner.
- 4 were from migrant communities from Africa, Africa via Europe or South America.

Please note, all names of clients have been changed, but alternative names have been used as a reminder of the personhood of all the clients.

Section 4.1: Routes into the Service

Access to the Service.
Many clients' referrals arose naturally out of their interaction with health visitors or GPs:

> 'It was the health visitor that told me. I said to her that I was finding things difficult' (Afua, 25-34)

> 'I think it was my doctor, it was ages ago. It was a while back and he said you can get help from them' (John, 45-54)

> 'I was seeing my health visitor because of my daughter's condition, she could see that I was continually in and out of hospital and she pointed out that this meant I could claim for my daughter.' (Emma, 25-34)

Referrals could come from health professionals other than health visitors and GPs:

> 'It was a guy from the CAT [Community Addictions Team] put me on this. He was doing a home visit and said you don't need help with this [alcohol] but you should get onto the CAB, you might be entitled to benefit' (Ian, 55-64)

> 'I'd been getting help from the nutritionist with my daughter who didn't seem to be eating too much, she couldn't cope with the change from the food from France. She asked me if I was getting Child Tax Credits or Child Benefit.' (Laure, 45-54).

Receptionists could also play their part:

> 'The doctor's receptionist told me about the service. I go in regularly for check ups. I mentioned the blue badge in passing, and she gave me a number to call' (Patricia, 65+)

One client had directly sought help from his GP and been referred to the project and been referred to the project as a result:

> 'I went to see the doctor with my ESA form. The doctor said- we don't do that anymore- but that there was a new service that could help me and he would pass me on' (Alan, 45-54).

In some cases clients were already primed to seek help because of conversations with family members or friends:

> 'I was speaking to a cousin, and I found out I wasn't getting what I should be. We were chatting and I could see that she was getting more than me' (Emma, 25-34)

In one case the client actually accessed the service through word of mouth:

> 'It was one of my friends told me about the service, not the health centre' (Clare, 25-34)

Some of the clients knew about the CAB from their professional lives. One had sought help herself on behalf of her father, ending up at the project after an initial poor experience with another member of Maryhill & Possilpark CAB staff:

> 'No one told me about the CAB. I knew about them from working with social work and contacted them myself. That initial appointment was a bit of a disaster, Amber dealt with me the second time.' (Marie, 45-44).

> 'I'd heard about the CAB before, I'd helped some of the families I work with to use the service, but I'd never used the service myself.' (Patricia, 65+)

One client had tried and failed to make appointments with the mainstream CAB service, before being referred by health staff:

> 'I tried to make appointments with the CAB. I'd come down but it was always too busy. Eventually we were referred by the health visitor, they made us a priority appointment as a matter of urgency. The health visitor was asking if I was OK with the situation and then made an appointment.' (Tania, 25-34)

It was notable that a couple of the clients from migrant backgrounds had come straight to the CAB through a referral rather than through the Scottish Refugee Council other organisations working on migrant issues:

> 'It was the health visitor that told me….I had heard of the Scottish Refugee Council yes, but I didn't get help from them or anyone else.' (Ayesha 35-44)

Without Referral?

Two sets of questions were posed to clients about the 'additionality' of the service. The first explored with them whether they would have accessed the service, or a similar service without the referral they had received.

Many clients felt that this would have been unlikely, highlighting their lack of awareness of what they were entitled to, often because they had not previously had to rely on the benefits system:

> 'I had never had anything to with the benefits system for all the time I'd been in work. I had no idea what I was entitled to, no clue what benefits I should claim….
>
> I probably wouldn't have gone without being referred, I would have had no idea. I had no idea what I was entitled to, I've always been in work.'
> (Katie, 25-34).

One client pointed out that she had not been offered help from other sources who might have been expected to have intervened to help them:

> 'I was behind on my rent…. I was never offered support from the housing side of things' (Clare, 25-34).

Some clients pointed out that although they were aware of the CAB's existence, they would not have sought help themselves, often because their idea of what the CAB could do for them was only hazy, and/ or because they thought that they would not be entitled to any help from the system:

'I knew that the CAB existed, but I'd never dealt with them, I'd no idea about this, I was totally ignorant.' (Ian, 55-64)

'I'd heard of the CAB, I just didn't know they did things like this face to face' (Alan, 45-54)

'I'd heard of the CAB….I just didn't know anything about them being able to help. I thought- we are pensioners and that's it, I had no idea we could get help.' (Patricia, 65+)

For others, it was more a simple matter of knowledge not translating into action:

'I'd of them before. It was a family member had been. But I'd not used them myself, so I just didn't go.' (Erin, 18-24).

Key Points, Routes into the Service:

- Referrals arise naturally from client interaction with health visitors and GPs.
- Other health professionals, including surgery receptionists, have also been making referrals, although these are not seemingly recorded as such, suggesting that awareness of the service is spread wide amongst health teams.
- Word of mouth also has a role in promoting self referral, or priming people to seek help.
- Some clients will find their way to this service through referral, despite previous struggles to access CAB services.
- There are barriers to self referral even for people aware of the CAB's existence:
    - Prior knowledge of the CAB service, even when gained professionally, does not necessarily translate into seeking help, particularly if clients have inaccurate beliefs their entitlement to benefits.
    - People may be aware that the CAB exists but have little or no understanding of the work that it undertakes.
- Lack of awareness of entitlement to benefits remains a major barrier to people seeking support; some people do not realise that there is anything they need support with.
- Feedback suggests that some people from migrant communities are not accessing specialist support from organisations like the Scottish Refugee Council in the way that might be hoped. It is also possible that the project is not referring to them in the way that might be expected.
- Other actors in the support/ advice system, such as welfare rights officers with social landlords, are not necessarily engaged with clients in the way that might be hoped.
- The service is getting to people who otherwise would not have accessed support and advice, or at best would have accessed it later in the development of their problems.

Section 4.2: Clients' Problems Faced.

Benefit Issues
The vast majority of interviewees reported that they had been experiencing problems in relation to the benefits system prior to seeking help from/ being referred to the CAB.

Given the target client group, it was no surprise that many clients were experiencing issues surrounding access to maternity or child benefits, a change in circumstances that people did not always know how to respond to:

> 'I was getting statutory maternity pay, only £30 per week…because of my income the previous year I wasn't entitled to anything more than that.' (Katie, 25-34)

> 'My income dropped by quite a lot [when I went on to maternity]. I wanted to see what I could get.' (Tania, 25-34)

Other family changes in circumstances had also had an impact on people's need for support:

> 'My mother had died. My father had worked all his life, so we didn't know what he might be entitled to, we thought not much because he had his own pension but we wanted to get it checked out' (Marie, 45-44)

Many other interviewees were seeking help with new claims for disability related benefits:

> 'We needed help with her PIP application, she'd been on a lifetime award for DLA before that' (David, 45-54)

This could be after a long period of not claiming what they should have been entitled to:

> 'I spent years not getting DLA. I didn't know about it till my daughter was three, no one had ever told me about it' (Emma, 25-34)

One client had had a previous claim for DLA turned down, which had put her off making a claim in the future until she had engaged with the CAB this time round:

> 'I applied for DLA at that time [when she had medically retired]. I didn't get it, but I never appealed it. I just thought- och we won't get anything because we were refused and it was just our luck.
>
> I was quite ill when I applied the first time, I couldn't believe that I didn't get anything, particularly when you saw some other people who do get it. It took me years to get my confidence back and try again. I just thought I wouldn't get it. My health has got worse though, perhaps they were right first time.' (Patricia, 65+)

Another client had experienced benefit problems in the recent past associated with welfare reform:

> 'We were hit by the Bedroom Tax. We got some discretionary payment to cover that, but we had to downsize.' (Alan, 45-54).

Clients could find themselves in quite complex situations, sometimes struggling to explain these fully to the consultant:

> 'I had a sick line in from my doctor. Then I was claiming ESA but they said I couldn't claim JSA because I was waiting for my ESA so they stopped it. They wouldn't give me the disability… the PIP aye, because they said I couldn't claim that.' (Clare, 25-34)

> 'When I went into my second job, my employer made a mistake. He put me down as never having worked in the UK before, that was a clear mistake.
>
> I couldn't understand the papers I was receiving at the time. I have better English now, but back then I did not. I was waiting three months for the child benefit, Child Tax Credit and Working Tax Credit to be done.
>
> I have been accused of fraud and they won't say why, which paper I gave they are saying is a fraud. I have given them my daughter's passport and birth certificate, and nothing has come back from them. It's odd, because the council tax people knew I was getting child tax credits but still wrote to me that I had no children.' (Laure, 45-54)

Consequence of benefit issues

One client had been living off money that he had managed to put by, he did not see this as a situation that was sustainable in the long term:

> 'I wasn't getting anything at all [since he had medically retired fifteen months before] I've been living off my savings. I was doing OK, but my savings are not a never-ending pot.
>
> 'If I don't get any support my savings are only going to last another 4/5 months. My worry is that I have got £1K going out of the door every month. That's going to dry up at some point.' (Ian, 55-64)

Benefits issues could be the source of considerable practical difficulties for clients. In particular they could mean threats to their housing situation/ threats of homelessness:

> 'All my benefits stopped and I wasn't getting any money in at all. I had to stay at a friend's house.' (Clare, 25-34).
>
> 'I thought I was going to lose my house, at times I felt I was really going to have to move out. I thought I would just go outside with my child, I hope that things don't get that far.' (Laure, 45-54)

A number of clients who were migrants to the UK reported being in a situation in which they were receiving no support at all from the state:

> 'I left my husband after he was violent. I wasn't getting anything at all, no income- just a bit of assistance from Social Work' (Ayesha 35-44)
>
> 'I wasn't working and I had to find money from somewhere' (Afua, 25-34)

Debt, Destitution and Money Management Issues

A majority of clients were facing some level of debt or destitution issues when they first went to the CAB.

Some had begun to fall behind on priority household bills:

> 'When he was in prison we got behind on our GHA arrears.' (Katie, 25-34).
>
> 'When we moved in we were told that Council Tax was included in our rent. We never got that in writing, we just assumed that was sorted and never thought to check. We didn't realise until months later when we got a message from the council that we were behind.' (Tania, 25-34)
>
> 'I was getting letters from housing officers threatening my tenancy because I was in arrears' (Clare, 25-34).

Two of the clients from migrant backgrounds had found themselves in this situation directly because of not being able to access/ having difficulties with accessing public support:

> 'I was not working and had to find money from somewhere. I was behind on my council tax and I had rent arrears piling up. The housing people and the council were sending me letters chasing me up' (Afua, 25-34).
>
> 'I had debts accumulating because it [a complicated benefit claim] was not getting sorted out….
>
> My Council Tax is very high, and I had to pay my rent. I was paying £98 per month for my council tax and £250 a month for rent. I am only getting £455 in pay so I am struggling. I'm glad I have this much but I still have my daughter to support' (Laure, 45-54).

One client talked through in some detail how she had fallen into consumer debt during the early period of her setting up home independently:

> 'I was badly in debt. What started it all was the washing machine breaking down and I got a new one from a catalogue. I was spending only £40 a week on that and only £10 of that was actually reducing the debt. I couldn't afford that.
>
> The catalogue people refused to help me, and I owed money to a couple of catalogues as well. I just couldn't afford to be paying it all back.
>
> If I paid my catalogue, that meant I wouldn't have enough money for my electricity. I really needed to stop paying too much out.' (Erin, 18-24)

Current difficulties could be compounded by long standing debts:

> 'I had a loan from the bank when I was a student that I still haven't been able to pay off. My husband's got a debt to the credit union that he thought someone else was getting paid but turned out not to be' (Tania, 25-34).

Families and friends were an important source of support to many clients, although the help they could offer was often still not good enough to resolve people's difficulties, and could in itself become a source of debt that could become a problem in terms of repayment:

> 'I owed everyone in the family and needed to get it sorted. They helped me deal with it, but they needed to be paid back.' (Tania, 25-34)

> 'My dad was having to step in and out, but that's something he can't always do. My family had to help… That was really tough, a really tough time for me. My dad helped out, he would come and live with me and check that I was OK' (Katie, 25-34)

> 'I was borrowing £5 here and there from others but anything more than that was too much.' (Erin, 18-24)

Issues with Money Management

Some clients spoke specifically of feeling that their money situation was out of control, or that not being able to manage money was a key part of the problems that they had faced:

> 'I don't think I was any good at managing money at the start. I was fending for myself for the first time and I'd never really had to that before, it was completely new for me. What I did wrong was to start with the catalogue.'(Erin, 18-24)

> 'Both our wages were disappearing as soon as they came in. That's why we spoke to the health visitor' (Tania, 25-34).

One client sought help on behalf of her father, being clear that he was not in a position to manage things himself in the wake of his wife's death:

> 'He was worrying [after her mother, his wife had died]. He used to come home, eat and work on his car whilst she looked after all the money. It was a very traditional relationship in that sense, she did everything in the house, he earned the money and that was it' (Marie, 45-44).

In contrast a number of clients were clear that they weren't experiencing broader money difficulties, something they put down to having learnt the relevant skills previously. Notably, the first of those clients below had previously lived in care:

> 'I was coping OK with money and wasn't behind on my bills or anything. I'm OK at managing money. I did everything weekly, plus a freezer shop monthly and I'd write it all down. I learnt this in care and they teach you all that' (Emma, 25-34)

> 'I have always been good at managing money.' (Patricia, 65+).

> 'I wasn't getting behind on anything. I was coping with the situation, I just needed help to explain the form, I wasn't running out of cash' (John, 45-54).

Psychological State.
Interviews explored with clients how they had felt about their situation prior to getting help from the CAB.

Clients were commonly extremely worried about their financial situation, compounding other challenges that they were facing:

> 'It was all very stressful. I was having to take from one place and put in another in a budget. I already had PND whilst all this was going on. That took over for a while, and then the worries about the money kicked in on the back of it.' (Erin, 18-24).

On other occasions, it was not so much that worry about their financial situation compounded those problems, just that it was another source of stress alongside others:

> 'I do worry about money. I think everyone does. I suppose that does have an impact, it's always there, you have to make sure that's OK. I'd struggle without my daughter there to be honest.
>
> I do have depression and anxiety, but they aren't money related. I worry about everything, I worry about my wife, about my kids- my youngest one is going off the rails a bit.' (Alan, 45-54)

Aspects of their involvement with the benefit system could be a trigger for higher levels of stress:

> 'I was stressed at first when the form came in. The last thing you want when you are depressed is forms coming in that you need to fill in. My daughter got me to calm down, and my doctor was really good.' (Alan, 45-54)

The longer term stability of their situation was what was of concern to some clients:

> 'I would be worried if I couldn't keep up payments and the landlord and agency started to ask what's going on here….I'm pretty sure it's all had an impact on my health' (Ian, 55-64).

People could feel as though they were lost, with no way forward in sight:

> 'I had got to a point where I didn't know what to do' (Ayesha 35-44).

Feelings of concern about their financial situation could be accompanied by a sense of anger/ frustration about the position they found themselves in:

> 'I was very depressed before, highly frustrated. We [she and her daughter] have been through a lot, moving around etc' (Ayesha 35-44).
>
> 'I was really getting frustrated by it all. It was coming up to Christmas and I couldn't get it sorted' (Clare, 25-34)

Some people reported a sense of impatience to get their finances in order in the context of other major life events such as having children:

> 'It was very important to me. I wanted to get things sorted, it was all too much and I was getting a bit down. I had a lot of other things to think about, the last thing I wanted to be doing was worrying about money'. (Tania, 25-34).

Worry about their financial situation could also impact on clients' physical health:

> 'We were very worried about it [the potential loss of their Motability car under reassessment for PIP]. I get depression and this put the tin hat on it. I lost over a stone in weight' (David, 45-54)

Other clients were facing such difficult financial situations that their physical health, and, in the case of one client, that of their children was being placed at risk:

> 'I was very worried. My baby was young at the time and I had to feed her. I had to buy formula milk which I couldn't afford because I couldn't eat enough to make sure that my breasts could produce milk.' (Afua, 25-34)

Clients were also worried about the potential impact of their financial situation on their potential loss of independence, in the case below, also associated with concerns about physical health:

> 'We were worried about how we were going to get about. My husband was getting really stressed because our car was getting older, and we couldn't afford a new one because we are not working and couldn't get HP. His heart condition means he can't walk about much, I was worried that I would lose him if we couldn't use a car' (Patricia, 65+).

Key Points: Clients Problems Faced

- The vast majority of clients were facing problems claiming their benefit entitlement.
- Issues were experienced associated with change of circumstances, including childbirth, bereavement and medical retiral.
- Benefit issues experienced could be complex, and difficult for clients to explain.
- Difficulties accessing the benefit system, or their lack of entitlement to benefits in the case of clients from migrant communities, could mean some clients living without state financial support.
- Benefit issues could trigger risk of homelessness, debt, or unsustainable financial situations.
- Clients reported falling behind on priority debts, including clients from migrant communities not entitled to state support.
- Some had also fallen into consumer debt, in one case as a result of the breaking down of a household appliance; events can overwhelm people with little financial resilience.
- Previous debts can compound the problems clients face.
- Loans from families are an important source of support in dealing with debt, but are not unproblematic themselves, and are generally not sufficiently large to deal with broader problems faced.
- Some clients felt that their financial situation was out of control, others that they had acquired the skills to deal with the problems they faced.
- Those problems may have been more limited partly because of their possession of these skills.

- Financial problems can be a source of intense stress to clients.
- Stress can be triggered by debt, worries about loss of particular goods and services, worries about loss of independence, or by the experience of claiming benefits itself.
- Stress related to worries about their financial situation may compound clients' other worries, or simply be additional to them.
- Clients may also experience anger or frustration as a result of their financial situation.
- The worry and the practical problems occasioned by financial problems can put the health of clients and their families at risk.

Section 4.3: Support Provided

Benefits
For a number of clients, the initial support provided by the project had been a comprehensive benefit check:

> 'They looked at his [her father's] history and how he was, and then they advised that he would be eligible for Attendance Allowance. They also looked at Housing Benefit. She was very thorough, and thought that he would be entitled to heating allowance and Council Tax Benefit too' (Marie, 45-44)

> 'Amber sat down and calculated everything for me. It turns out I was getting £25 per week less in tax credits than I should have been' (Emma, 25-34).

For one client, this had stemmed from a much more specific enquiry:

> 'When I went in we talked about the blue badge. We touched on my entitlement at that point. I never realised that one thing led to another and it was very helpful' (Patricia, 65+).

Most clients had received some support with filling in forms. Work with clients on one benefit could lead to a claim being submitted for another:

> 'Later that day [after the initial benefit check] they squeezed him in and filled in the form for him. That was great, I didn't want things to go on and on. We are to phone them when we are making an application for Housing Benefit' (Marie, 45-44)

> 'She filled out the ESA form for me. Then she asked if I was getting PIP because it looked as if I should. I said that no one had ever said about that, no one had ever told me about it. She made a call, and told me to come and see her when the form arrived' (Alan, 45-54)

People often described the role of the adviser as being to 'sort things out for them', to fix their problems:

> 'They are fixing my benefits for me, Council Tax Benefit, everything. I've been to see her five times to get my paperwork sorted, she's fixing my life really' (John, 45-54)

Alongside the filling out of forms and sorting out of problems, the explanation of situations in which clients found themselves had been important:

> 'She sorted the benefits stuff out. She filled out the PIP form for me, that was the second time we met. She just explained everything that was happening' (Clare, 25-34)

That explanation and support role could be particularly important when working with people from migrant communities:

> 'The CAB have helped me understand things, they have been speaking to HMRC on my behalf. I answered the security questions and then they spoke to them on my behalf ….' (Laure, 45-54)

For some clients, the major support they had needed had been to help them navigate a unfamiliar system:

> 'She told me what I had to do, what I had to tell people. I just didn't understand what I had to say to people, I've never been on benefits before' (Katie, 25-34).

Sometimes more intensive support, such as chasing up responses from the benefits bureaucracy had been provided alongside form filling to deal with issues that had arisen:

> 'I didn't get my ESA, there seems to have been some sort of issue with paperwork being lost. She's been on the phone to them about it, 50 minutes she was waiting, and she's started my application again. When I get my ESA50 through I'll go in and see when I do. She's put in a PIP form for me.'
> (Ian, 55-64)

That intensive support had gone to the level of providing support with appeals, and with getting benefit claims restarted:

> 'She filled in the form for tax credits and helped me with my appeals.'

Some clients had not needed much help with filling in forms beyond some tips, hints and advice, although they had been offered help if needed:

> 'She didn't help me fill in forms. I'm OK with forms but she did say if that if I needed it I could get in contact,
>
> Filling in forms is not really a problem for me, though some questions seemed a bit tricky, and she did tell me what to say on one of them' (Katie, 25-34).

Clients also played a role in getting some of their documents together:

> 'She took notes and helped me fill in some of the forms. Some of the bits I did myself, getting my documents together for example' (Tania, 25-34)

Clients had been helped to access financial support from outside the main benefits system:

> 'She's put in an application to the Family Fund Trust. We're trying to get a holiday, I'm waiting to hear back on that.' (Emma, 25-34)

Debt Advice

The first contact with advisers had often involved taking stock of their situation in respect of debt:

> 'That first meeting was just about to talking through the situation.'
> (Tania, 25-34).

A key element of the support provided to clients on debt issues was inevitably making contact with the creditors:

> 'Claire got in contact with all my creditors. They've written to Scott and Co [a debt management company who had taken on her Council Tax Debt] about the money I owe on my Council Tax' (Tania, 25-34).

‘’She spoke to the housing officers for me [about her arrears] and wrote letters to the different people.’ (Clare, 25-34)

‘Claire went to them, the council tax people and the housing benefit people and asked them to keep a hold on things’ (Laure, 45-54).

One of the clients was being taken through the bankruptcy process by project advisers. For her too, the process had begun with a taking stock of the situation:

‘We started just working out how much I had coming in and how much I had going out.

We decided I would be better off going through bankruptcy. It’s a long process, getting all that paper together. It really takes its time.

She phoned round people on my behalf, speaking to people I owed money to. She was working to get to the bottom of the situation, trying to get everything clear. She let me know what was going on’ (Erin, 18-24)

Advice on Money Management / Budgeting and Destitution.
Advice on managing money given to clients generally seemed to have been given once initial pressing problems had been resolved, or were on the way to being resolved, the client quoted below had been receiving support going through a bankruptcy process:

‘Another lady said I should look to switch bank accounts to make sure to make sure that the bank weren’t coming after the money that was in my account’ (Erin, 18-24).

Sometimes the advice could be very simple in relation to basic household bills:

‘She told me where I could get cheaper food’ (Afua, 25-34)

‘Claire got me the Warm Homes Discount’ (Clare, 25-34)

Some clients reported a small amount of chat about managing money:

‘We spoke a little about managing money, but it was mostly about what benefits I was entitled to and who I had to tell about it.’ (Katie, 25-34).

Some clients still using the service reported that they had been asked questions about money management, but that things had not yet moved to full consideration of those issues:

‘She’s asked me how my money is, but mostly we’ve been talking about benefits’ (Ian, 55-64)

‘Next time we’re going to talk about money management. Claire has said to me that she can see we aren’t going crazy, but we are still spending more money than we have because our income has gone down.
One of my issues is that my phone bill is too high. I took over a contract from my mum when she left the country, but it looks like I can only cut it from £50 to £47. We looked at fuel bills but she said there was nothing too bad there’ (Tania, 25-34).

For some clients, the review of how they managed money was about confirming they were on the right track, or they indicated to advisers they did not need any advice:

> 'They did look at other things, they were very thorough. They talked through the way I help my dad, the way I have two accounts for him, one for paying bills with' (Marie, 45-44).

> 'They asked about my money, but I said I'm OK, my daughter handles all that' (Alan, 45-54)

> 'Amber asked me about money but I said that it's OK, I keep on top of things anyway.' (Emma, 25-34)

The project had also linked people to various sources of help to support them to deal with crises/ destitution. It is notable that two of those assisted in this way were from migrant communities:

> 'At Christmas time she spoke to people at the church, and made sure that I had some money for Christmas.' (Clare, 25-34)

> 'She helped me by telling me where to go for the foodbank' (Ayesha 35-44)

> 'She told me about the foodbank, and where I could go to get clothes' (Afua, 25-34).

Support Provided

- Clients receive a variety of support in relation to benefit issues:
    - Comprehensive benefit checks.
    - Assistance with filling out forms/ completing forms on their behalf.
    - Explanation of the system/ situation in which they find themselves.
    - Chasing up progress from an unresponsive system.
    - Assistance to access grants and funds from outside the statutory system.
    - Appeals against decisions.
- Benefit checks may start on the basis of discussing one benefit related issue, and conclude with looking at several more.
- For some clients, more light touch support may be all that is required.
- Explanation of the benefit system may be particularly important for clients from migrant communities.
- Debt advice begins with a taking stock of clients' situations.
- Advisers had also phoned creditors on their behalf, and one client was being taken through the bankruptcy process.
- Advice on money management generally followed problem resolution, although initial conversations were being had even before that point and more detailed conversations were planned later.
- Often clients had felt that they did not need advice on money management, or that this aspect of the service was only a small element of the support provided, in the manner of a quick health check that they felt confident, capable and were on the right track.
- Advice might be as simple as pointing people in the direction of cheaper food/ fuel bills.
- Some clients require direction for support to deal with destitution/ access humanitarian aid.
- Clients may see the support they receive as 'fixing things' or even 'sorting their life out'.

Section 4.4: Additionality of the Service.

Clients were asked whether they would have been able to resolve their problems without the support and intervention of the project, and what might have happened in their personal situation without the input of the project.

Over and again, clients identified that advisers had been able to resolve their benefit problems in way that they would not have been able to do themselves.

This was the case for the people from migrant communities who had used the service:

> 'It was very good help. I don't think I would have been able to manage it myself.' (Ayesha 35-44)

> 'It has made a difference. Sometimes I have tried to understand what they [the benefit system] want, sometimes I don't understand anything. I wouldn't have been able to deal with this without them. I had been trying to sort this out myself and nothing was moving.' (Laure, 45-54)

That point was often made in the context of the complexity and length of benefit application forms, which could be the source of stress:

> 'The way she filled out the form, I wouldn't have been able fill out that book in that way' (David, 45-54).

> 'I never had anything to do with the system before. The paperwork is horrendous, without help I don't know what I would have done' (Ian, 55-64)

> 'Without the CAB I wouldn't have been able to fill the form out. I'd definitely not be able to do that. You start with they forms, it just stresses you right out. They look like a book, where do you start?' (Alan, 45-54).

People felt that they lacked the requisite knowledge, skills or stamina to do the forms:

> 'The adviser filled out the form. Neither my husband nor me would have been able to do it. There are so many pages on the forms. Perhaps I'd be better if I could do it over the phone, but as it is, no way. Just trying to do it yourself, with the spelling etc would be too difficult for us.' (Patricia, 65+)

Some clients highlighted the way in which support had been available to them at a time of significant emotional problems:

> 'I'm really indebted to the service. I really couldn't have coped with the support. It was only a short time since my mother had passed and I couldn't have coped with filling in forms at that point. I couldn't have coped without Amber, she knew her job.
>
> The service was invaluable. It took the pressure off me, I couldn't have dealt with the situation otherwise.' (Marie, 45-44).

One client highlighted the extent to which advisers could make effort that they could not cope with:

> 'She's been on the phone to them for 50 minutes. I don't know how she has managed it.' (Ian, 55-64)

Some clients highlighted that there were no other alternative sources of help and support available to them:

> 'I didn't have a clue about claiming benefits….he [her husband] was in prison so he couldn't help. I just didn't know anything about Child Benefit and what you had to tell people.
>
> If it wasn't for Claire I wouldn't have been getting support when I needed it. It was quite a tough time, I've no family in Glasgow, it was quite tough going without their support, the CAB helped me when I was desperate.'
> (Katie, 25-34)

Clients were often clear about the consequences of not having been able to resolve the challenges they faced, consequences which were sometimes potentially dramatic, other times less so:

> 'I'm certain I wouldn't have been able to sort all this out myself. I'd still be living with debt.' (Erin, 18-24)
>
> 'I thought I was going to lose my housing, at times I thought I was just going to have to move out, I thought I would just have to go outside with my child, I hope that things don't get that far.' (Laure, 45-54).

Some clients gave a more general sense:

> 'I would have been stuck without that help, I don't know what I would have done without that help at that time.' (Clare, 25-34).
>
> 'It was very helpful. I couldn't have done it without the service. I think I would just have gone on with things getting worse' (John, 45-54).

One client felt that she would have been in a situation involving ongoing debt, but that she might have escaped losing her home:

> 'I couldn't have done all this without Claire's help. Things had got so difficult with the Council tax, they wouldn't accept that the little I could give them was enough. Things would have got worse there. I don't think that my landlord would have chucked me out though, because I have a baby' (Afua, 25-34).

In one case the client felt that their own attitudes would have played a role in them not accessing the support they were entitled to:

> 'I don't know what might have happened if I hadn't been referred. Other people were telling me I might have been entitled to stuff, but I was saying no, no, we are pensioners, we won't get anything.' (Patricia, 65+)

Key Points: Additionality of the Service

- There is clear direct evidence from client feedback that the service is additional, in that it helps them resolve problems that they feel they would not have been able to deal with themselves.
- Those who had been provided with support on benefit issues report that:
    - They would not have been able to deal with the complexity and length of benefit forms themselves.
    - They would have lacked the knowledge, skills and stamina to have completed them themselves.
    - They would have lacked the persistence to deal with an unresponsive system.
- Clients who had been experiencing emotional difficulties at the time of accessing support were particularly clear they would not have been able to deal with the challenges they were facing.
- Clients often lacked access to other support.
- Some clients felt that they would have suffered significant harm without support, either being placed in a unsustainable financial situation, or seeing their housing situation put at risk.
- Even without being at risk of such harm, clients felt that they would have been 'stuck' without help.

Section 4.5: Impact of the Service, Practical, Psychological and Behavioural

Practical Impact.
For some clients, help from the project had helped them meet basic needs.

Two of the clients focused on the increased affordability of milk and other basics for their children after they had been supported to claim additional benefits:

> 'The foodbank was able to help me a lot, and some other people did too.
>
> I could afford formula milk. That is so expensive and it was impossible for me before, the diapers and formula were costing £15 and I was only getting £40, I had my daughter and myself to feed on top of that' (Ayesha 35-44)

> 'The Child Benefit has really made a difference, I can pay for the milk now. I'd been trying to breast feed but that hadn't been going well, so a lot of the Chid Benefit money has been going on formula and making up for that extra expense' (Tania, 25-34)

Basic advice on where to purchase food had also made a difference:

> 'When I was working I used to do my big shop every month, but I can't do that anymore. Claire showed me where I could get food cheaper. That helped a lot' (Afua, 25-34).

One client focused on the way that the benefit that they were newly claiming would help them deal with some of the extra costs of having a child with a long term health condition who would be undergoing some hospital tests/ treatment:

> 'My daughter's going to England for tests and I'll use some of it for that. They pay my travel, but we'll need somewhere to stay, and food and that, and we're not sure how long we will be down there for' (Emma, 25-34).

Energy bills were another area in which clients reported experiencing a difference:

> 'She got the number for the electricity people and made sure enough was put in the meter. She got me the Warm Homes Discount. That's been a huge help to me, I've not had to put anything in to the electric.' (Clare, 25-34).

Clients also spoke of the greater affordability of Christmas time, or of the accessing of direct help with Christmas costs as a result of advice:

> 'I was able to get Christmas gifts for my children [from the foodbank]' (Ayesha 35-44)

> 'At Christmas time she spoke to people at the church, at least that meant I had the money I wanted for Christmas.' (Clare, 25-34).

> 'I'm putting a bit of the extra I'm getting away for Christmas. I've not been worried in the past because they were a bit younger and not as bothered. We'll see if I need to worry this year [laughs]' (Emma, 25-34)

Some clients focused on the impact on them of being able to get/ maintain a car. Notably, they reported a significant psychological impact from being able to do afford this:

> 'He's been delighted. He was worried, mum [who had died recently] had a Motability car through DLA. He has been able to get a little car and doesn't have to worry about money.
>
> He doesn't go far, just locally, doing bits of shopping, bits and pieces, and occasionally down to see me. The main thing is to keep his independence, we don't want to disempower him in any way, and the car helps him keep that' (Marie, 45-44)
>
> 'We are going to sort a car out, it will help with the payments for that. We aren't as stressed, my husband is a lot calmer now. We both feel better about life….' (Patricia, 65+)

One client spoke of making other big purchases, using a back payment on a benefit claim for furniture after they had been support to make a successful appeal:

> 'Money is OK now. I used that back pay to get a new sofa and a bed' (Emma, 25-34)

For a number of clients, the practical benefit of having more money was seen in there being less pressure on their spending:

> 'It's been a big help, definitely a big help. I get mobility and daily living [components of PIP], it helps towards my bills, and just a better quality of food' (Alan, 45-54).
>
> 'The extra money has been a help with our bills, it makes life a little bit easier that we have got that bit more money' (Patricia, 65+)

Clients spoke of the flexibility this gave her to spend more money on her children:

> 'At the end of the week I still have some money left, I can afford to take the boys out to soft play, things like that.' (Erin, 18-24)
>
> 'I can use that extra for some days out with the kids, they can be really expensive' (Emma, 25-34)

A client who was single also saw the potential for him to be able to do more in terms of leisure activity:

> 'I'd like that extra money. It would help me get out for a day, and would make my life that little bit more comfortable.' (John, 45-54)

One client focused on the possibility of using Attendance Allowance to buy her father some extra support:

> 'We might use some of that money to get him a befriender' (Marie, 45-44).

For some clients, there was a limit to how far they felt the additional money might help them:

> ‘I’m not sure how far the money I’m waiting on will fill the gap. I don’t think the extra will be very much, but to be honest I’m grateful for what I can get’ (Tania, 25-34)

Resilience.
Clients were asked to think about how they would cope if they faced a sudden expenditure, or a drop in their income.

Many saw themselves as being able to cope if the sudden expenditure was in relation to an item like a washing machine breaking down (this was sometimes used as a prompt by the consultant in interviews), either because they had made provision for such an eventuality, or because other sources of help were available:

> ‘If things like my washing machine break down, I can get a Care in the Community Grant’ (David, 45-54).

> ‘We’d definitely be able to cope if something went wrong. Washing machine and fridge, they are the important things that you need so we’ve got breakdown cover for them. Someone comes out and fixes them, and they give you a new one if they can’t manage that’ (Katie, 25-34)

Others were much less confident about their ability to cope:

> ‘I definitely wouldn’t be able to find £200 from somewhere. If it was for a washing machine or a television or something like that, I would have to go to see Curry’s and see if they did finance, but that can be difficult if you’re not in work.’ (Alan, 45-54)

Psychological Impact
Many clients pointed to a positive psychological impact from the assistance they had received:

> ‘We are not generally worrying about money in the same way’ (David, 45-54)

> ‘I do feel a little better, a little more relaxed about the situation. Even though we still owe a lot, I feel that we can deal with the situation, if it takes longer, we will still deal with that situation in the end.’ (Tania, 25-34).

> ‘It’s a relief to have a bit of extra money, things aren’t as bad as before, it’s one thing that I don’t have to worry about any more’ (Alan, 45-54).

That positive impact could partly be a result of being able to support their children properly:

> ‘I was really worried and I didn’t know what to do. I can now eat properly and so can my baby. Life is OK compared when I first made contact with the service. I can feed myself and my kids’ (Afua, 25-34)

One client, going through bankruptcy, already felt better, despite the process being ongoing, partly due to reduced hassle from her creditors:

> 'Things are getting better, though I've not had my letter yet….Claire has let them all know [about the bankruptcy] and I've stopped getting calls because of that. I'm feeling a whole lot better about things.' (Erin, 18-24)

In contrast, psychological relief had been slower to come for one client, who had remained stressed about the outcome of his benefit application until it had formally been received:

> 'I was still on edge until it came through' (Alan, 45-54).

Some clients were anticipating further challenges in the future, which meant that they feared their current reasonably positive situation would get worse:

> 'I'm going to start worrying again because my standard maternity pay is going to run out, I think I will be going back to work if I can, but probably only part time' (Katie, 25-34)

It was clear that for a number of clients the claiming of benefits was not a comfortable experience, and was not one that they wished to continue for too long, although they remained grateful for the support they had received from the service. The client below was also keen to stress that they were in genuine need:

> 'I didn't want to depend on benefits, I didn't want that to be my way of life. When I start work again I don't want to be in this position. I need to work, it's something that I have always done, I don't want to stop that….
>
> I've always paid my tax, I genuinely need support. I'm genuinely struggling and need help' (Katie, 25-34)

A couple of clients spoke as if, more than anything, they were hoping for a period of calm, the service for them had been part of helping them get to a position where they might hope for that, although in the case of the person quoted below from the migrant community, they had ongoing concerns about their asylum case:

> 'Things have been very difficult, particularly for my daughter having to change schools, they have been tough. I hope now to be able to settle down for a bit' (Ayesha 35-44)

Some clients faced situations that were so complex that they still felt significant frustration and anger about the difficulties they were facing. The client below, from a migrant community, was grateful for the support that she had received, but hugely frustrated about the situation in which she found herself, and angry about what she saw as possible prejudice against her on the part of the authorities:

> 'I wanted to have a better life but I have got into difficulties for no reason. I've been accused of fraud and they won't say why, they won't tell me which of the papers I've given them is a fraud. I gave them my daughter's passport and birth certificate, and nothing has come back from them.
>
> I wonder if it is because I am a woman that they treat me like this, or if it is because I am black. Are they trying to get at African people, is that it? Yes, I

was born there but I grew up in Europe. I don't understand, it's just wrong to treat people badly for no reason, and to talk about fraud when they can't prove it' (Laure, 45-54).

Even for this client, the support that she had received had made a difference:

'It was a very bad time. If I had not got the support it would have been a kind of hell' (Laure, 45-54).

Behavioural Change.
Clients reported both that they had changed the way that they behaved financially after the support they had received, and that they felt differently about their money management:

'I'm going to do things differently going forward. No more using catalogues. I'm going to budget and put money away. It was a real problem for me, getting that credit and not being able to pay it back.

I feel quite confident about that, I feel I can do it better this way' (Erin, 18-24).

For one client, greater control had come partly through the help offered by the service, partly through the natural settling down after having a child:

'We have been spending less the last couple of months. We've been given a couple of nights out by the hotel [where she and her husband work]. We don't go out in the same way though, we don't go out for food etc. We just make sure we have got what we need and spend the money on our daughter.'
(Tania, 25-34)

This could be the result both of direct advice they had received on managing their money, and of the resolution of their problems:

'I feel more in control now, I feel different about the way that I do it.

My husband and I are working together, we deal with things together now. We plan ahead for the different extra things, the things that are coming round'
(Katie, 25-34)

The feeling of being in control and changing behaviour could in itself have a positive impact on people's wellbeing:

'I'm not as stressed as I was, not as worried. I feel more in control than I was. It's really helped with my mental health problems, I'm not crying all the time. I can budget across the two weeks for which I get paid, that's not a problem' (Clare, 25-34)

'The situation feels under control. I don't have lot of problems at the moment. That feels great and a bit of a relief.' (Afua, 25-34)

Clients were asked whether they would use the service again if they had another problem. Almost universally they reported that they would. Having this source of support available was also seen as having a psychological benefit for clients:

'I know that I can see Claire if I need to' (Clare, 25-34).

Key Points: Impact of the Service

- The service has a significant practical impact on the lives of its clients.
- For some clients, this is about enabling them to meet basic household needs, including the purchase of baby milk formula, or at least enabling them to meet such needs more cheaply.
- Other clients were now able to meet specific additional expenses, for example food and accommodation bills associated with a child's hospital treatment.
- Clients also saw an impact on their ability to pay basic household bills, including energy bills.
- Clients had received humanitarian support in relation to specific events such as Christmas time, or were better placed to meet the costs of such events.
- Back payments on benefits can be used to make large purchases for example of furniture.
- Maintaining access to a Motablity car, and thereby to independence was a key outcome for some clients.
- For some clients, outcomes included less pressure and greater flexibility over spending, whether on better food, on children including on leisure activities, or on leisure activities for themselves.
- Clients cannot always completely take themselves out of financial difficulties as a result of the support many received.
- Clients have mixed views as to whether they are truly financially resilient as a result of the service.
- Some continued to see aspects of their resilience in terms of access to benefits, others felt that they had made appropriate provision to deal with financial challenges, others felt that they would struggle to access finance if they needed to replace household goods. The latter point suggests that messages about affordable loan products have not been absorbed or that alternative loan products do not meet their needs.
- The resolution of financial problems has had a positive psychological impact for many clients.
- For some, that resulted simply from being able to support their children properly, for others from no longer being hassled by creditors.
- The service had given some clients the space to breathe and take a step away from pressure on them before starting to rebuild their finances.
- Some clients who felt they had been the victim of discrimination still felt huge frustration at the situation they had found themselves in, the service cannot completely resolve that.
- Some clients reported changing their financial behaviour, sometimes quite significantly.
- This could be as a consequence of the advice and help on money management offered by the service, and/or the determination to avoid a repeat of existing problems once they had been resolved.
- This feeling of greater control could in itself reduce stress.
- For some clients, empowerment will be about seeking help from the CAB at the right time if problems arise in the future, not about being able to resolve those problems directly themselves.

Section 4.6: Quality of the Service and Recommendations for the Future

Quality of the Service.
Feedback from clients was almost uniformly positive about the quality of the service with which they had been provided.

The understanding attitude of advisers was much appreciated, as was their professionalism, reliability and responsiveness:

> 'They try to understand everything. They always get back, they are quite efficient and helpful. I could count on her, she was very helpful' (Katie, 25-34)

> 'She's been very professional and a huge help. She's been excellent she's explained everything' (Ian, 55-64).

> 'Karen was really good, she did everything and made you feel comfortable' (Alan, 45-54)

Their expertise and knowledge were also much appreciated:

> 'She was extremely knowledgeable' (Marie, 45-44)

That ability to understand could extend to dealing with difficult circumstances with great sensitivity:

> 'They were really empathetic with me considering I had just lost my mum and was no fit state to fill any form in, let alone a lengthy one.' (Marie, 45-44).

> 'They were really helpful. They understand how stressful it all is, and how they can help. They were very kind and understanding and did everything to get things sorted' (Erin, 18-24)

> 'She was very sympathetic to us, she made us feel comfortable. She showed me a lot of concern because she knew how much I was worrying about something happening to my husband.' (Patricia, 65+)

Clients felt that being listened to, and being trusted and not judged by the advisers was a key part of the quality of the service they had been provided with:

> 'The girl that filled out the form for me. She was so nice and good at her job and seemed to be able to listen. I didn't feel that she thought I was telling lies, so it didn't make me uneasy. She sat and listened to us. She didn't question us much, she filled out the form and put us at ease. She knew who we were and what our situation was.' (Patricia, 65+)

Other clients stated their general positivity about the support they had received:

> 'I can't speak highly enough of them' (Ayesha 35-44).

> 'Brilliant, fantastic, it's a great service. I can't thank them enough' (Alan, 45-54)

> 'Brilliant, good, just put down what sounds best' (Emma, 25-34)

'Really good and really supportive, it was just Claire I dealt with, and she was absolutely brilliant' (Clare, 25-34)

'It was a first class service, she was really nice lassie. She was really helpful, she really knows her stuff.' (John, 45-54)

Clients were also specifically positive about their first contact with the service:

'That first contact was great, really lovely. It was very helpful to be able to talk over the situation and be offered help. They were both really happy and helpful. It's great to have someone happy when you are dealing with something really serious, it's comforting.' (Tania, 25-34).

One client focused directly on their positive feelings about the way in which they felt service had empowered them:

'They teach you how to do things better. They don't just tell you that you need to do things better, they tell you how you can do it' (Erin, 18-24)

Some clients compared the support that they had received from the CAB with other services they had used:

'It's been more helpful than other services I have used.' (Katie, 25-34).

'I've been to the Job Centre. The advice here was much clearer. I went down there and they told me that that was nothing they could do for me because I wasn't on benefits. They said you might apply for this, you might apply for that, but there is nothing that we can help you with. It was useful and useless at the same time if you know what I mean. I just thought it was quite strange that they couldn't really offer me any help because I wasn't on benefits' (Tania, 25-34).

'I used the Milton Advice Centre about 20 years ago. That was really good, but this was even better.' (David, 45-54)

A small number of interviewees had used other advice services previously. For one client this had been a mixed experience, although despite that she had taken up a referral from her health visitor:

'I went along when we lived in Shettleston, and when we lived in Edinburgh. I went to see them [in Shettleston], that was before my child was born and I wanted to see what I could get. I didn't get anywhere so I kind of dropped out of contact' (Katie, 25-34)

Two clients did raise issues where the service, or other parts of Maryhill & Possilpark CAB had not been as effective or delivered support as well as is ideal, although for both people this should be set in the context of feedback that was positive overall:

'I've not been speaking to her recently, she's been a bit hard to get hold of. I've been texting her and things, it can be a bit difficult to catch her at a good time' (Erin, 18-24).

'The initial appointment, I contacted the CAB and was told that Woodside [Health Centre] was the closest place that I could go to.

> It was all a bit messy [at Woodside]. The adviser didn't seem to know we were there so didn't come out for us, and the receptionist didn't seem to know much about it and said it was nothing to do with her. It was a bit frustrating.
>
> [When they saw him] The adviser kept saying that he couldn't answer that and we would be as well to wait for their proper appointment.
>
> After that first meeting, the guy was supposed to get back to us with a second appointment. He didn't, and so I contacted them [the CAB]. That's when I got put in touch with Amber' (Marie, 45-44).

Using the Service Again/ Recommending the Service.
There are two acid tests of a service, whether or not people would recommend it to others, and whether or not people would use it again themselves.

Clients were uniformly positive about the idea of using the service again if they needed to:

> 'I'd head up there if there was any issue.' (David, 45-54)
>
> 'I'd head back again if needed' (Ayesha 35-44)
>
> 'The next time, if something is wrong, I'll contact Claire again' (Afua, 25-34)

Some did not foresee that they would immediately need the help of the service, but were prepared to go back and get help if needed:

> 'My husband and I, we're not greedy people. We are happy with what we get, it's more than enough for us. We could ask for help in the future, at the moment what we get suits us.' (Patricia, 65+)

Not a single client indicated that they would not recommend the service to others and a number already had:

> 'I've already recommended it to my youngest. He lost his job and was worried about his house so I told him to head down there, go to the CAB and they will help' (Alan, 45-54)
>
> 'I've recommended it to my mother in law, now she has an appointment' (Emma, 25-34)

One client phrased her willingness to recommend the service in a more guarded way, indicative perhaps of her underlying attitude to benefits:

> 'I would recommend it to someone if I thought they deserved it [the benefit they wanted help with]' (Patricia, 65+)

Clients were also clear about the extent to which the service was delivering something that no one else was, which meant that it should be recommended to others:

> 'It's great to have them there, there is no one else doing what they are' (Katie, 25-34)

Recommendations for Improving the Service

Most of the clients did not have any recommendations for improving the service.

Many wanted simply to focus on the need for the service to continue, and highlighted that there would be a gap left if it did not:

> 'I just think the service should continue. There are a lot of people need help and advice, a lot of people who are unemployed and don't know what to do' (Katie, 25-34).

> 'There's nothing I would change, I just think it's a pretty good thing for people to know that there is help out there.' (Clare, 25-34)

Others wished that some way could be found of getting to people earlier in the development of their problems:

> 'I can't think of any way that the service could be improved. I would like to have known about it when I left work, I didn't know at that time what I was entitled to and what I could get. Maybe I was a bit naïve, it would have been nice to get help' (Ian, 55-64)

> 'Nothing should really change. I'd like to have got to them sooner, I'd probably have got my PIP sooner.'

The client who had felt that she had not been contacted consistently enough did have some feedback relating to that, although it was not expressed particularly strongly:

> 'There's nothing that needs to change….I suppose they get so caught up in dealing with the situation that perhaps they could contact you a little more.' (Erin, 18-24)

Key Points: Quality of Service and Recommendations for the Future

- Clients are very positive about the service, both generally, and when highlighting specific aspects of the service.
- They see staff as being understanding, professional, reliable, expert and knowledgeable.
- Clients felt they had been dealt with great empathy at moments of real stress.
- They also felt listened to and not judged.
- Two clients had slightly more negative experiences. One felt that the service could do better at remaining in contact with them whilst their case was being worked on, another had found another service provided by the CAB that they had previously accessed to be disorganised.
- The service was compared favourably to other sources of support.
- The service passes two acid tests; clients would recommend it to others, and would use it again themselves.
- There are few recommendations from clients for improving the service, but there is some suggestion it could be more effective at staying in contact with clients, and some implied that more publicity more generally for CAB services would be helpful in terms of getting to people sooner.

Section 5: Feedback from Partners and Project Staff.

13 interviews and 1 focus group were conducted with project partners; including both health visitors and GPs, the Health Improvement Team at NHS Greater Glasgow and Clyde, project staff and CAB managers.

These explored their views on the:

- Issues affecting clients.
- Project set up.
- Partner relationships and referrals
- Service model and pilot project.
- The impact of the service and its additionality.

Section 5.1 Issues Affecting Clients.

Benefit Issues/ Welfare Reform
Welfare reform was felt to be at the centre of the range of issues affecting clients.

Both GPs and the health improvement team identified particular challenges for clients around the transition from DLA to PIP. For some clients this meant a disruption to their income, or suspension of payments, for some significant knock on effects damaging to their mental health.

GPs reported that significant issues had been arising for clients in relation to Housing Benefit entitlement and the Bedroom Tax, though these had reduced with the Scottish Government's mitigation work.

Sanctions and the withholding of benefits were also seen as key issues by GPs, and, notably by health visitors who were, to a greater extent than GPs, making referrals of families with young children to the project. The effect of sanctions on people's mental health in particular was suggested to be quite profound. Sanctions were seen for many patients as resulting from them being uncertain about how to fulfil work related requirements. One health visitor suggested that some of her patients would particularly struggle to avoid sanctions, lacking maturity, or having issues with authority.

More generally, the changes brought about by welfare reform were seen as leaving people in situations of significant uncertainty about how they were supposed to navigate their way through the system, and not being clear about how to respond to contact. It was suggested that this leaves many people slipping through the safety net that the system is meant to provide. Part of the blame for this uncertainty was laid at the door of the media, seen as constantly sending out misinformation about the benefit system.

Destitution/ Extreme or Severe Hardship.
Many interviewees suggested that the numbers of people facing destitution or extreme or severe hardship had increased. Asylum seekers with no recourse to public funds were seen as being particularly vulnerable to finding themselves in such a situation, to the point of being left without the means of sustaining themselves.

Pressures on Young Parents.
Health visitors identified the heavy pressure that many young parents, usually mothers, are under, one describing them as facing a daily struggle for survival, with all their effort needed just to get their child into school and fed properly every day.

For some young parents debt was seen as having become a way of life, a way of managing their finances.

Escape from the situation in which they found themselves through finding employment was seen as a huge challenge, particularly in a context in which they might struggle to access adequate or appropriate childcare.

Health visitors saw particular challenges for parents where they were:

- From outside the UK.
- Also dealing with drug and alcohol issues.

There was some debate around the impact of drug and alcohol issues, one health visitor suggesting that they were seeing fewer people dealing with these issues than they had used to.

Money Management.
There was considerable debate about the reasons for young mothers facing particular financial pressures.

Some health visitors suggested that young mothers face particular challenges in managing their money and setting a budget. It was suggested that these challenges were sometimes connected with not being able to cook, or even with lacking the basic utensils to enable them to cook.

Two members of project staff suggested that the belief that money management skills were generally the main issue for clients was ill informed, with many clients actually having skills equal to those of the advisers themselves. They felt the main issue was parents and clients more generally simply struggling with a sheer lack of money, with problems around financial capability only being the most significant issues in situations where people have other complex problems such as addiction.

One project adviser observed that what might appear to be inappropriate money management, for example the eating of ready meals, or use of taxis might actually represent rational responses to challenges faced, in these cases to the time demands of work or caring/ or the need to attend hospital appointments.

However project staff did suggest that:

- Parents can be driven to make financial decisions that are unwise by always wanting the best for their children, and not wanting those children to miss out.
- Clients do often manage from payment to payment, and then find it difficult to withstand particular pressure points when higher spending is demanded, Christmas is identified as just such a time, but less predictable spending requirements can also trigger difficulties, with people borrowing to be able to afford things that they need/ meet unexpected costs.
- People facing complex situations in terms of interrelated health problems and family situations can suffer from a lack of confidence to deal with their problems.

Debt

GPs see significant numbers of their patients impacted by debt. In many cases it is seen as being the result of a cut in income, perhaps in benefits, turning an already difficult situation in which they have no 'wriggle room' into something unmanageable.

It was also suggested by staff that even though people do not necessarily lack financial management skills, there still may be some cultural issues that drive debts. Some clients are seen as almost regarding debt as 'funny money' that they don't necessarily have to pay back, others may have inappropriate ideas about what should be seen as essentials, for example regarding satellite TV as a priority.

Project staff see people as struggling to access alternative forms of credit which would make their debt issues more manageable. People will still use home credit to borrow money, because of ease of access which can be almost immediate, and despite the price. Credit unions are not seen as a potentially useful source of credit for many clients due to the requirement that members develop a savings record before they can borrow.

Housing

A number of partners reported clients experiencing difficulties with housing. Particular difficulties were noted for families with young children, living on the upper floor of closes and struggling to take prams and buggies upstairs, or facing overcrowding and long waiting lists for a new house after the birth of an additional child. People with health conditions/ disabilities were also seen as struggling to access appropriate housing.

Impact of these Issues on Health

Three overriding issues relating to the impact of financial issues on people's health were picked up by partners:

- There is a very significant mental health impact associated with financial concerns, whether those relate to uncertainty about benefit entitlements in a new system, the loss, or fear of loss, of support previously relied on, or benefit sanctions. Debt and financial problems can trigger a downward spiral in people's health.
- Where benefit and debt issues exacerbate families' poverty, they also risk impacting on child development.
- Where patients do have financial worries, these may dominate to the exclusion of all else, partners may not be able to achieve their health related objectives with patients until their pressing financial concerns have been resolved.

Key Points, Issues Affecting Patients and Clients

- The financial pressures reported as being faced by families with young children confirm that the project selected its core target group appropriately.
- Financial worries have significant impacts on the health and wellbeing of patients, both their mental health, and their physical health.
- Issues around debt and benefit take up may also have an impact on child development through reducing household income.
- Welfare reform is seen by partners as a key driver of the financial problems facing their patients.
- This can be through generating general uncertainty about entitlement, exacerbated by media coverage, or through, for example in the case of the transition between disability related benefits, creating specific fears about loss of entitlement, or through practical problems including suspension of payments.
- Sanctions can leave people facing situations of extreme hardship, and have a severe impact on their mental and physical health.

- Particular pressures may be experienced by parents also dealing with drug and alcohol problems, or who are from migrant communities or in the asylum process.
- There is a debate about the extent to which the issues facing young parents and other clients relate to money management.
    - Some suggest that a lack of household management skills such as cooking play an important part in causing financial difficulties.
    - Others suggest that most clients who are not facing addiction issues are competent money managers, but just face a different set of financial 'choices' from those who are better off.
    - Lack of cash is seen as the major issue for most clients' money management.
- There is agreement that sudden financial shocks, pressures on expenditure that can in theory be planned for such as Christmas, and the natural desire of parents to ensure their children don't miss out, are all risk factors for turning highly stretched household budgets into something unmanageable.
- Patients who refer to the project may also struggle to access affordable credit.
- Those accessing credit may not take the need to pay it back seriously enough, or may have their own particular ideas about household essentials.

Section 5.2: Project Set Up

Partners were asked about how their initial engagement with the project.

It was clear that a number of those involved saw the project largely as being a continuation and extension of the previous Healthy Start project. In that sense, the first stage of those partners' engagement with the CAB had come before the Tackling Money Worries Project had started, when they were engaging with, and making referrals to Healthy Start. That previous project was seen by some as providing a sound base on which the relationships at the heart of Tackling Money Worries could be built.

It was also clear that that previous project, and its worker, had been very highly thought of by project partners, but the level of provision under the new project was seen as closer to meeting potential demand.

However, that continuity was not seen as sufficient to have prevented something of a degree of hiatus in between the end of 'Healthy Start' and the start of 'Tackling Money Worries'.

At the beginning of this project initial contact had been made in a number of ways through:

- Communication between the Health Improvement Team and health professionals.
- Direct attempts at contact by Maryhill & Possilpark CAB.
- Contact through the multi agency Possil Connections meetings.

Challenges.
Feedback from the Health Improvement Team and project staff highlighted a number of significant challenges that the project had had to deal with during its early period, many of which had taken longer than expected to get resolved. These efforts had effectively dominated those early stages, sometimes to the detriment of the focus on clients, and the issues that had proved difficult to resolve had sometimes acted as barriers to the referral of clients.

It had taken until the end of the second quarter after the beginning of the project to recruit the senior project worker. The CAB manager was not certain about why this was, speculating on there being competition in recruitment from other projects, and that people might not be keen on working in the more isolated manner that a health located project demands, or had not wanted to get involved in the inevitable moving between offices that the project would demand. The issue had been resolved in the end through the raising of the worker's salary using underspend.

Accommodation issues had not been easily resolved, with what was described as 'toing and froing' continuing over a long period being triggered by a lack of adequate space in each of the practices, in a situation in which even the manger of the health visiting team did not have proper office space. Alongside these accommodation issues, questions around project staff's access to a place where they were able to store paperwork had not been easily resolved.

Other issues which had not been resolved quickly included:

- Access to Information Technology, including laptops and NHS email addresses.
- Basic things such as signage and key fobs.
- The basic nuts and bolts of the referral process, discussed in more detail in the next section.

There was a degree of frustration experienced by both members of the health improvement team and project staff as a result of these difficulties. It was suggested that:

- NHS bureaucracy had turned very slowly in the resolution of problems that had arisen, and understanding and negotiating a way through rules had proved difficult. There was reported to have been a lack of 'wriggle room' and flexibility, whether or not this was inevitable and justifiable, in the way that NHS rules and regulations were applied.
- The process should have been quicker given GPs' commitment to the Deep End approach.
- Despite the interest in, and commitment to, the project from primary care colleagues, resolution of some of the practical barriers that it faced often took longer than ideal.
- The CAB had been surprised at the extent to which GP practices operate independently, with few opportunities to meet with them collectively.

It was suggested that these issues could have been resolved more quickly if:

- More preparatory work had been done prior to the launch of the project, particularly as the depth and intensity of engagement between the project and health workers was going to exceed that which had been the case in the previous Healthy Start project. It was felt that this preparatory work had not happened, because there would have been reluctance on behalf of health professionals to devote too much time to development of the project in advance of the award of funding.
- A project steering group had been established, something that had not been possible due to time constraints.
- There had been an earlier appointment of a specific project co-ordinator might have speeded up initial process.

However, interviewees did suggest that it was important not to be too harsh in judgements on the speed of setting up. The project was in some ways breaking new ground, with no clear route map to deal with all the issues presenting themselves, and lessons had at least been learnt. Furthermore, CAB staff remained positive about the supportive role in resolving many of these issues that had been played by the Health Improvement Team.

Key Points, Project Set Up

- The project was able to some extent to build on pre-existing relationships between the health visiting team and Maryhill & Possilpark CAB, based on their work together under the Healthy Start project, although the time gap between that project and this had fractured that relationship somewhat.
- The project faced significant organisational challenges during set up.
- There is consensus that many of these issues took too long to resolve, particularly given that the practices involved were part of the Deep End movement, although it was acknowledged that most of the pressing practical problems had now been dealt with.
- The causes of delays in recruitment, not concluded until the end of the project's second quarter, are not clear.
- NHS bureaucracy and inflexibility, whether or not justified, and pressures on accommodation at the health centre were identified as the key causes of delays to resolving issues around accommodation, access to IT and some of the practical challenges around referral.
- It was suggested that a project steering group or the earlier appointment of a project co-ordinator might have been able to resolve these issues sooner, and that it was unfortunate that lack of certainty about accessing funding had curtailed prior preparation work.
- Partners and project staff were, however, clear, that delays were also the simple result of the project breaking new ground, there had been no pre-existing route map to creation of something that would function effectively.

Section 5.3: Partner Relationships and Referral.

The project cannot function without effective working relationships between health professionals and advice staff, and effective processes for identifying and referring clients in need of support.

This section explores:

- Partners' and advice staff's views on the quality of their relationships, and of the effort put in to maintaining and developing those relationships.
- How GPs and health visitors do identify patients in need of support.
- The practical mechanisms through which patients are referred.

Building working relationships in the health context presents considerable challenges, but is essential to projects like this. The theory is that the more that health workers interact with advice staff, the more they know them, the more they develop trust in them, the more they remember to ask patients about financial issues and remember that they have a source of help to offer with those issues, and the more they make referrals to the service.

There is not always a high level of informal interaction between GP practices and the advice staff. It was suggested that GPs may pass advice staff in the corridor, but only when they are rushing to be somewhere else, and if a GP does not work at a time which coincides with advice workers being present, even that level of contact may happen hardly at all. Advice staff highlighted that their experience was often one of being only seen by receptionists when on the way in and out of the private rooms within practices that were being used for appointments.

Other GPs indicated a closer relationship, with the project adviser constantly popping in and out of practices to check on things, over and above the one session a week in which she was actually present, and more consistent contact with GPs.

Barriers to building effective formal working relationships between GPs and the advice project were reported. GPs were felt to have a huge amount on their plate at the moment with the shift of the focus of services from secondary to primary care, and the integration of care agenda. In this context, informal approaches to relationship building, or getting regular slots on the agenda of meetings can be very difficult, approaching GPs without a clear offer of something is often not successful.

There has clearly been some variation in the way that health visitors interact with the project over time.

- The previous Healthier, Wealthier Children project had very significant interaction with the health visiting team, with regular engagement with its project worker.
- This was continued when the project began, with one of the advice workers being based alongside the health visiting team in their office.
- However, this had not been continued as a result of pressure on office space.

There were some different views about the extent to which the advice workers had succeeded in integrating into the health visitor team. One interviewee suggested that there had not been as much communication with the senior project worker as there had been with the previous Worker, with less communication about the progress of cases coming back to health visitors unless they chased it. Others felt that there had been excellent integration with the team, with the advice worker properly being

accepted as part of that team, something that it was suggested does not always come easily in health settings.

The basis for the effectiveness of the relationships between the project and health visitors was seen as co-location and as being the project worker's ability to come into team meetings and be able to be proactive engaging with health workers in this context. One of the advisers did suggest that she would invest more intensive effort in that relationship building if they were to run the project again.

The project had initially been conceived as a co-location project, which would be based full time in the primary care setting. This had not transpired, due to lack of space. The CAB manager felt that a more appropriate description of the project was therefore 'intensive outreach'. The project co-ordinator felt that a sweet spot was now being hit in terms of the balance between staff presence at the Health Centre, and their being in the bureau and able to access peer support.

The particular challenge of building the relationship with health workers was acknowledged, one interviewee suggesting that it is quite a specific skill set to be able to approach and build relationships with a range of professionals with a different set of perspectives to you.

CAB staff felt that they had developed effective relationships with the Health Improvement Team, who had been hugely important to them as a bridge into engaging with primary care staff. That said, the CAB still felt that found it a challenge at times to deal with three sets of health workers; the Health Improvement Team, GPs, and the health visitors and other primary care workers. Building the number of different relationships required is a challenge. Health improvement staff acknowledged the challenges inherent in their building of relationships and encouragement of engagement with the range of different professionals they were involved with.

It was felt that the changing of staff had fragmented some of the relationships within the project, and that it takes time to build up trust with new workers. The new project worker was very aware of this, indicating a major effort in the early stages of her taking up the role to build links to staff including practice nurses, mental health staff, receptionists, and some success in generating referrals from these sources. She was working hard, through initiatives like a coffee and cake morning at which people could come and talk to her, to raise awareness of the service.

Identifying and Referral: Expansion of Target Group

Interviewees reported that the project had expanded its focus beyond its initial concentration on families with young children, to include adults facing long term health conditions.

The rationale for doing so stemmed from the fact that from the start, the Health Improvement Team and CAB had been more focused on the need to build links across primary care, to GPs as well as health visitors, and on the value of co-location in reaching out to people in the Possilpark area than they had been on the value of the specific targeting of families with young children.

The demand from GPs' patients for advice has largely been from adults with long term health conditions, in particular from people with mental health problems and those experiencing chronic pain. This has partly been driven by the impact of welfare reform, particularly the impact of people making the transition from DLA to PIP.

The service has responded positively to this demand, ensuring that the relationships between GPs and the project are strengthened. There was also, as one project adviser suggested, the sense that the project could not take up space at the Health Centre without responding as flexibly as possible to the needs of GPs.

Identify and Referring Practice.
Partners were asked how they identified people in need of support who they could then refer to the project.

For a number of partners, identification of potential clients for the service came about naturally over the course of their engagement.

One GP practice reported that this was particularly the case for people with mental health problems. Consultations with people with people from this group would involve exploring the reasons why they were experiencing mental health difficulties, and this would often identify financial issues as being one of the causes.

This practice suggested a slightly different identify and refer process with people with physical health problems. People with cancer and long term conditions were referred to the Macmillan project based in Glasgow. However, some clients with physical health problems were identified as needing advice if they raised lack of money as a barrier to exercise.

Other GPs saw themselves as engaging in a combination of actively seeking out information about patients' financial situation, and these issues arising naturally in consultations. Some of the assessments they carry out automatically touch on financial situations. At the same time patients often begin to talk without prompting about their housing problems, or raise issues about being sanctioned or their benefits.

However, GPs did consistently make the point that despite their awareness of the financial problems affecting patients, time pressures within 10 minute consultations meant that they did often struggle to get onto questions about money issues.

Health visitors have a slightly different relationship with patients, often being in and around their home. Both health visitors interviewed reported that:

- Identification of people in potential need of support was partly a matter of 'keeping an eye out' for the signs that someone was struggling, and then asking if all was OK. These signs might include a lack of furnishings, or a lack of food in the fridge.
- They would also ask relevant questions of patients; about what benefits they had coming in, or how they were coping financially. Both felt that they did not ask a set list of questions of patients, but instead relied on their own knowledge and experience to probe. This went against the feedback of the health visitor manager who suggested that there was now a list of set questions health visitors were expected to use related to patients' financial situation.
- Not all the people they recommended the service to would choose to engage, some would simply prefer not to.

Between their ability to spot the physical signs of financial struggle and their confidence in raising financial issues, both health visitors felt confident in their ability to identify those in need of the service.

It was acknowledged by partners that there was some variation in the level of referrals that were made by different health visitors. Different explanations were offered for this:

- One health visitor suggested that time pressures made referral difficult for some of her colleagues.
- Health Improvement Team staff suggested that occasional judgemental attitudes created barriers to referral amongst a few health visiting staff, and a small number continued to pay lip service to the importance of this type of service.

Health Improvement staff suggested that considerable and ongoing work was required to drive up the levels of referral from health visitors, and make them aware of who they could refer. Messages were not always received as quickly or as clearly as would be ideal, for example some health visitors had not fully absorbed the fact that the service could help asylum seekers and refugees. They also felt that there needed to be more work to embed referral into health visitors' plans and performance management.

A further explanation may be evidenced by the difference in understanding of the referral process between the health visiting team manager and the health visitors on the ground. The latter, as described above, do not see themselves as using set questions on money issues with patients. The former referred to there having been development of standard questions through NHS Greater Glasgow, on which this project was to have built.

Practical Referral Process.

Partners make referrals to the project in different ways:

- Some make paper referrals, preferring what they see as an old fashioned, tried and tested, mechanism.
- Others think that is bureaucratic, and welcome the opportunity to use the new e mail referral system.
- Other make referrals by phone.
- Some use whichever mechanism seems easier at the time of referral.

Managing the different referral systems has at times been a challenge for the advisers and their admin colleagues, there have been some issues with the speed with which paper referrals were being picked up from some of the practices. This was reported as being frustrating both for the primary care staff making the referral, and the project staff themselves.

Project staff also reported that occasionally clients would be referred without them being sure why that had been the case, and that sometimes insufficient information about their needs would be provided to them accompanying the referral.

However, there was an understanding that being flexible about referral mechanisms was essential to encouraging referrals; busy primary care staff need to be able to refer to the project in a way which is as little a burden for them as possible and fits with their personal way of working.

Key Points, Partner Relationships and Referral.

- The project cannot function without effective working relationships between project staff and primary care staff. Without trust, there would be no referrals, without referrals there would be no project.
- That building of relationships requires effort.
- Interaction between project and primary care staff is key to having that trust.
- However, there are barriers to informal interaction between advice staff and GPs, mainly the few opportunities they have to engage with other, and barriers to formal interaction given the huge agenda facing GPs and consequent pressure on time to meet.
- Interaction with health visitors has been more intensive, although project staff are no longer sharing accommodation with health visitors due to pressure of space has reduced the extent to which it happens.
- Despite that, the project workers have become well integrated with primary care workers, although staff changes will necessitate further work to rebuild links.
- There have generally been good working relationships between Maryhill & Possilpark CAB and the Health Improvement Team which have been critical to project staff's ability to create the necessary links with primary care staff.
- The groups targeted by the project have expanded to include adults with health conditions as well as families with young children.
- This has been a reasonable response to the demand for the advice on money issues that has been channelled through GPs. Whilst continuing to meet the needs of families with young children, the project has determined developing their relationship with GPs was more strategically important than seeking to build links with other organisations who work with families with young children.
- Primary care staff identify patients in potential need of advice on money issues both through deliberately seeking to discover whether they are in such need, and over the natural development of their engagement.
- GPs may often refer people with mental health problems when their exploration of the causes of those problems identifies money difficulties as one of the issues. However, the number of referrals like this may be limited by the time constraints they face on consultations.
- Health visitors are in the homes of young families in a way that few other professionals are. They use that presence to identify visual clues that patients might be struggling financially, as well as asking parents direct questions about financial circumstances.
- There are variations in the extent to which different health visitors make referrals to the project, and encouraging health visitors to make referrals remains an ongoing challenge.
- Barriers to increased referrals may include health visitors facing time constraints, but it may also be the case that there are some attitudinal barriers to referral amongst a few, and that a few pay lip service to the idea of referral.
- It is possible that greater use of standard questions by health visitors with patients, and greater focus on referrals in work plans and meetings, might generate a greater number of referrals.
- Practically, referrals may be made through paper, email and phone channels.
- The number of channels reflects the need for flexibility so that primary care staff can refer in a way that makes sense to them.
- There is, however, a considerable amount of effort required to make these different referral channels work effectively and ensure prompt response.

Section 5.4: Service Model and Information Sharing Pilot

Discussions with project and CAB staff explored issues around the delivery of the service model, and the new information pilot involving the sharing of information from patient records.

The focus of the project has been on standard interventions on benefits and debt issues; benefit checks, assistance with filling out forms, preparation for appeals, negotiation with creditors.

There has been less work around financial capability and financial inclusion than had been expected, and the project has had to be flexible around this rather than pushing this aspect of the work. One project adviser suggests that all of the clients she sees must have issues around financial inclusion or financial capability in a broad sense, i.e. they struggle to navigate their way through the benefits system, but that only around 50% of clients face those issues in their narrow sense involving lacking of skills around money management or lack of access to financial products (This is in contradiction to project statistics, suggesting a potential recording issue). For those clients, advisers will attempt to discuss a range of issues, including talking about how people might be able to access more affordable credit, for example from a credit union.

Project staff did observe that many clients do not appear to want advice around money management, they want to have their problems resolved and then move on. This can be despite their need for money management advice being obvious. Project staff suggested that even where this was the case, it was still essential to communicate clear messages about debt being real money that needs to be paid back. A connected point was made in relation to clients facing debt and benefit issues. Clients appeared much more open when talking about the latter, one adviser said dealing with a client on both benefit and debt issues could be like dealing with two different people. Despite this, clients would engage on debt issues where they might not on issues relating to money management.

There was general agreement that the balance that had been struck between the problem resolution and longer term advice elements of the service was appropriate, because it simply reflected the demand from clients.

Advisers have worked across a very wide range of subjects with clients, including immigration (to level 1), housing and employment alongside benefits, debt, financial capability, financial inclusion and energy advice.

On referral remains a key part of the project. Referrals were made to G-Heat in relation to food poverty, The WASP Project for people needing advocacy support with benefit assessments, smoking cessation, the Coach House Trust for employability support for younger clients, the gardening project at the Possilpark Health Centre, Lifeline UK for people suffering with depression and anxiety, and Ruchill Furniture Project. Most of the issues on which they make referrals arise naturally, though the advisers suggest that raising smoking cessation is not always easy. Referrals are also made to internal projects within Maryhill and Possilpark CAB, for example immigration cases requiring more than level 1 advice are passed on to the bureau's Equalities Project.

Advisers were clear about the way that the service involves and requires more than a single meeting with clients:

- The initial meeting is generally used to gather information from clients.
- Clients will open up more at further meetings once they have established a degree of trust in their relationship with advisers.
- That following through and opening up of discussions with clients is an essential part of what the service offers.
- Money management is never the first thing that is discussed with clients, clients need to resolve the pressing difficulties they face before considering the longer term, and jumping straight to long term issues does not get a good response.

Caseload management is a challenge in service delivery. This can be seen in two ways; the need to be able to accommodate new referrals whilst providing the ongoing support required for existing clients, without moving those clients on too quickly; and the need to meet the level of demand for appointments.

One adviser acknowledged that there was something of a tension between the ethos of the CAB, to empower clients, and the demand for ongoing support to existing clients.

One project adviser reported that there had been a recent shift to 45 minute appointments away from one hour. This meant seeing 8 clients back to back. Without careful management this could mean not giving clients enough time, and a struggle to carry out follow up work. It remained essential, particularly when form filling for disability related benefits, for clients to have access to longer appointments of up to 2 hours, and to continue to try to be creative in the service offered.

One significant challenge was reported which almost certainly reflects the personal problems facing some clients. Clients did not always stay engaged with the project. Specific groups of clients could be particularly difficult to contact, people with mental health problems changing numbers, people who had been subject to domestic violence changing numbers and their address. When these issues occur, contact with health workers to maintain a line of communication with a client can be essential.

Group Sessions.

The project has delivered a number of group sessions. These have generally used a seasonal hook to bring people in 'Christmas on a Budget' and 'Summer on a Budget', and have been delivered in conjunction with Glasgow Life. That partnership ensures that they have a venue organised, and people ready to engage with them.

Inputs have tended to be quite short, linked in to healthy eating provision, with participants doing the session and then going off to make/ eat soup together. Project staff have developed their own materials for use in the sessions and for people to take away. One member of staff fed back that she wished they had been able to spend more time tailoring these materials to their specific needs.

Project staff consider the group sessions to have been a success, with very positive feedback from those who have attended. There have been issues, project staff report that it has been difficult to get everyone to focus when children are running about the venue and participants want to engage with their friends, but broadly speaking they have generated good discussions, are enjoyable, and give people the chance to share tips and experiences with each other. One member of staff felt that although their impact would not be life changing, they were still worth doing if attendees learnt at least something new, and became more aware of the CAB as a result.

Staff do feel that more sessions could be run, engaging with a wider range of partners to reach more people. One project worker was clear that group sessions would be of benefit to more people than just families with young children.

Access to Patient Records Pilot Project
The project has just begun to pilot a new partnership approach to better supporting clients who are applying for disability related benefits, based on work in Edinburgh, where advice staff would access clients' patient records directly and use that in support of claims.

Applicants for disability related benefits can bolster their chances of success through providing medical evidence supporting their claim. Such evidence may be provided by GPs or other health professionals.

Providing such evidence can prove burdensome for GPs, and some partner practices no longer get involved in providing medical evidence. GPs report having had a number of consultations in the past which were solely about patients seeking their support with benefit applications. The pilot was sold to the practices at the health centre on the basis that it would reduce this burden whilst still ensuring clients had the necessary expert support with their claims.

The Health Improvement Team took the lead in this work. They linked the project to the Edinburgh pilot so that practical issues in the set up of the project were explored, lessons could be learnt, and the boundaries of what might be acceptable to practices explored. They then led the negotiation with each GP practice in turn, particularly the practice managers, to ensure that the systems put in place respect confidentiality and the specific requirements of practices appropriately.

The pilot is viewed as now working effectively. Although some initial teething troubles were reported at the time of a change in staffing at the project these have effectively been resolved. The project is seen as reducing the number of people presenting to GPs seeking help with applications, and improving the information submitted to decision makers.

From the point of view of the Health Improvement Team, the amount of leg work in getting to each practice and dealing with barriers has been considerable. Practices inevitably had their concerns relation to confidentiality, it is a significant step for GPs to allow access to their records. However, this work has ultimately been successful.

GPs had a slightly different perspective on this process. For one, the pilot project was complete commonsense, and only marked the extension to an additional agency of her willingness to share information. Whilst she felt that past experience and her commitment to the social model might have made her more sanguine about this than her colleagues, she suggested that they had also not resisted the pilot project to any significant degree. Others indicated that they had such concerns about the burdens they were facing in respect of increased demand from patients claiming benefits, and about letting their clients down, that they had been keen to explore any way of dealing with the situation.

The focus group with one GP practice was also attended by one of the project advisers. It became apparent during that discussion that not all the GPs had a clear idea of what was being done in the pilot project. The pilot does not involve the advisers producing medical reports- the assessment contractors only accept these from medical practitioners- but rather reports *informed* by medical evidence. These then reduce the

number of occasions on which the assessment contractors ask clients to seek additional medical evidence.

Advisers do not get GPs to sign off on their reports, but do speak to GPs if they need to clarify things. The GPs involved in that focus group appeared to have still expected requests for medical reports to be routed through them to the advisers, and had been concerned by the lack of demands upon them in this regard, which had suggested to them that their patients had been missing out on the support they needed.

Key Points, Service Model.

- The majority of the project's work is standard welfare rights and debt advice.
- There has been less work than was predicted in the funding bid on financial capability and financial inclusion in the sense of providing support with budgeting and to access financial products:
    - Only half of the clients are reported to need financial capability and financial inclusion support.
    - Many clients are not open to a discussion of money issues, or do not believe they need advice on budgeting.
- However, all debt clients do receive basic messages about the importance of paying back money borrowed.
- The balance between problem resolution and capacity building is seen as reasonable and as being determined by the balance of client wishes and needs.
- On referral, in house and externally, on issues as varied as immigration, mental health and smoking cessation is a key part of the project.
- Resolving clients issues typically takes a number of meetings, not least for trust to develop and clients to open up about the issues that they face.
- Some tensions do require management, in particular the tension between empowerment and control, between meeting the needs of existing and the needs of new clients, and between moving people on and providing them with all the support they need.
- There are time pressures on the service when referrals are high, challenging in a context in which so many clients need intensive support.
- There are specific groups which can be difficult to engage or remain in contact with, particularly people with mental health problems and people experiencing domestic violence.
- Group sessions have been delivered effectively by project staff, though some challenges have been experienced in delivering to mothers where children are present, and because of the short time slots available.
- There is an appetite to do more group sessions, engaging with a wider range of partners as a way of raising the profile of the service as well as of communicating key messages to service users.
- A pilot project has been run involving advice workers accessing clients' patient records and using the information to submit supporting reports as part of clients' disability benefit assessments.
- This has been working effectively, despite some teething issues.
- Pressure on GPs to deal with benefit applications appears to have reduced as a result of the pilot.
- The process of setting up the pilot involved considerable work, but there were fewer barriers than might have been expected from GPs, with any concerns about confidentiality talked through, and overcome by GPs' pressing need to deal with a source of considerable pressure on them.
- It is essential that project staff communicate clearly with GPs about the project and the people it is engaging, so that there can be full appreciation on all sides of what it is achieving.

Section 5.5: The Impact of the Service and its Additionality.

Interviews explored the impact that they felt the project was having, and their views on additionality.

Impact of the Service.

On Patients
Partners reported a noticeable impact of the service on the patients that they had referred to the project.

The impact of the service could be practical:

- Patients have more money.
- Patients have their rent arrears dealt with in a fairer manner, reducing the amount they have to pay on a repayment plan.
- Patients are able to furnish their house properly because of grants they can access.

One interviewee highlighted the impact of what she felt had been the exemplary service provided by one of the project advisers which had made a real difference to a vulnerable young mother. The client was a migrant who had been forced to leave her relationship because of domestic violence and had not yet submitted an asylum claim. With little recourse to public funds, she had been left unable to afford nappies for her child, until she had received support from the project worker.

Practical impacts were seen as leading to psychological impacts. In the words of one of the health visitors, 'You see them getting on to the right benefit, and then you see their stress levels drop.' Families were seen to be under less pressure because they had 'got the right help at the right time'. Mothers were reported to particularly benefit from being able to access additional financial support to equip their home properly.

More than one interviewee identified a clear impact of the service on people's depression and anxiety, whether that was a mother less concerned about not being able to provide for her children, or someone with mental health problems less concerned about their financial situation or finding their way through the benefit system.

On Usage of Services
There were some differing views from GPs about whether patients would consult them less frequently as a result of using the service, aside from the particular impact of the pilot project discussed in the previous section.

The GP practice focus group felt that that it was hard to identify whether this was the case. However, they did acknowledge that they had observed clients whose depression had been reduced because they had been able to access PIP and use it to maintain their social life. Cases like this might mean that as a result of the project there were fewer people who they would have to see and then 'pump full of drugs'.

The other GP interviewed suggested that some of her patients were seeing her less because of the impact of the project, and that this was a good thing, reducing the burden on her, and the health problems that they were facing.

Change in Practice
Consistently partners reported that their practice had shifted, that they were more likely to raise financial issues, and ask questions about people's financial circumstances as result of the service's presence alongside them.

The manager of the health visitor team suggested that this should not necessarily be viewed as referral relationships becoming deeper, but as them becoming easier.

However the change in practice was characterised, partners were clear that the project had strengthened their engagement with the advice sector.

Furthermore, it was felt by interviewees that the project has the opportunity to influence broader practice, lessons have been learnt from the model used in this project, and from the challenges faced in its setting up that can be applied in primary care settings elsewhere.

Previous Practice.
Some questions focused on the way that GPs and health visitors had previously (i.e. prior to the Healthy Start project) responded when benefits and other financial issues had been raised by their clients.

Partners reported 'trying to their best for people'. Variously they had:

- Tried to complete forms, or small sections of them, themselveson an adhoc basis.
- Given basic advice about/ pointers to form completion.
- Signposted people on to the CAB, particularly when they needed help with appeals, this not being an area they could handle themselves.
- Signposted people on to the DWP for budgeting loans, or referred themselves on to social work.

Partners identified the key problem with this approach as being that they did not have the knowledge or experience required to provide in depth support, particularly in a fast changing benefit system that was difficult to keep abreast of.

Most critical was the creation of a gap between the referral of people to advice services and their first engagement with those services:

- They could not be certain that people they signposted to the CAB and other services would engage with that other support, and suspected that, in fact, that many had not done so, because they were not familiar with the environment to which they had been referred.
- Fundamentally, signposting people on to support put the onus on them to act, rather than a service coming to them. For vulnerable people this could prove barrier too high to surmount.
- Health visitors felt that vulnerable families in particular were 'disappearing into the ether' rather than making referrals to the service.

The previous Healthy Start service had been much appreciated by partners for the ease of access it provided to primary care staff, and partners saw clear continuity between that service and this one. However, they were also clear that the expansion from the service being available 1½ days a week to the current level of provision was a significant step forward for them.

Strengths of the Service.
Interviewees clearly identified the key strengths of the project as relating to its co-location alongside primary care workers; the project encourages more referrals from health partners, and increases the chance of clients engaging and sticking with the service, and getting better support from it.

Some of the issues surrounding the co-location of the service and referral have been captured above. Partners did identify the particular strengths of co-location of dedicated staff as being:

- Changing their own practice, becoming more likely to ask people about their financial situations and then make referrals, because they have a clear way of resolving these issues.
- The smoothness (despite some of the challenges) of the referral process.
- The ability to follow up in relation to individual cases, checking whether people had engaged, and chasing them up if they had not. This could also be useful for project staff chasing up particularly vulnerable clients who had ceased to engage with them or were proving uncontactable.
- The development of trust in the relationships between primary care and advice staff. Primary care staff are careful about who they will make referrals to, they do not want to risk patients getting a bad service. The level of trust that exists might be seen as being evidenced by the setting up of the pilot project.

The Health Improvement Team felt that the service had gone a long way towards making itself part of the system of support for primary care staff, in a way that other partnership projects such as the partnership between NHS Greater Glasgow and Clyde and the Wheatley Group had not managed. For health visitors, the project now felt like a natural continuation of the variety of referral work that they do. The focus on families with young children allowed them to make sure that those families have somewhere to go that is ready for them and understands their problems.

Partners felt that their patients were being seen much more quickly as a consequence of co-location. This in turn encouraged them to make referrals, whereas with other services you might expect it to be a long time before patients were contacted, they knew that project staff would be responding quickly to referrals. Another interviewee captured the difference in speed of access as being that between taking 10 days to access this service, rather than 10 weeks to access specialist support at the mainstream CAB. For some people in crisis, 10 weeks can be far too long.

Clients can access the service somewhere they feel comfortable, and which is close to them. One of the GPs suggested it was very easy to forget how vulnerable many patients are, there is real reassurance for them in being able to go somewhere they feel comfortable, and they will be more likely to relax and respond better to the advice and support they receive. That particular advantage may be looked at in another way; the health centre is somewhere that clients may go regularly for all sorts of reasons, it's not somewhere that is solely associated with being in crisis.

Some of that vulnerability may have resulted from previous negative experience in the benefit system, when they have dealt with people who appear to have been trying to catch them out rather than assist them to access their due. The more welcoming and familiar an environment can be under those circumstances, the better. This is not a theoretical concern, one of health visitors highlighted the number of Did Not Attends that her own service had to deal with, suggesting that anything that could reduce this issue for other services was desirable.

The service also offers consistency of support. When people attend the main office of the CAB they may see different advisers every time. For vulnerable clients in particular, but even for less vulnerable clients seeking support to unravel a difficult set of problems over time, trust is an essential basis for the service, and this cannot as easily be maintained in a situation in which clients are seeing different staff. Having a named person within the CAB to whom referrals are made is also a valuable element of building up trust. Even looking at the delivery of the service from a purely practical point of view, passing clients between advisers when delivering holistic casework is often not ideal.

One point was raised by a number of partners. The presence of the service makes them more likely to raise financial issues with patients, because they know they can help patients access a solution when problems are identified.

Response to Prospect of Losing the Service.
Interviews explored partners' thoughts on the potential consequences of the service not continuing beyond the end of the financial year.

There was real concern about this prospect. Partners felt that the service had become a valuable part of the range of assistance that they were able to offer patients, a key part of their toolkit.

Partners described their responses variously:

> 'very uncomfortable with the idea of it going, we would feel terrible if we couldn't help people with these problems'

> 'I'd feel like leaving if we couldn't provide people with services like this. I'd feel like I was basically p*ssing into the wind.'

One GP felt that concerns about the service and its sustainability reflected the broader difficult situation in the public sector, and that they felt that they were currently constantly involved in administering cuts, something that risked giving them compassion fatigue.

Practically, partners felt that they would have to return to their previous practice for dealing with clients with financial problems, unsatisfactory as that was. One felt that relying on signposting or referring to the main CAB would see the number of referrals fall, and fewer people who were referred would actually make it to the service. People who were stressed and in crisis would be less likely to attend a service that wasn't as local and as easily accessible for them. Another felt that she simply wouldn't know where to send people, and that the project's loss would mark a very retrograde step, back to the situation that had existed several years ago.

Both GPs and the Health Improvement Team identified the potential negative impact of the disappearance of the service on the workload facing GPs, suggesting that people would fall back to seeking advice and support from GPs on their claim for disability related benefits.

Key Points, The Impact of the Service and its Additionality.

- The service is seen as successful in raising patients' incomes, dealing with debt and preventing them from experiencing destitution. Its impact can be as basic as helping a young mother afford nappies.
- This practical impact has a positive impact on patients' mental health and well being, amongst mothers of young children as much as adults with long standing depression and anxiety.
- There may be some reduction in the number of appointments that some clients seek from GPs.
- Primary care staff report that the project has changed their practice, increasing the likelihood that they will raise financial issues with clients because they know they now have a way of dealing with those issues.
- The project is also seen as having the potential to be an exemplar project influencing practice more widely.
- Prior to the project's existence primary care staff would provide adhoc and limited support to their patients in relation to the completion of benefit application forms, and/ or signpost them to the CAB or other services.
- This situation was seen as an inadequate way of dealing with the issue, increasing the risk that people would not make it to advice services, because it placed the onus for taking action more on to patients, some of whom were vulnerable.
- The co-location of identified workers with health staff is at the heart of the project.
- This basic model is seen as having given people the opportunity to access a service in a familiar and nearby location in which they feel comfortable and non stigmatised, delivered by a person whose name they know and in whom they can develop trust over time.
- The referral processes themselves are seen as smooth, and as tailored to the specific demands of individual practices, and the tight relationship between advice and primary care staff as meaning that non engagement can be followed up.
- The service has become an essential part of the support to which primary care staff can link their patients, and it would be a huge frustration to them if it were lost. Its loss would represent yet another gap in the range of support services available to patients.
- Its loss would be seen as a very retrograde step, which would risk hurting the vulnerable, and risk fewer people accessing appropriate advice and information.

Section 6: Conclusions

The central questions considered by this evaluation are:

- Has the delivery of the service been managed effectively?
- Has the service been effective in meeting the needs of the people it has targeted, and has it had a positive impact on their lives?
- Has the partnership between the CAB and primary care staff that lies at its heart been successful?
- Does this partnership deliver added value to clients sufficient to justify the continuation of the project model?

Has the delivery of the service been managed effectively?
The delivery of the service has faced a number of significant practical challenges. Recruitment to the posts was slow, neither of the initial staff are now in post, and there were issues that took a long time to resolve around accommodation, access to IT, e mail addresses and storage.

These issues did appear to have affected the project's initial ability to deliver its objectives, and were a distraction in its early stages. There have been barriers to the creation of the sorts of mechanisms, such as a project steering group, which might have been able to resolve them.

However, the service has, despite there being a something of a forerunner version, been breaking new ground. Furthermore, it has successfully introduced a new way of working through its pilot project on patient record access that has required complex discussions.

It looks therefore as if the difficulties in service delivery have largely been about the challenges inherent in working up a partnership between primary care and advice staff, challenges that can be reflected on and dealt with more quickly in any replication of the service.

Has the service been effective in meeting the needs of people in need of adviceand has it had a positive impact on their lives?
There is strong evidence that the service has been effective in meeting the needs of people in need of advice.

There have been two significant changes to the project that was initially envisaged; the project has more focus on problem resolution than supporting people to change their long term behaviour, and it has taken referrals of adults with health conditions as well as of parents with young children.

However, these changes have been a response to demand, to the needs of clients, and the balance of need for advice observed by GPs amongst their patients.

The project has shown the flexibility to respond appropriately, and to prioritise the need to develop effective working relationships with GP practices by encouraging referrals. In the first case their experience also reflects that of similar projects which have found that clients need to resolve pressing financial problems before focusing on changing their behaviour in the long term.

The interviews with clients make clear the extent to which the service has succeeded in reaching people facing significant financial issues, something confirmed by primary care staff reporting on the problems facing their patients. Project statistics are clear

about the extent of financial exclusion amongst clients, a majority appear not to use mainstream or even sub prime financial products.

It is also clear from the interviews that the service has succeeded in making a real difference to the financial situation of clients, through increasing the amount of benefit they are claiming and resolving their debt problems. People's financial behaviour has also been changed. Clients have no doubt that they would not have been able to resolve the situations they faced without the help of the project. However, it is possible that the project has not engaged with the issues of financial exclusion as it might have done.

Changing people's financial situation has often resulted in significant gains to their mental health. Dealing with the situations of destitution facing some clients has meant that they have been able to care more effectively for their children.

In its first 12 months, the project did not reach as many clients as was desirable. That situation has been at least partly dealt with over the latest nine months of the project. The project delivers well for those who are referred, and there is capacity to ensure that it delivers well for an even greater number of people.

Has the partnership between the CAB and primary care staff that lies at its heart been successful?
The initial failure to generate sufficient referrals points to the challenges the project faced in creating effective partnerships with health colleagues.

However:

- The growth in referrals is testament to some improvement in partnership working.
- Some health visitors and GPs report a very positive relationship with the CAB.
- The closeness of those relationships has changed the practice of those primary care staff, they are more likely to identify clients facing financial problems than they were before, and they have a clear route for responding effectively to those problems.
- The pilot project involving advisers having access to patients' records could not have happened without the development of effective working relationships and trust between primary care staff and the projectand the intervention of the Health Improvement Team.
- Those clients who have accessed the service would in most cases not have done so had it not been for the referral through primary care staff.
- Referral rather than signposting reduces the likelihood of clients not engaging with the service once their issues have been dealt with.

The challenge for the service now is to ensure that the warmth of the core project relationship extends across all primary care staff within Possilpark Health Centre, and those warm relationships translate into further increases in referrals and more consistent identification of need. There will no magic recipe for this, just constant engagement and work feeding back on project progress.

It is clear that the co-location of the service has been a factor in the success it has had. Most importantly, clients have been able to access support in a location close to where they live, in a location in which they feel comfortable, and which is not in any way stigmatised. Joint work with primary care staff has enabled project staff to maintain contact with clients.

Does this partnership deliver added value sufficient to justify the continuation of the project model?
Despite the challenges the project has faced in generating sufficient referrals, the answer to this question must be yes.

Yes, because the service is getting to people who cannot resolve their financial difficulties themselves, who might otherwise not have accessed appropriate support, or might not have stayed engaged with advice, and is impacting positively on both their financial situation and their mental health.

Yes, because the service has begun to shift the practice of primary care staff in a way that will help their patients.

Yes, because the service would be much missed by clients and by primary care staff, and its loss would lead to fewer people accessing support, more pressure on primary care staff, and clients with greater health problems.