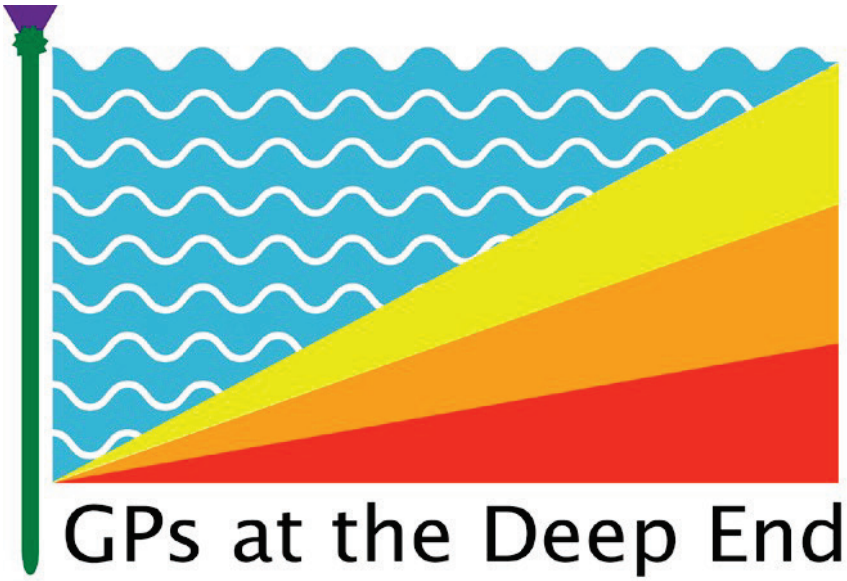

Deep End Report 25

Strengthening primary care partnership responses to the welfare reforms

54 colleagues from general practice, homeless services, addiction services, citizens' advice centres, housing associations, other community-based advice centres, the Health and Social Care Alliance, Glasgow City Council, Greater Glasgow and Clyde Health Board, the Glasgow Centre for Population Health and the University of Glasgow met on 22 May 2014 for a half day meeting to consider how they could work better to help Glaswegians cope with changes to the welfare benefits system.

November 2014

A meeting was held on 22 May 2014 involving general practitioners and other organisations, services, advice centres and groups in Glasgow, providing information, advice and support for people receiving or applying for welfare benefits. The main focus of this report is on how improved joint working with general practice could help welfare benefit applicants, recipients and appellants in Glasgow. It is not the purpose of the report to review other financial inclusion activities.

SUMMARY

- The Glasgow population is set to lose £259 million per annum as a result of ongoing changes to the welfare benefit system, the largest of any Scottish city and second only to Birmingham in the UK.
- The changes have caused much hardship, uncertainty and anxiety. More changes are in the pipeline.
- The Financial Inclusion Contract is a partnership between Glasgow City Council, NHS Greater Glasgow and Clyde and the Glasgow Housing Association, with combined annual funding of £4.3 million for the support of core advice agencies in the city.
- Services are contracted at three levels, providing information (Type 1 workers), general advice (Type 2 workers) and specialist advice (Type 3 workers), via a range of community-based and central locations.
- The Glasgow Advice and Information Network (GAIN) is a network of over 200 third sector and public sector organisations involved in financial inclusion. Less than 10% of referrals to GAIN advice services come from the NHS sources.
- General practices have regular contact with most patients. Routine and urgent contacts with GPs, practice nurses and receptionists can be used to signpost patients to advice centres. Many patients, especially those with mental health problems, including addictions, require additional help and support.
- General practitioners are often asked to provide supporting medical information for benefit applications and appeals, but are not necessarily well informed about changes to the benefits system or the availability of support services.
- Welfare Rights Officers need help from GPs in representing their clients, but GPs are busy, especially in very deprived areas, as a result of the inverse care law (which provides a flat distribution of the GP workforce in Scotland, irrespective of deprivation).
- Although benefit problems are concentrated in practices serving very deprived areas, no additional resources are provided to address the additional workload.
- There is very little slack in general practices serving very deprived areas. Initiatives need to be “time-neutral”, or work saving. Work-generating initiatives are unlikely to be taken up.
- The role of general practice teams includes recognising patients with financial problems, signposting patients to advice centres, referring patients to advice centres and (via link workers) providing support for patients to access advice centres.
- Current referral data show that there is huge potential for general practices to increase their referrals to GAIN services.

- Many local systems for benefits advice and support (including general practices) consist of poorly connected parts, with little sense of joint ownership or shared learning.
- Different advice agencies have had varying success in trying to work more closely with general practices and health centres. “What works” needs to be understood and applied more widely.
- General practices would welcome reliable information on local advice services and authoritative briefings on changes to the benefit system e.g. the new PIP arrangements, ESA appeals, the roll out of Universal Credit and welfare sanctions which can precipitate families into crisis.
- Audit of referrals to GAIN services can identify areas where the provision and uptake of information could be increased.
- Much can be done centrally in terms of standardised information, referral forms, letter templates and IT development.
- Local health fairs could help introduce potential local colleagues to each other.
- Practices could be briefed on imminent appeal hearings involving their patients, to improve the content, timing and focus of the information they provide.
- NHS badging of local systems could help to establish that financial advice and support is a legitimate health care activity.
- There is a need to learn from experience (positive and negative significant events), including the experience of professionals and of services users, both to improve local systems and to inform lobbying at a higher level (e.g. via the Glasgow Poverty Leadership Panel).
- Educational activities, based on practical knowledge and experience of the welfare benefits system should be developed for GP training and protected learning activities for practice teams.
- A programme of initiatives in these areas could lead to more effective joint working between general practices and other agencies concerned with the experiences and outcomes of Glaswegians engaging with the welfare benefit system.

CONTENTS

General Practitioners at the Deep End" *work in 100 general practices, serving the most socio-economically deprived populations in Scotland. The activities of the group are supported by the Scottish Government Health Department, the Royal College of General Practitioners, and General Practice and Primary Care at the University of Glasgow.*

GPs at the Deep End

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INTRODUCTION

In October 2013, General Practitioners at the Deep End, serving the 100 most deprived populations in Scotland, including 76 in Glasgow City, produced a report "GP experience of welfare reform in very deprived areas" (Annex A). At the instigation of the Glasgow Poverty Leadership Panel (http://povertyleadershippanel.org.uk/), a meeting was held to bring together not only GPs but also all other organisations, services, advice centres and groups in Glasgow involved in providing information, advice and support for welfare benefit recipients.

The meeting shared experience and views and went on to consider what actions could be taken jointly in the short and medium terms to improve the spread, content, timeliness, delivery and quality of advice and support provided for people in Glasgow having to cope with welfare benefit changes.

PARTICIPANTS

54 people, mostly from Glasgow but some from Edinburgh, took part in the meeting (Annex B), from the following groups

General practice	13
Health services for people who are homeless	2
Addiction services	3
Citizens' Advice Bureaux	7
Department of Work and Pensions	1
Housing associations	3
Other community-based advice centres/group*	7
Greater Glasgow and Clyde Health Board	8
Glasgow City Council	3
Glasgow Centre for Population Health	3
Health and Social Care Alliance	2
University of Glasgow	2
***Money Matters, Glasgow Carers' Forum, Castlemilk Law Centre, Arndale Resource Centre, Carr Gomm, Greater Easterhouse Money Advice Project and Eastbank Conference and Training Centre**	

FORMAT

After brief introductory presentations, the meeting broke into small multidisciplinary groups to share experience and views of current problems (Annex C). A note was taken of each discussion. After a brief plenary feedback session, the groups re-convened to consider actions to address the problems. After a final plenary session and the end of the meeting, 20 participants stayed on for a further session to consider next steps.

SETTING THE SCENE

Linda De Caestecker
Director of Public Health

The Glasgow Poverty Leadership Panel (PLP) was established by Glasgow City Council to develop a collective, civic approach to the problem of poverty in the city. Following the example of the Poverty Truth Commission, the PLP engages both with people affected by poverty and people employed to mitigate its effects.

The six areas being addressed by the PLP are:

- Attitudes towards poverty
- Children and families
- Credit and debt problems
- Welfare reform
- Work and worth
- To involve people with direct experience of poverty

The panel aims to identify actions which can be taken at a city level, by Glasgow City Council and its partner agencies, and locally, by professionals providing services and by people living in the city.

WHAT PRACTICAL TOOLS ARE AVAILABLE AND WHAT DO THE LOCAL DATA SUGGEST?

James Egan
Glasgow Centre for Population Health

The Glasgow population is set to lose £259 million per annum as a result of ongoing changes to the welfare benefit system, the largest amount of any Scottish city (Annex D), and second only to Birmingham in the UK.

In August 2013, there were 41,280 people in receipt of Employment Support Allowance in Glasgow City with 38% in the support group and 37% in the work-related group potentially facing tougher work-related conditions.

In 2013, over 77,000 Scots accessed food banks provide by the Trussell Trust and similar organisations

Between 2003 and 2013, the number of jobseeker sanctions across Glasgow, Lanarkshire and East Dunbartonshire tripled from around 10,000 to 30,000.

These benefit changes provide a partial view of poverty in the city, and take no account of “in work poverty”.

The Glasgow Advice & Information Network (GAIN) is a network of over 200 third sector and public sector organisations involved in financial inclusion.

GAIN includes voluntary organisations, citizen’s advice bureaux, legal, housing and independent money advice agencies, credit unions, job centres, libraries, housing providers and food banks as well as relevant public sector departments and services.

Any not-for-profit organisation involved in tackling poverty and supporting improved financial inclusion can join GAIN, which has two primary roles: to support access to free, confidential and impartial advice to people who live or work in Glasgow; and, to support, train and enable services to work together sharing information and delivering joint activities.

The Financial Inclusion Information and Advice Service contract (2012-2015) - also known as the FI Contract - is an important vehicle for funding core advice agencies in Glasgow.

The FI Contract is a partnership between Glasgow City Council, NHS Greater Glasgow and Clyde and Glasgow Housing Association with combined annual funding of around £4.3 million. It is managed by the GCC Financial Services Financial Inclusion Team. Current contracts run from 2012-15.

Services are contracted at three levels : Type 1 workers provides information via leaflets or details of casework services; Type 2 advisors are usually generalists across a range of topics (form filling, benefits checks, housing applications etc), deployed across a range of community settings; Type 3 advisors are usually specialists in their field (benefit appeals representatives, formal debt management, housing representation etc), based in central offices.

The job titles “welfare rights officer” and “money advisor” are ambiguous, as currently used, and can apply to either Type 3 or Type 2 activities.

For community-based access points (Type 2), sixteen agencies are contracted to deliver services from 20 main locations and provide outreach at over 100 community based locations.

Around 85 (whole-time equivalent) frontline advisers and lawyers, supported by volunteers, offer assistance in welfare benefits, money advice, financial capability, housing problems, employment issues and legal advice.

Twelve of these advisers operate in health settings and 11 within local housing offices

Specialist services provide targeted support at a range of locations, such as Glasgow Sheriff Court, homelessness services, schools and Yorkhill Hospital.

During the two years of 2013 and 2014, over 70,000 interventions by FI-contracted services generated £125.3 million of financial outcomes in the city.

The FI Contract is delivered through a formal procurement process with two consortia of agencies responsible for managing sub-contracted services.

There are plans to move towards a more partnership-based model at the end of the current contract.

29,714 people accessed GAIN advice services in Glasgow City in 2013-14, of whom 2,613 (9%) were referred via NHS-funded services.

The top NHS referral sources were Health Visitors (867), general practitioners (373) and practice nurses (356).

GPs were the main referrers in the south of the city while practice nurses were the main referrers in the north-west.

Midwifery and alcohol and addiction services are underexploited sources of referral.

Referral needs to be distinguished from “signposting”, and implies additional support for people who need it.

The third sector is an important provider of services, at lower cost than statutory services, but lacks security, as a result of competitive tendering for short term contracts.

WHAT ARE THE CHALLENGES FACING PRIMARY CARE AND ADVICE SERVICES AND WHAT COULD HELP? SOME INITIAL THOUGHTS

Raymond Orr
General Practitioner, Glenmill Medical Centre

Welfare Rights Officers need help from GPs, in representing their clients, but GPs are busy, especially in very deprived areas, as a result of the inverse care law (which provides a flat distribution of the GP workforce in Scotland, irrespective of deprivation).

Although benefit problems are concentrated in practices serving very deprived areas, no additional resources are provided to address the additional workload.

The advice from the Local Medical Committee (i.e. the BMA) is that GPs should not carry out work which is not contracted

The Scottish Government also advises that advice and support for benefit problems should be sought from other sources than general practice.

All these positions have their reasons and justifications.

Solutions need to be found, despite the intransigence, but must make it easy for GPs to be involved. “Solutions” involving substantial extra work are unlikely to be adopted

There is work to do in developing IT solutions which allow GPs to provide relevant information with minimal effort.

CHALLENGES FACING ADVICE AND HEALTH SERVICES

Robert Hinds
Welfare Rights Officer, Social Work Services

The challenges are going to get greater in the near future as a result of changes to tax credits, more difficult appeal procedures and the benefits cap.

37,000 Glaswegians will be affected by the change from Disability Living Allowance (DLA) to Personal Independence Payments (PIP).

Current DLA recipients need to know that when invited for re-assessment, they must attend or will lose not only their DLA but other benefits too.

Vulnerable people will need to be identified and supported as early as possible to ensure they do not fall out of the system

A large number of appeals has been generated, in relation to the DLA/PIP changes, with over 80% pending, as a result of delays in re-assessment. This was likened as a "dam waiting to burst" as the system catches up and generates cases with negative decisions requiring support.

A similar blockage has arisen in relation to appeals on Work Capability Assessments (WCA) for Employment Support Allowance (ESA), with implications for numbers requiring support.

Sanctions are currently the biggest problem, with Glasgow having the largest number of adverse Job Seekers Allowance (JSA) decisions (12,500), compared with Edinburgh (5,500) and Dundee (3,500).

Glasgow has the highest proportion of adverse JSA decisions (61% of claims), but this varies across the city from 70% in Laurieston to 50% in Parkhead.

Sanctions leave unsuccessful claimants with no income. The new sanctions arrangements from October 2012 involve three sanctions levels. The lower sanction can result in a 4 week penalty for a first failure, then 13 weeks for second and third failures. Although qualifying for hardship funding, applications for this still have to be made. Food banks are often the only recourse.

Universal credit will combine most benefits in a single monthly payment to be paid to one person, with unknown consequences for partners with abusive relationships and for budgeting, with possible effects on temporary credit worthiness, pay day loans and rent arrears.

All parts of the system, including claimants and services, are going to be under increased pressure - the sooner that problems are identified and helped, the better.

Evictions, involving expensive use of social work, health education and housing services after the event, need to be prevented.

WHO IS DOING WHAT, WHEN AND WHERE?

Based on notes from six discussion groups

The impact of welfare reform varies geographically across the city, mainly according to the pattern of socio-economic deprivation. While all general practices have some patients who are affected, the work is concentrated in Deep End practices, where 44-88% of patients have postcodes in the 15% most deprived Scottish data zones.

These practices form the majority of practices in the North and East of the City, about 50% of practices in the South West, and smaller proportions in the West and South-East. A GP said that two patients in every surgery (of 12-15 patients) involve issues of poverty, sanctions and welfare reform, taking time away from the management of medical conditions.

Accessing the welfare benefit system was considered to be complicated and slow, especially for people without the knowledge, skills and confidence to engage with bureaucracy. Lengthy forms take time to complete and there can be long delays between stages of the application and appeal processes. In general, health and other professionals do not have time to spend on lengthy form filling. Patients may need support to cope with the process of waiting. It was said that suicide rates are lower if people are supported.

Current referral data show that there is huge potential for general practices to increase their referrals to GAIN services. While financial problems may not be a patient's presenting complaint, they are often an underlying component of a patient's problems. GPs may be more confident in raising such issues if they are also knowledgeable and confident about the availability, accessibility and usefulness of local advice service, based on feedback on what has happened to referred patients.

Where advice services lack capacity to receive large numbers of referrals, there is a need to highlight the types of cases where referral is most needed.

Contractually, GPs are obliged to provide information in support of initial claims, but this is usually confined to medical diagnoses. GPs tend not to know the practical implications of diagnoses on patients' daily lives, especially when patients may minimise their disabilities. Often, GPs are aware of relevant mental health issues, complicating the effects of physical conditions, but DWP assessment criteria focus on the latter, rather than the former.

The British Medical Association advises that GPs should not provide detailed medical reports for benefits purposes, such as appeal letters (because it is additional work to the GP contract and is not paid for). Some practices follow this advice but it is difficult for GPs in very deprived areas to ignore the needs of their patients. Some practices charge for such letters (for example, if the request comes from a legal firm) but most do not. The time for writing such reports comes at the end of a working day, outside consulting hours. The work is concentrated in Deep End practices.

General practices have contact with most patients during a year, and virtually all patients over several years. Routine and urgent contacts with GPs, practice nurses and receptionists can be used to signpost patients to advice centres. Such advice is sufficient for some people, but many, especially those with mental health problems, including addictions, require additional help and support.

The Keep Well programme not only systematically screened practice populations for cardiovascular risks, but also took a note of where benefits advice might be helpful and had direct local links to colleagues who could provide such advice. The planned withdrawal of the Keep Well programme may remove this valued resource.

The Link Worker Project (http://www.alliance-scotland.org.uk/what-we-do/projects/linksworkerprogramme/) involves seven general practices in Glasgow which have been given a full-time community links practitioner in order to develop and use links with community resources for health, including welfare and money advice centres, and to help patients who need help and support to access such resources. Many people need face to face contact if they are to engage with the system.

The independent nature of general practices, and the lack of links between practices to share views and experience, can result in substantial variation between practices in how they address similar problems. GPs are not necessarily well informed about changes to the welfare system and would value briefings, for example, on the new PIP arrangements and welfare sanctions, which can precipitate families into crisis.

A variety of advice services are available, including via the NHS, advice agencies and Housing Associations, which provide demand-led services. Audit of referrals show that the NHS accounts for only about 10% of referrals, with considerable variability between potential sources of NHS referrals (health visitors referring more people than GPs). Audits of referral rates by general practice are not currently possible.

Consistent NHS branding of advice services (using the NHS logo) was thought to be encouraging for patients and a way of highlighting the connected nature of different parts of local systems services.

The different agencies have had varying success in trying to work more closely with general practices and health centres. Some CABx have used Lottery funding to employ community information workers and Scottish Legal Aid Board (SLAB) funding to employ dedicated appeals workers.

It was suggested that “every practice should have access to a welfare rights officer”, but it was not known whether and how this might be achieved.

Health Improvement Teams within the Glasgow City CHP have played a longstanding role in developing links between health care and welfare advice across the city. Recently, they were an important catalyst in supporting the referral role of Health Visitors during the establishment and subsequent development of the Healthier, Wealthier Children child poverty project.

With many current developments in primary care, such as the Link Workers Project, the Govan Integrated Care Initiative, GGC’s 17c GP contract initiative, and the development of integrated care nationally, there are opportunities for welfare rights and advice to be incorporated as part of local health systems.

The GAIN Directory (Glasgow Advice & Information Network) provides useful information on available services, but is probably not being accessed as much as it should. In general, there is a constant challenge in keeping information up to date, keeping messages simple, shortening communication times and ensuring prompt responses by the system.

Looking ahead, there is uncertainty and anxiety about the roll out of Universal Credit – who will receive the monthly payments, will there be an increased problem of debt, rent arrears and pay-day loans?

HOW CAN WE STRENGTHEN CURRENT PRACTICES AND ADDRESS THE IDENTIFIED GAPS AND CHALLENGES?

Based on notes from six discussion groups

Current welfare benefit changes are causing much hardship, uncertainty and anxiety. More changes are in the pipeline.

Having gathered all of the main Glasgow groups involved in providing advice and support for current and future welfare benefit recipients, there is an opportunity to share experience and views, from Glasgow and elsewhere, on such issues as ESA appeals, benefit sanctions, the new PIP arrangements and the roll out of Universal Credit.

While one outcome of such sharing may be collective lobbying to try to change the system (e.g. via the Glasgow City Poverty Leadership Panel), the immediate priority is to apply what is known and what has been learned to the provision of pertinent, timely and effective advice and support for Glaswegians engaging with the benefit system, to reduce and not compound their difficulties.

The Financial Inclusion Contract provides an obvious mechanism for considering and developing advice and support services as a city-wide system.

A large amount of relevant information is already available through the Glasgow Advice and Information Network (GAIN), concerning services which are available at a variety of locations including Job Centres, fixed and outreach advice centres, shopping centres, pharmacies and Jobs & Business Glasgow, an arms length organisation that aims to deliver economic development activity on behalf of Glasgow City Council. Ongoing tasks for GAIN are to keep its information up to date, easily accessible and widely known.

General practices have variable contact and experience of the benefits advice system, but could play a larger role, based on their regular contact and existing relationships with the majority of Glaswegians engaging with the benefits system. Perhaps their most important role lies in helping patients who are having difficulties with the system as a result of mental health or other problems.

This work is complicated, however, by being concentrated in general practices serving very deprived areas, with heavy burdens of need, a lack of resource (including consultation time) and poor links to other services. Additional work providing help for benefits claimants competes with many other demands on practice time. It follows that any changes to improve the system must either be appropriately resourced, or designed to minimise workload implications for the practice.

General practitioners need ready access to key information concerning particular welfare benefits, including who can provide advice and support locally and the situations in which GPs can make an important contribution. They need leaflets and sticky labels with key information which can be handed to patients, and the appropriate referral forms for other services. Practice information systems need adaptations which can flag and follow process. Template letters could be provided for specific purposes (following their successful development and use in Edinburgh). Practitioners would welcome advice on the type and content of communications which most likely to be effective in supporting appeals.

In the Link Workers project, seven general practices have full-time community links practitioners whose role is to identify and facilitate links between the practices and community resources for health, including financial advice, and to help vulnerable patients to make use of these links.

It remains to be seen whether link workers become a definitive model, or a prototype for other ways of carrying out their tasks, such as the use of health care assistants. Most practices do not have link workers.

A consistent message from the Deep End Project has been that in very deprived areas, referral routes from general practices to other services must be short, quick and familiar, if referrals are to take place. Confidence and trust are easier to build when the referral is to an individual whose name and contact details are known and with whom there has been a succession of successful referrals, complemented by shared experience and learning.

Referral pathways might be simplified. For example, it was said that referrals via Sky Gateway are not compatible with the Money Advice Service referral form.

The Department of Work and Pensions (DWP) is an important potential local partner. When there is substantial local knowledge of systems not working, the PLP is in a strong position to lobby the DWP locally and nationally.

It is important to learn from examples where advice and support information and services have been located within general practices or health centres.

Systems are unlikely to improve, in terms of coverage and efficiency, if there is not a parallel information system to record and audit activity. The ability to "measure omission" (i.e. what has not been done, who has not been included) is a key step forward from simply recording activity. For example:

- What is the "fit" of the current geographical distribution of advice centres in relation to the geographical distribution of Deep End practices?
- What is known about the number and case-mix of referrals to advice centres from general practices? Can routine information be enhanced to provide such data?
- What is known about the outcome of referrals to advice centres in terms of uptake, process and outcome?

Practices vary in the extent to which they are ready to take on an enhanced role. Progress is more likely to occur via pioneering and then "early adopting" and "late adopting" practices, ironing out teething problems and establishing new norms, than by blanket exhortation. Protected time is needed to share and learn from experience. It needs to be established that helping patients with benefit issues is a legitimate and important part of holistic care. Embedding in GP training is important for younger GPs who will be the next generation of practitioners in deprived areas.

Although Deep End practices have the highest concentrations of patients living in very deprived areas, where benefit problems are most prevalent, most patients living in very deprived areas are not registered with Deep End practices (i.e. they are registered in the much larger number of practices with a broader social mix). It follows that much of the learning in Deep End practices needs to be rolled out to other practices, which are often nearby geographically.

Although there is substantial capacity within the system, which could be increased by more effective joint working, it is not known what are the limits of current capacity, nor how current capacity would be best used.

NEXT STEPS

Many local systems for benefits advice and support (including general practices), consist of poorly connected parts, with little sense of joint ownership or shared learning.

It would be helpful to have descriptions of successful local systems, including their essential ingredients, as a guide for the strengthening systems elsewhere. What is the best balance between simple signposting, referral and supported referral?

Much can be done centrally, in terms of standardised information, referral forms, letter templates (a resource pack for practices), IT development etc, and rolled out locally, but local systems depend on relationships and circumstances.

Local systems should be branded with the NHS logo, encouraging patients, legitimising financial advice as a NHS activity and linking the components of local systems.

The role of general practices includes recognising patients with financial problems, signposting patients to advice services, referring patients to advice centres and (via link workers) providing support for patients to access advice centres. The best balance of such activities can only be determined locally.

Practitioners can be very effective in providing information for appeals, especially if briefed about the type of information that would be most helpful in particular cases.

The important first step is always engagement. Local health fairs, using the “speed dating” model may help to introduce potential colleagues to each other. In Glasgow South, a money advice centre offered to give a presentation to the local GP committee.

The Link Workers project may provide useful information on the development and use of enhanced links between general practices and local advice services.

There is also a need to learn from examples of Welfare Rights Officers based in or near general practices. What characterises a successful and productive placement?

The potential for learning from audit, measuring not only activity (based on numerators) but also gaps in delivery (based on denominators) should be explored, for different pathways (ESA, JSA, PIP, appeals, sanctions etc), to assess the strengths and weaknesses of currently available data.

Is it possible to define a minimum data set for monitoring the advice and support system? What are the yardsticks (e.g. coverage, speed, outcomes) by which the quality of city wide and local systems can be assessed?

There is a need to learn from experience (positive and negative significant events), including the experience of professionals and of service users, and to share such learning throughout the system.

Collated experience should be fed back throughout the system and used for lobbying locally and nationally.

A public information campaign is needed, so that there is civic understanding and support for the programme.

Questions for further discussion include:

- Is there a need to target resources to areas of greatest need (for example, by attaching welfare benefit advisors to single general practices or clusters of

practices), in which case what types of needs/patients are the most important to address (e.g. those with mental health problems)?

- In what ways could advice centres be more helpful to general practices, and vice versa?
- What can be learned from the experience of link workers in terms of identifying, accessing and making better use of advice centres, including the types of patient in most need of support in order to access and use advice?
- What support could be provided for general practices, and advice centres, to collaborate in the provision of effective support letters for benefit claims and for appeals?

The development of improved joint working between general practices and the welfare advice system should begin with volunteer practices (pioneers and early adopters) before being rolled out to all practices.

Educational activities, based on practical knowledge and experience of the welfare benefits system should be developed for GP training and protected learning activities for practice teams.

ANNEX A

DEEP END SUMMARY 21 GP experience of welfare reform in very deprived areas

In March 2012, GPs at the Deep End produced a report on "GP experience of the impact of austerity on patients and general practices in very deprived areas". Eighteen months on, Deep End practices are seeing increasing problems associated with the welfare reforms. This short report provides a follow-up to last year's report, and comes at a time when GPs across the UK are receiving criticism for their role in the welfare process.

- Changes to welfare have both intended and unintended consequences, which need to be measured and reflected upon, otherwise they may result in great damage.
- We remain concerned that, in its entirety, the welfare reform programme will be detrimental to the lives and well-being of the poorest in society.
- The Welfare Reform Act (2007) removed Incapacity Benefit (IB) and the Personal Capability Assessment (PCA) and replaced them with Employment Support Allowance (ESA) and the Work Capability Assessment (WCA).
- The entire ESA application process is too long and complicated. Many people, but particularly those with mental health problems, addictions, and cognitive impairment, find the process of form-filling, assessment, rejection, then the appeals process, punctuated by meetings with welfare officers, lawyers and the need for further medical evidence, to be confusing and demanding to navigate and, ultimately, damaging to their health.
- Requests for medical information and support fall most heavily on general practices serving very deprived areas, in which the numbers of such requests are concentrated. This places additional demands on an already overloaded system and compromises the time available for other aspects of medical care.

- We all recognise the health benefits of appropriate work. ESA should be part of a process which enables people to maximise their potential in achieving that benefit. Therefore, the underlying ethos of this process should be that of support, understanding and enablement. ESA, as it stands, fails in that endeavour.
- The Welfare Reform Act (2012) has introduced a number of additional changes, including Universal Credit, the Personal Independence Payment (PIP) to replace DLA, and changes to housing benefit, widely referred to as the "Bedroom Tax".
- The real costs of the "Bedroom Tax" are unknown, but there are early indications that, since its introduction in April 2013, there have already been damaging effects on communities, families and support networks for society's most vulnerable.
- This report sets out a number of recommendations to make the welfare system fairer, simpler, and easier to navigate. Central to this is the need for a radical overhaul of the Work Capability Assessment, which is not fit for purpose.

"General Practitioners at the Deep End" work in 100 general practices, serving the most socio-economically deprived populations in Scotland. The activities of the group are supported by the Scottish Government Health Department, the Royal College of General Practitioners, and General Practice and Primary Care at the University of Glasgow. Full report available at http://www.gla.ac.uk/deepend

ANNEX B LIST OF PARTICIPANTS

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Carol	McGurin	Eastbank Conference and Training Centre

Dr Chris	McHugh	Townhead Health Centre
Dr Angus	McIntosh	Castlemilk Law Centre
Margaret	McIntyre	Greater Pollok Citizens Advice
Veronica	McIntyre	Department of Work and Pensions
John	McMenamin	Arndale Resource Centre
N	Mirza	NHS GG&C
Fiona	Moss	Glasgow City CHP
Frank	Mosson	Bridgeton Citizens Advice Bureau
Dr Anne	Mullin	Govan Health Centre
Norrie	Murray	Maryhill and Possilpark Citizens Advice Bureau
Lynn	Naven	Glasgow Centre for Population Health
Hugh	O'Neill	Drumchapel Citizens Advice Bureau
Dr Raymond	Orr	Glenmill Practice
Dr Elizabeth	Paton	Easterhouse Health Centre
Tony	Quinn	Easterhouse Money Advice Project
Dr Matt	Rohe	Croftfoot Surgery (Locum)
Lyn	Ryden	Carr Gomm
Noreen	Shields	NHS GG&C
Hazel	Smith	Glasgow Housing Association
Tracy	Stafford	Addiction Services, Glasgow City CHP - North East
John	Thomson	Glasgow City CHP - North West
Dr Nick	Treadgold	Pollok Health Centre
Kirsty	Ward	Glasgow Housing Association
Dr Graham	Watt	University of Glasgow
Dr Andrea	Williamson	University of Glasgow
Dr Marie	Wilson	Easterhouse Health Centre
54		

Facilitators

Paul Lafferty	Health Improvement Lead, South Sector, Glasgow City CHP
Carol McGurin	Health Improvement Senior, North East Sector, Glasgow City CHP
John Thomson	Health Improvement Lead, North West Sector, Glasgow City CHP
Jane Beresford	Health Improvement Lead, NHS Greater Glasgow and Clyde
Heather Jarvie	Keep Well Planning Manager, NHS Greater Glasgow and Clyde
Lynn Naven	Public Health Research Specialist, Glasgow Centre for Population Health

GP participants

Name	Location	List size	Deprivation ranking
Dr Mal Duffy	Drumchapel HC	2861	23
Dr Maria Duffy	Pollok HC	4161	39
Dr Richard Groden	Tollcross MC	6776	71

Name	Location	List size	Deprivation ranking
Dr Kate Magee	Easterhouse HC	2462	8
Dr Colin McCrossan	Pennan Practice	2185	154
Dr Chris McHugh	Townhead HC	12290	203
Dr Anne Mullin	Govan HC	8476	87
Dr Raymond Orr	Glenmill Practice	6113	36
Dr Elizabeth Paton	Easterhouse HC	2462	8
Dr Nick Treadgold	Pollok HC	4161	39
Dr Marie Wilson	Easterhouse HC	2462	8

ANNEX C PROGRAMME

14.00 **Introduction**

Dr Linda de Caestecker, Director of Public Health, NHS Greater Glasgow and Clyde and member of Glasgow City's Poverty Leadership Panel

14.10 **Three short presentations**

What practical tools are available and what does the local data suggest?
James Egan, Glasgow Centre for Population Health

What are the challenges facing primary care and advice services and what could help? Some initial thoughts
Dr Raymond Orr, Glenmill Medical Centre, Glasgow and member of General Practitioners at the Deep End project

Challenges facing advice and health services
Robert Hinds, Welfare Rights Officer, Social Work Services

14.30 **Workshop 1** ***Who is doing what, when and where?***

15.30 **Plenary** ***Review of main messages from workshops and introduction to Workshop 2***

Lorna Kelly, Glasgow Centre for Population Health

15.45 **Workshop 2** ***How can we strengthen current practice and address the identified gaps and challenges?***

16.45 **Plenary** ***Review of main messages from workshops and agreement on implications for practices and for Poverty Leadership Panel***

Professor Graham Watt, General Practice and Primary Care, University of Glasgow

17.00 A **post event meeting** took place to discuss the identified gaps and challenges and how they can shape a joint action research proposal (open invitation)

ANNEX D BACKGROUND INFORMATION

Welfare benefits that are currently being reformed include:

- Housing Benefit – Local Housing Allowance
- Non-dependant deductions
- Household benefit cap
- Disability Living Allowance, being replaced by the Personal Independence payments (PIP)
- Incapacity Benefits, being replaced by the Employment and Support Allowance (ESA)
- Child Benefit
- Tax Credits
- 1% uprating
- Universal Credit

In Scotland it is estimated that the reforms will take more than £1.6 billion out of the Scottish economy, or about £460 per year for every adult of working age.

32% of the reduction is due to changes in Incapacity Benefit, 18% to Tax Credits, 18% to the 1% uprating, 14% to Child Benefit and 11% to Disability Living Allowance.

Glasgow City is estimated to lose about £259 million per annum, or about £620 per working age adult, which are the largest figures for any Scottish local authority (Table 1, overleaf)

It is estimated that in Calton ward, the loss from incapacity benefit changes alone (£350 per year per adult of working age) is almost double the financial loss from the whole welfare reform package in St Andrews.

In mid-2014, much of the financial loss in the poorest wards is still in the pipeline. The incapacity benefit reforms will not come to full fruition until 2015-16, when means-testing for ESA claimants in the Work Related Activity Group will affect large numbers of people. The changeover from DLA to PIP has barely started and is not anticipated to be completed until 2017-18, while the below-inflation up-rating still has another year to run.

Source Welfare Reform Committee 5th Report, 2014 (Session 4). Report on Local Impact of Welfare Reform. Scottish Parliament, 23 June 2014

Within Glasgow, the estimated overall financial loss per adult of working age varies between electoral wards

Ward	Scottish ranking	Overall financial loss per adult of working age
Calton	1	880
Springburn	2	760

Ward	Scottish ranking	Overall financial loss per adult of working age
North-East	3	750
Drumchapel/Anniesland	4	740
Southside Central	5	730
Shettleston	7	720
Canal	9	700
Garscadden/Scotsounhill	11	690
Govan	12	690
Bailieston	13	680
East Centre	14	680
Linn	16	670
Craigton		630
Greater Pollok		630
Newlands/Auldburn		590
Maryhill/Kelvin		560
Langside		500
Pollockshields		460
Partick West		450
Hillhead		360
Anderston/City		350