

Deep End Report 27

Improving partnership working between general practices and financial advice services in Glasgow: one year on

This report contains a wealth of information, experience and views of professionals involved in helping people cope better with changes to the welfare benefits system, and is presented as a resource for others wishing to understand the challenges of joint working.

December 2015

SUMMARY

A half day symposium was held at the Lighthouse in Glasgow on 30 June 2015 to review progress in joint working between general practices in Glasgow, the Glasgow City Financial Inclusion Partnership, NHS Greater Glasgow and Clyde, the Wheatley Housing Group, Third Sector organisations and the Glasgow Centre for Population Health. A previous meeting took place in May 2014.

Key points

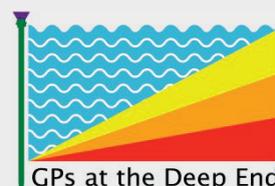
- The Glasgow Financial Inclusion Partnership (involving Glasgow City Council, NHS Greater Glasgow and Clyde, the Wheatley Housing Group, Citizen's Advice Bureau and other Third Sector organisations) has secure funding for three years and a strategic programme of activity to support citizens in their engagement with the welfare benefits system.
- This period will be increasingly challenging because of changes and cuts to the benefits system and resource constraints within public services generally.
- Substantial added value could and should be added to the programme by more effective joint working with general practices in the city, making use of their population coverage, cumulative knowledge of patients, clinical records and continuity of contact with patients at various stages of engagement with the benefits systems, including referral for advice, applications, appeals and sanctions.
- Mental health problems are very prevalent in very deprived areas, both as a cause and a consequence of problems with benefits
- General practitioners in the Deep End, serving the most deprived populations, are already under severe pressure dealing with the large numbers of patients with complicated medical, psychological and social problems.
- In a gross example of the Inverse Care Law, the largest concentrations of patients who need most help in engaging with the benefits system are found in general practices which are least able to take on this extra work.
- Improved links between clinical practice, welfare advice, employability schemes and housing could provide more holistic, personalised support for many individuals, families and households.
- A "coalition of learning" is required, following the adage that "the best anywhere should become the standard everywhere" and involving improved communications and protected time for sharing information, evidence, experience and views.
- General practices need to be briefed with general and practical information about the benefits system (especially ESA, PIP and sanctions).
- They also need bespoke local information (a "toolkit") on referral pathways, forms and contacts, for use in referring patients for financial advice, supporting applications and appeals, and dealing with financial emergencies.
- The new Scottish GP contract, which is being developed for introduction in 2017, should include a mechanism to provide targeted resources for this work.
- The preparation of medical evidence from review of clinical records does not need to be carried out by general practitioners, but practitioners should review, edit and sign off such work.

- With patient consent, colleagues from outside the practice team (with honorary NHS contracts where necessary) could access clinical records within practice premises. Such arrangements are only feasible, however, on the basis of local relationships, involving mutual understanding, confidence and trust.
- Centralisation of welfare advice services allows efficient use of resources, but may not suit all people in need of such advice. Several examples demonstrate the value of advice workers who are embedded within health centres or groups of practices, improving referrals by the practice team and uptake by vulnerable groups.
- The substantial variation between general practices and between health professions in their rates of referral to advice services needs to be addressed, on the basis of audit and feedback.
- The most useful feedback for general practice teams may be timely information on what has been achieved financially for the patients they have referred.
- A continuing challenge is how to provide general practices with timely, bespoke advice on the type of information most likely to help patients submitting appeals.
- An immediate proving ground for joint working will be the coverage and effectiveness of the programme in helping Glaswegians with Disability Living Allowance (DLA) engage with the new arrangements and criteria for Personal Independence Payments (PIP).

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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.



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BACKGROUND

In May 2014, a partnership event was held with the aim of considering the role of GPs and primary care teams and how they could work with other partners to mitigate the effects of welfare reform for their most disadvantaged patients. A subsequent Deep End Report (Number 25) was published in November 2014, which described a set of 'next steps' that were required to strengthen primary care partnership responses to welfare reforms.

A follow up meeting was held at the Lighthouse, Glasgow on 30th June 2015 with the following programme.

- 13.45 **Chairperson's introduction**
Lorna Kelly, Glasgow Centre for Population Health
- 14.00 **Progress Report 1** *Grieg Inglis, Glasgow Centre for Population Health*
- 14.15 **Progress Report 2** *Sarah Littler, University of Edinburgh*
- 14.30 **Progress Report 3** *John Thomson, Glasgow City CHP – North West Sector*
- 14.45 **Links Workers Programme update** *Mark Charlton, Links Workers Programme*
- 15.00 **Progress Report 4** *Kate Burton, NHS Lothian*
- 15.15 **Refreshment break**
- 15.45 **Reflection from general practice** *Maria Duffy, Pollok Health Centre*
- 15.50 **Reflection from Money/Welfare Advice Services**
Geraldine Cotter, Money Matters
- 15.55 **Reflection from Glasgow's financial inclusion partnership**
Lesley Haddow, Glasgow City Council
- 16.00 **Plenary discussion: successes, challenges and further actions**
Jackie Erdman, NHS Greater Glasgow and Clyde; Lesley Haddow, Glasgow City Council; Sharon McIntyre, Wheatley Group, Maria Duffy, Pollok Health Centre, Geraldine Cotter, Money Matters
- 16.40 **Summary and closing remarks**
Graham Watt on behalf of General Practitioners at the Deep End
- 16.50 **Close**

For a list of participants, see [ANNEX A Participants at the meeting in June 2015](#)

ABRIDGED SUMMARY OF MEETING

Lorna Kelly, Associate Director at Glasgow Centre for Population Health introduced the afternoon event as a follow-up to the meeting held in May 2015 exploring how General Practices could work with other partners to mitigate and manage the effects of welfare reform. She highlighted:

- the scale of the continuing welfare reform challenge in Glasgow and the financial impact across the city as a whole.
- the financial impact on individuals, the impact of changes to conditionality and sanctions and the corresponding impact on the range of services that individuals use.
- the imminent devolution of some welfare budgets to the Scottish Government
- the huge potential benefits to people of universal health services, financial advice services and welfare advice services being able to work together more effectively so that there is better understanding, coordination and access to support.
- the disproportionate workload implications for general practices in very deprived areas where patients with benefits issues are concentrated.
- the complexity of promoting joint working between systems that are separately fragmented, under pressure and involved in substantial internal change.

Greig Inglis, Researcher, Glasgow Centre for Population Health had interviewed three commissioners for the Financial Inclusion Partnership in Glasgow City (including representatives from the DHS, Wheatley Housing Association and Glasgow City Council), three health improvement leads from across the city and GPs working in Deep End Practices in Glasgow.

- GPs are frequently asked to provide letters of support, or to support with applications for benefits, or appeals. One of the common suggestions, particularly from health improvement staff and the commissioners is that it would be helpful if money advice services could provide GPs with guidance, or templates that inform them of the types of information that is required, streamlining the process, saving time and increasing the chance of success. Quite a bit of work has been done around this area in Glasgow city but the lessons learned could be shared more widely.
- A recent pilot study found that generic templates don't work particularly well because every case is different.
- A GP described how they had been trying to develop a template that could be used to elicit specific information to support appeals or applications. It was difficult to find a one stop shop for information and to figure out which information is important and what they could put in these letters to try and support patients.
- There is a need to pull together what's happened so far to try and understand what works and what doesn't work. It may help to have a colleague from health improvement to act as a liaison between primary care and money advice to try and work out what would be helpful for both parties.
- GPs comment that they are often asked to provide information about how a health condition impacts on their patients functioning day to day, which they may not know enough about to actually comment.

- Another GP commented they often don't know what happens when they signpost a patient to money advice and that when they do receive feedback it tends to be from patients who are dissatisfied with the service they have received.
- On the other hand, another GP told of a really positive experience speaking to a money advice worker who told them about how much financial gain they had managed to generate for clients and also how encouraging it was to hear from money advice how important GP input can be in determining a client's outcomes.
- It may be that one way to encourage GPs (which health improvement staff are currently working on across Glasgow), is to provide feedback on what was achieved for patients and for clients.
- It can be very difficult to get a GP's time and attention, so there needs to be discussion with GPs around which types of information would they find helpful and also what is the best method, or the best forum, to communicate that information.
- One commissioner suggested that there may already be enough capacity within the advice sector at present within Glasgow and that the real challenge is how to get the various systems to link up and work better together.
- For example, are there ways to improve working between housing services and health? Many patients who are registered with Deep End Practices are also registered with social housing landlords but there is very little connection at present between Health, Primary Care and Housing Associations.
- The commissioners also described some of the substantial funding opportunities that are available e.g. Lottery Funds and European Social Funds.
- There is currently a big push towards modernisation within the advice sector in Glasgow, with efforts to try and increase the amount information available for people who are able to self-serve whilst also maintaining capacity to provide one to one more in-depth support for people who may be more vulnerable and who need more assistance.
- There are also issues around how service supervision could change to meet the needs of client groups who have been identified within the Financial Inclusion Partnership as being priority groups for the next few years – Housing and Homelessness, Under 25s, Mental Wellbeing, Domestic Violence, BME, In-work Poverty and Financial Capability. Given general practice involvement with some of these groups, especially people with mental health problems, a primary care voice in planning discussions could suggest ways in which primary care could be better supported to support some of these priority groups

Sarah Littler, Medical Student, Keppoch Practice, Possilpark had spent six months of a sabbatical looking into the interaction between the Keppoch Practice, local Financial Inclusion Services and the benefit system more broadly. (For the report of that project see: http://www.gla.ac.uk/media/media_419088_en.pdf)

The Keppoch Practice, is based in Possilpark Health Centre, with a practice list of 3300 patients, of whom 88% live in the 15% most deprived datazones in Scotland.

Her initial impression was the complexity of the benefits system and the fragmented nature by which the benefits system interacts locally with the GP practice and Financial Inclusion Services.

At the application and assessment stage, the GPs have a both direct and indirect role in that they provide medical evidence directly for the DWP relating to disability benefits

and also indirectly in that they support patients through the dehumanising assessment process and all the stress that comes with that and the risks of losing benefits.

Whether benefits issues are brought up in consultations depends on several factors including time constraints after medical problems have been dealt with, how openly patients talk about money issues, and how confident the GP feels in bringing up money issues.

In a climate of ongoing reform and ever changing bureaucracy within the benefits system, GPs and practice staff (especially new staff) need readily available information. GPs also need to know the referral procedures to local Financial Inclusion Services, e.g. how to refer someone to money advice, where to find the referral form (in Docman), and what to do when someone presents in a financial emergency.

For completing ESA forms, GPs don't receive any extra funding - an example of the Inverse Care Law, given that the Keppoch GPs spend a lot of time completing those forms in contrast to practices in more affluent area where less patients apply for ESA and GPs don't have the same workload.

When SL felt competent in processing the necessary forms, she took a single month to document all the disability benefits forms that were received and how long they took to complete. ESA forms took on average of 47 minutes, amounting in total to 6.3 hours, which is the equivalent of twenty five, 15 minute GP appointments.

PIP forms first began to arrive in May and required much more detailed information. The practice receives £33.50 to process each PIP application. All the PIP forms that were received came within one week which may relate to the geographical roll out of PIP. The forms had to be returned within 5 working days and took on average 97 minutes to complete, with a total which was again, equivalent to twenty five 15 minute appointments

This brief analysis provides only a snap shot of the work that a GP practice might see in a month but gives some indication of the potential implications of the roll out of PIP in the near future.

With few time constraints, SL was able to spend time reviewing and extracting information from historical notes and letters. GPs under time pressure don't have the time to review medical notes in this way.

SL was able to complete most disability benefits forms without difficulty. After completing the forms in draft, she would send them to the GPs for review and they would add additional information, but quite often the GPs didn't need to make amendments and when they did it was more time efficient because SL had spent time going through the old historical notes getting the dates of diagnosis and the clinical findings. Having medical knowledge was useful but often unnecessary in order to comment on how a patient's conditions impact upon day to day life. Other colleagues were often better placed to comment on these issues e.g. a CPN for mental health patients, or the occupational therapist.

GPs need to be up to date on welfare reforms and their practical implications, because they can then identify patients who need attention (e.g. at risk of sanctions or the roll out of PIP) and refer such patients for money advice.

SL developed an information tool kit (Annex B) which was specific to the Keppoch Practice and its local services, but could be customised for other Deep End practices.

GPs don't receive formal training on benefits as part of their medical training. SL delivered a teaching session on benefits for GP trainees in the North West sector as

part of a wider deprivation teaching session. This kind of resource would be useful for practices to improve the knowledge of trainees coming into the practice.

John Thomson from Glasgow City CHP described other work in Possil and the North West during the last year which generated nearly £900,000 for benefit recipients.

Referrals for financial advice vary enormously between areas and between health professions, such as GPs, health visitors, practice nurses, CPNs etc. Evidence of such variations can provide a useful spur to local change.

Claire Montgomery, CAB Advisor, is one of two advisors based in Possilpark Health Centre, who are employed on a Scottish Legal Aid Board (SLAB)-funded project. The project focuses on child poverty and takes clients who have children under 8, including expectant parents and kinship carers. The service is embedded in the GP practices, unlike outreach arrangements which involve having advisors in health centres at fixed times, perhaps two half days per week. The Health Centre is the primary place of work, therefore, alongside Health Visitors, Specialist Children Service, Special Needs in Pregnancy etc. CAB advisors are seen as extended members of the team and are exploring new ways of working together, piloting different strategies in different GP practices.

The main areas of work involve debt, money advice, and benefits, but the advisors also see employment issues and can deal with housing problems.

The usual approach is to see each client for appointments lasting 45 minutes, usually meeting repeatedly over a period of weeks or months, as most referrals involve people with a multitude of interrelated problems and it takes time to get that full picture and to build trust.

Having advice workers embedded within GP practices and Health Centres makes advice accessible to the most vulnerable, hard to reach people in the community. Although the Citizen's Advice Bureau office is always very busy, the service doesn't necessarily get the most vulnerable, the most marginalised people proactively coming to seek advice.

Most people are in contact with their GP over a year and almost everybody over three years. Putting advisors in a health centre is a good way to ensure that the most vulnerable people are not falling through the safety net.

Health professionals who work in Deep End practices see patients everyday with non-medical financial problems. It's not their role to address such problems but if they know advisors who are in their practice on certain days at certain times, they are well placed to refer them in a straightforward way.

Having advisors in a health centre means it's a safe familiar place in the community for people to get their welfare rights and money advice. Some people feel stigma in coming to an advice agency, and prefer the health centre setting, where they are anonymous and could be going to the health centre for a million different reasons (See also the case study in [ANNEX C](#))

Embedding advice workers also leads to increased awareness of the service within the health centre. With a set weekly slot with each practice and colleagues within that practice knowing when to expect advisors to be present, that's when they can raise queries and share information.

In addition to providing standardised feedback on the outcome of referrals, feedback is also provided informally based on numerous informal meetings.

Mark Charlton Director of the Links Worker Programme

The Links Worker Programme is a two year randomised control trial in practices across Glasgow, with extended funding up to five years. The project hopes to make an impact at three different levels: first with patients, clients, people, individuals; second, with the General Practice team, and third, with the local community resources and community assets around the practice.

Seven practices take part in the programme, each hosting a full-time community links practitioner, who is employed by the Health and Social Care Alliance. Practices can also apply to the Practice Development Fund, for a separate grant up to £17,500 per year for the first two years for which they have to produce a business plan. At the outset, seven capacities were identified which practices need in order to work more closely with their community assets

The first capacity is their own well-being. Particularly in Deep End practices, GPs constantly feel watched, under pressure to perform and constantly completing their QOF framework. So we need them to take stock of their own well-being, and how could they use the opportunities presented by the Links grant to support positive well-being in the team,

The second capacity is how they share learning. GPs, clinicians, and anybody making referrals to different resources need to know the outcome of that referral in order to continue that practice. Practices are asked to use the Links approach to share the learning within their clinical and administrative teams.

Practices are also asked to consider their level of awareness of what's around them, what are the bus routes, who is the local Money Matters Service etc. How do they refer and what are the barriers? Even if templates are found on the Health Improvement Directory, or Docman, wherever the practice choose to find the referral forms, sometimes they can't be sent electronically because as soon as they are saved the files cannot be read at the referring resource. GPs have to print off, add a sticker, or complete it manually and then post the referral forms. The project tries to identify and resolve such practical problems.

Practices are asked to consider how they manage information. Even with a brilliant tool kit, there is the challenge of keeping it up to date. Practices are encouraged to use ALISS (A Local Information System for Scotland) which can link up existing databases and has the capability of talking to the Health Improvement Directory and other resources that other people are populating and keeping up to date. Anyone can go into ALISS and search what's in their local area.

Community Links Practitioners are tasked with mapping on to ALISS whatever they find around their practices, so that everyone can see what's available locally. They work with receptionists to identify the unique role and opportunities that receptionists have in signposting people to relevant resources.

Practice teams are asked if they would like more support on how to ask people about their money situation, or enquire about reading and writing skills.

Local problems provide an opportunity to report, describe and solve the problem, and then share the learning with other practices.

The final practice capacity is networking within the local community. Practices are encouraged and supported to get out in the community, meet the different assets that exist and see the quality of the product that's out there in the third sector and in statutory services that can meet the needs of patients.

A working assumption, given the high prevalence of financial problems is that everybody is experiencing a crisis with their household finances. People don't always talk about it but most of the people we work with are in some sort of financial crisis, which may not be recorded as everything else that's going on around may be more important at the time.

Kate Burton, NHS Lothian described the Welfare Rights Advice and Health Project in NHS Lothian. For the last fourteen years Welfare Rights Advisors have worked in GP practices, funded by NHS Lothian and the local authority. In the last three years funding has increased, not only in practices in areas of deprivation but also practices which work with vulnerable groups, like sex industry workers and homeless people. Twenty two practices or primary care services across Lothian are supported by the project, in partnership with the voluntary sector.

It is considered important to work with voluntary organisations who know the local area, rather than to bring in a national voluntary organisation. The service provides support and information to patients about welfare benefits, income maximisation, employability issues and housing problems. It also provides a representation service.

The service is available to anyone who is a registered patient with the practice and thus gets referrals from midwives, health visitors, GPs, indeed anyone within the primary care team, covering patients across the whole age range.

What is crucial, has been learnt over time and is now embedded within the service is that the advisors are integrated into the practice team and have honorary NHS contracts which allow them access to the patient's medical records, allowing speedy access to medical evidence.

Integration is not just about access to notes; it is also about the advisors attending practice meetings, sitting in on case conferences as appropriate and, most importantly, they go on nights out and are invited to the Christmas party. When advisors started to get invited to the practice Christmas parties, that was a big deal because they were quite exclusive before.

The other thing for many people is that having the Welfare Rights Advisor in the practice is non-stigmatising. Some people don't want to have to walk through somewhere that says CAB or Financial Advice on the door. They are happier to be referred to someone in the practice who is endorsed by the GP and they don't feel stigmatised by going for that help and advice. (See the case study in [ANNEX C](#))

Given the current UK economic climate and political makeup, what's very concerning for primary care and GPs is the fact that from this autumn 200,000 people who are currently in receipt of Disability Living Allowance are going to be reassessed for Personal Independence Payment. We know that a third of those two hundred thousand are going to miss out under the new regulations for PIP, which is going to hit primary care and GPs who work in areas of deprivation extremely hard. We need to be ready for this because we weren't ready when ESA was introduced and all the reassessments that happened with that. We need to be ready for PIP this autumn

Question from Sandra Barber

Obviously it was a new way of working, putting your workers into GP practices. Was it widely accepted, or did you have a bit of work to do? If you did, how did that come about and evolve?

Answer from Kate Burton

We did have to do some work with the GPs, but we had a very supportive clinical director and one of the first advisors went into her practice. That was very helpful and she was a huge advocate for having the advisors in practices. Now when we put advisors into practices, the GPs absolutely recognise how positive the impact is of having an advisor there who can deal with patients' socioeconomic issues, while they deal with the clinical and medical needs. Having a clinical champion from the outset made it a lot easier. In several places in Scotland, including Dundee, Aberdeen and Highland, local authorities are putting advisors into GP practices, recognising the importance of placing advisors where people are, as opposed to where their base is. These places don't have as many workers in their advice shops, and put them instead into a health centre, or a GP practice. Getting clinical director support and the right advisors has been hugely important. An advisor going into a GP practice has to be respected as a professional in their own right. All the advisors who started working fourteen years ago are still there and it's working very, very well.

Question from Graham Watt

There aren't many Deep End practices in Edinburgh but they are big practices, about two or three times the size of Glasgow practices. I wonder whether that's made it easier to justify embedding advisors within the practices. Also, what would be the implications of bringing that model over to the west? How many advisors would be required?

Answer from Kate Burton

For a practice population of about ten thousand people which is what the average in in Edinburgh, you need an advisor for about two days a week. That's an advisor working in somewhere like Craigmillar, or Muirhouse, where there is severe socio-economic deprivation. But we also have advisors working in South Queensferry, on the outskirts of Edinburgh, which you could describe as a leafy suburb, but child poverty is a huge issue in that area. I would say that for a 10,000 practice population we would put in an advisor for two days per week.

Question from Noreen Shields

Our NHS GDC Financial Inclusion Group got a briefing on PIP and the wider eligibility for it. A lot of people will lose out but in terms of wider eligibility we've agreed to do public and staff awareness campaigns about people with mild to moderate mental health problems, people with learning disabilities, people with addiction problems who weren't eligible for DLA, but may be eligible for PIP

Answer from Kate Burton

It is really important to encourage people to apply for PIP because when we get the devolved benefits budget it will be based on current recipients. We'll only be able to maximise that if we make sure we have as many people as possible on PIP.

COMMENTARIES

Maria Duffy GP, Pollock Health Centre in the South of the City

The changes in the welfare system interest me because of the detrimental effect they can have on the lives and well-being of the people that I serve, some of the poorest

and sickest. In Pollock I understand that each adult of working age is set to lose on average £630 per annum because of the benefits changes.

From my perspective the patients who will be most affected will be the most poorly equipped to navigate through the system. They've often got mental health problems, they're not good self-advocates, and they need help.

At the welfare meeting last May, a colleague from North Glasgow told me how much money they had found unclaimed, which ran to tens of thousands of pounds. It made an impact on me that this was money people were entitled to but weren't getting - patients like mine who live in poor areas and are battling with mental and physical health problems. That was important feedback.

Another thing that struck me was when one of the welfare tribunal officers said that appeals are often successful, so if people do appeal and get medical evidence it is often to their benefit.

I was humbled by the statement that information from General Practice, even if it is just a scribbled letter, can be very influential. Often when patients ask me face to face for a letter, I'll scribble down what I think at the time and I think, hopefully, that will do something but I actually feel quite ashamed that that's the level of input that I can give them.

Therein lies the problem. There are manpower and workload issues in General Practice. My practice has 4700 patients and 2.1 GPs. So a GP like me looks after 2240 patients. That is a lot of face to face work and a lot of paperwork. Many benefits appeals involve patients in practices where we're already tackling the problems of multiple deprivation. It is the Inverse Care Law. We have increased needs but we don't have increased resources. So often, if I do these benefits letters, they are done on my own time, at home, using remote access after working a twelve hour day. We don't have enough capacity.

After last year's meeting I met a colleague from Central Citizen's Advice, and we tried to see if we could come up with a solution that would make the GP response fit into a ten minute interval, equivalent to a routine appointment. She came up with some targeted information that they were looking for from GPs. I tried that out on a couple of my patients, trying to answer the questions that were asked. It was a lot better than a patient just coming in and saying 'hey doc can you give me some information I'm appealing' but it didn't fit within the ten minute window. Despite not fitting within that window, my partners and I agreed that if any appeals were going forward, we would provide a letter, time how long it took, and work with the advice services. Sadly, none of my patients were dealing with Central Citizen's Advice. They were being advised by Money Matters, or Pollock's Citizen's Advice, and Central CAB couldn't get involved. So I decided I would go straight to the Tribunal Service, which deals with appeals and went up to Granite House in the City Centre to see if I could get help round this. I proposed a few patients who I knew were going through appeals but they weren't going through appeals at that office. So the system is fragmented. We're not really connected to each other and we didn't get anywhere really in the end.

What I've concluded is that GPs are best placed to give the information but we don't have time. I've heard today about advisors being embedded in practices. That's a good way forward because although GPs are pushed for time they do have a valuable overview. A CPN, or a Welfare Rights Worker might be able to extract information from the records and the GP could then more quickly give an overview.

I don't have a solution but I think that using template letters and being very specific what you ask from GPs will help. We should look more at patients granting access to

their records, enabling others to work up their case and then checking with the GP. The idea of more feedback is excellent, but GPs are simple creatures. If we know that the work we've done has won our patients money we'll enjoy that, and be encouraged to do more.

Paul Pearson

Money Matters is a designated partner agency for Glasgow South, which works at various health outreach locations, and also through the referral system. I've heard what's been said about going back and giving some feedback. That's a valid comment. If advice providers gave more feedback about what they've done, there might be more buy in from doctors.

In terms of templates, I've agreed to write up some template letters. There are probably three templates to write and correspondence to doctors to make them aware, on one page, of what the rules are behind PIP, ESA and other issues. For instance, if somebody fails to go to a medical, they'll automatically be sanctioned but if there is a mental health problem behind that, then medical evidence will strengthen the appeal. If there are no medical issues, and the sanctions issue is non-cooperation, an appeal is more difficult and can take a long time. The person's only option then to get benefits is to go to Job Seekers which is probably inappropriate for somebody with mental health issues.

A particular current concern with Job Seekers sanctions is that they appear to be sanctions for the sake of sanctions, with no consideration given as to whether or not there's an underlying health condition contributing to lack of cooperation. That situation brings in its own problems - how to get by the sanctions, how do we help somebody to live while waiting for their appeal. We automatically appeal on all sanctions because what you tend to find is a person with one sanction will then have another, and another, so what you're doing is appealing the first one, to get the first one out of the way. So that the second more intensive sanction becomes the first one because then you can go from a four week sanction up to unlimited, two year, three year sanctions.

In terms of a sanction for non-attendance at an ESA medical, this often fails to establish if a health problem has contributed to this issue. At that point if we have a template letter that a GP thinks this decision is nonsensical because the person has a mental health condition and couldn't attend, it may help, avoiding a wait of three or four months for an appeal. We do anything we can to get people back on track again as quickly as possible.

In terms of DLA and PIP, it's too early to know what the actual cost or implications will be. Clearly PIP was designed to get a lot of people off DLA. The qualifying criteria are changing and are more open to manipulation.

Short term awards are intended to be a feature of PIP. For people with mental health problems, a four or five year award means that their benefits are safe, but with two and three year awards, every time a new claim comes out there's a risk of it not being completed and sent back.

The current welfare reforms are creating significant financial difficulties which we can all see from the increase use of foodbanks. This is even before the next tranche of welfare reform cuts which appear to be centring on tax credits. This will clearly lead to more work and child poverty. There's compelling evidence that children from disadvantaged backgrounds fall significantly behind their peers in literacy. It's not unreasonable to speculate that the reforms will have a significant impact on general mental health, suicides, family breakdowns, relationship breakdowns etc. That's all the depressing view I wish to give you.

Lesley Haddow Glasgow City Councils Financial Inclusion Team

Many of you know that we are now two months into a new Financial Inclusion Partnership, which has moved from a contract arrangement to a partnership arrangement, the funding partners being Glasgow City Council, the Wheatley Group and the NHS. This is allowing us to provide financial advice to citizens through seventeen individual advice agencies across the city. There is growing demand on the advice sector due to the welfare reform changes. We're fortunate that the savings that the Council has had to make, which have been widely publicised in the last week or so, have not yet impacted on Financial Inclusion Services. It is worth mentioning, though, that there are still financial challenges on providers due to increased running costs, workplace pensions, etc. and we have a role within the partnership to work with providers on this.

What it does mean is that we need to target services, work smarter and make better use of our resources. There's no doubt that welfare reform changes impact on citizens and we're already working with the DWP to mitigate against this. I think this answers the point about being prepared. For example, personal budgeting services are being funded by the DWP for universal credit claimants. This is the first of a series of changes that the DWP have agreed to fund. It's our responsibility to make that a success, so that when somebody presents with personal budgeting service challenges when moving on to universal credit and they can't budget for themselves, the advice providers in the city are being funded to provide that service.

Another extremely successful example is the co-location of advice services in libraries. The DWP is encouraging claimants to go to their local library to make their claim for Job Seekers Allowance, or Universal Credit. Through the library network, if a claimant is struggling with either personal budgeting, or any other money advice issues, they can actually make an appointment with the CAB. It's just an outreach provision but is proving really successful.

It's been very interesting to hear about many of the projects that are under way and to consider if we can look at what evaluation can be added to see what the outcomes are.

The library work has been tracked end to end, which has been a complete nightmare and very resource intensive, but what we have found is that by following-up with the customer we've been able to establish what additional income they've received as a result of that appointment. So it has been a very worthwhile exercise.

As part of the new partnership model, there is a Core Group, a Specialist Group, a Modernisation Group and a Service User Engagement Group. The Core Group has been tasked with reviewing the monitoring framework for Financial Inclusion Service. NHS and Wheatley colleagues are also on that Group.

Applications to the European Social Fund and Big Lottery Funding bids are being prepared. It is worth mentioning that they are very restrictive and dependent on organisations being able to commit to three years of matched funding.

In the Modernisation Group, we're looking at branding, telephony and IT, including a new web platform which would provide an online referral option, which should allow NHS colleagues and GPs to refer to us more easily. We're inviting other people on to the Groups to make sure we capture everybody's needs. So I would be interested in linking in with Mark Charlton on issues regarding electronic referrals, and the ALISS system. We're continuing to work with local GPs. Communication issues should be relatively easy to fix. We need to engage with NHS colleagues because we know there is some confusion, not only for GPs and other organisations but also customers in terms of what is GAIN (Glasgow Advice Information Network). That needs a rebranding

exercise. I also wonder if there are opportunities for the Council to help in providing information on the outcome of appeals.

The West Lothian model seems to be a complete success, especially in accessing GP patient data. In terms of the scalability of the model in Glasgow, it would be a significant challenge. The Financial Inclusion Partnership currently funds eighty five full time equivalent staff across the city. There are about a hundred and sixty GP practices in Glasgow.

Another option is to centralise resources and access patient data from there, using Welfare Rights Advisors to support PIP applications. Because of the increase in workload due to the welfare reform changes, the challenge is how best to service the clients that need those services, and in some cases centralising seems to us as being the way ahead. As long as we have the correct access points for customers to be able to access services, we're fairly convinced that that's the right thing to do because we are being inundated with enquiries for outreach provision. For example, foodbanks are constantly contacting us. Obviously there's a need there, or customers wouldn't be turning up at foodbanks. Even though funding is in place for the next three years, we are still up against a lot of challenges in terms of delivering the service for the same money.

Jackie Erdman *Corporate Inequalities Team, NHS Greater Glasgow and Clyde*

I'm here to day on behalf of Fiona Moss who chairs the Financial Inclusion Group for the NHS GGC area. The Group coordinates good practice and several initiatives have come out of that Group, particularly in terms of giving patients information about welfare reform e.g. Healthier Wealthier Children and the SLAB-funded project in the North West

The tool kit is a great idea. We should look at whether and how patients' records can be accessed to help prepare PIP applications. We shouldn't lose the link between welfare reform and employability because at the end of the day the people that we're working with have got aspirations beyond claiming benefits. We know that low pay is a huge issue, so it's not just people who are on out of work benefits, it's also people who are claiming in work benefits who are in a very precarious position. The elephant in the room is engagement with the DWP. Do we have and use opportunities to say how policies are impacting on our workloads and our patients? I was staggered to learn that GPs are not paid for the ESA113 form. In terms of renegotiating the GP contract that should be on the table because it is obviously having a huge impact on GP workload.

We need to counter the implicit assumption that people who are applying for benefits are malingerers as this is seldom the case. Patients' views are very important. We need to capture their voice.

It's hard to explain to people why one GP practice will charge sixty pounds for a letter and another won't charge anything.

The final thing from me is "What is the role of the NHS in tackling poverty?" Do we all agree that the NHS should be trying to tackle poverty in our day to day work? If so, how is that going to be funded? The Deep End point is that as long as we have a flat distribution of GP resources it doesn't look like the kind of health service that wants to tackle poverty. So we really do need to make our voices heard on this and, most important, to make our patient's voices heard also.

Sharon McIntyre *Wheatley Housing Group, Glasgow*

The Wheatley Housing Group is the biggest social landlord in Scotland but not the only social landlord in Glasgow. In Glasgow there are sixty nine registered social landlords.

Glasgow is unique in having such a high number of Registered Social Landlords (RSLs) that make up the social housing market. That said, Wheatley Housing Group does have the biggest tenant population in Glasgow, which includes Glasgow Housing Association, Cube and Loretto social housing. With a combined tenant population of 40,000-45,000 tenants, we have a very high number of tenants who rely on benefits and who are stuck in low paid employment i.e. in work poverty. For us housing and welfare are very closely related. We are crucially aware that many tenants vitally depend on welfare support to be able to maintain their tenancies. Therefore, we have carved a significant role of providing welfare advice, information and support for ourselves through a significant investment in the Financial Inclusion Partnership, and the creation of our own Welfare Rights Information and Advice Team, a Fuel Advisory Team and Tenancy Support Team. We have also developed products and services that make a real difference to the lives of our tenants i.e. hardship fund, eat well food packages, recycled furniture packages etc.

The big issue for housing in general is that it isn't regarded in national policy arenas as having the ability to make transformational change to people's circumstances through the provision of welfare advice and support. As a housing group, we have a key role in the Glasgow-wide Poverty Leadership Panel where we see housing as being integral to tackling poverty, not only on a local scale but also a national scale. We don't just want nice houses for people to live in, we want people to have great lives in those houses and to achieve those aspirations of 'great lives' we need to work very closely with Health, Local Authorities, and third sector partners. We believe in working collaboratively with partners outwith our own world of housing in order to make macro change. We're a big investor in welfare services and, we're serious about tackling poverty and working better together to meet our common aims of housing, health and wellbeing.

QUESTIONS TO THE PANEL

Question (unidentified)

The suggestions about other people looking at the records and helping to complete applications and appeals sound very practical and useful. If someone from a service wanted to go in and look at GP records, would there be lots of obstacles to that, or do our information sharing protocols allow that to happen?

Answer (unidentified)

There is already a model in place in improving the cancer journey, with a joint advisor who has access to NHS records.

Answer from Maria Duffy

Patients have to give their consent and sign a mandate. Then, in general practice all we need to do is find a room, but it would need to be in the practice. I don't think we'd want information to go out of the practice. It could be extracted from the records but I don't think we'd want the records to leave the practice because of confidentiality issues about where it goes after that but if the patients consent is there I don't see an issue. We copy records all the time and send them to people so long as the patients consent is there, it's their record.

Question (unidentified)

How would GPs like to receive feedback? We do a variety of things in the North East sector, including regular email updates, team meeting visits and breakfast events. Is there any of them that would work in your experience?

Answer from Maria Duffy

A very simple letter saying “Dear Doctor, we managed to save X amount of money for this patient”, that’s all we need. We don’t have time to go to meetings. It’s unrealistic to expect that, because every morning and afternoon we have fifteen patients, house calls, phone calls, lots of bits of information, hundreds of emails. So I think something very simple might get our attention. If we saw it on our electronic system, we’d think “That’s positive feedback, yeah that was worthwhile, that’s helped my patient, probably a lot more than prescribing X, Y or Z for them”. So yes, something very simple like that.

In my local CHP there are protected learning events every six months and I know that some of you have been involved in attending these events and trying to let people know what you’re doing so that the GPs, practice nurses and other people in the Primary Care Health Team are using your services. But I don’t know how well attended they are, particularly by GPs, because I know that at my own CHP events I’m likely to choose clinical topics. I’m not likely to choose benefits topics just because in terms of ongoing educational needs that is not top of my list, although it’s important.

So feedback should be done very simply and quickly, in a letter just saying this is how much money we’ve managed to find this patient that they’re entitled to that they wouldn’t have had had we not appealed.

Answer (unidentified)

Currently the systems that are in place make it difficult to provide such individual feedback, because of the length of time it can take for the cases to be processed. But maybe that’s something that we could look at.

Answer from Petra Sambale

In Possil we have feedback from the Employability Service every three months in which we get the list of patients we referred and then a spreadsheet showing whether they have attended. When they get discharged, we also get a letter and that’s useful. We can read it, circulate it to the doctor who referred and that’s probably what’s best for us.

I don’t want to complain all the time but we really are facing a crisis in General Practice at the moment. The fall back mechanism for all services is “Go and see your GP”. That might seem logical, but we are really reaching breaking point. I would say that for every patient I see I probably don’t see five patients, or I miscount the diagnosis at the end. In our practice, for example, we have made a decision that we can’t do these appeal letters when patients come in because we need to concentrate on medically sick patients. Similarly, we can’t use our appointments for seeing patients to give PIP evidence because we have so many really, really sick people that need to be seen.

I think you should always end with a positive note. When I started fifteen years ago in Possilpark we didn’t have any of these services, so it’s great and quite often when I ask what about money advice it’s either housing, or the local CAB, or they’ve seen one of my colleagues has referred already. So I think it’s really quite good to see that we have the services on our finger tips and that we can refer and that is something we didn’t have ten years ago, so that is fantastic.

Comment from Rukhsanna Jabbar

I work for Jobs and Business Glasgow in a project called the Bridging Service. We work with clients who are unemployed living in the Glasgow area and we cover employability in the widest sense possible. So as long as a person has an aspiration to go back into work we provide a service. A lot of the work involves dealing with low mood and confidence building, working with clients on a one to one basis and putting them forward for personal development training.

I'm surprised that employability has not been embedded within Financial Inclusion Advice. We work very closely the local Health Improvement Team, trying to bring employability into the frame. I totally understand where the GPs are coming from in terms of letters and advice. We make referrals to Financial Inclusion Services on behalf of clients via our access to NHS Financial Inclusion. I think the Bridging Service is a good bridge for GPs to lessen their burden and take on some of the work in addressing barriers of health and well-being and building up skills and vocational training.

Comment (unidentified)

We're very lucky within the North West in that we have an occupational therapist as part of our team who can help them take first steps in considering what patients can and can't do.

Comment from Sharon McIntyre

Working in partnership with the Council and NHS, we (the Wheatley Housing Group) have introduced a new service called 'My Great Start' for all new tenants joining our group in Glasgow. Our aims include financial capability, and ensuring all new tenants have the tools they need as they start up a new home with us. We help them help themselves with money management (budgeting, savings), moving to less expensive forms of credit, energy awareness, getting into jobs/progressing in jobs etc. We've also developed a tool called The Cost of Running Your Home, which helps people see what they need to watch out for, in terms of the hidden costs of running a home.

Through the MGS service we encourage tenants to register with a GP and dentist to ensure their health and wellbeing is an important focus for them in their new homes. The big challenge is how we help bridge services for people in our communities across sectors and partners. We are all aware of the need for better integrated approaches to tackle fragmentation and the post code lottery.

When we set up My Great Start, we felt lucky to be able to put the brakes on and look at who's doing what, and where. The service tries to build on what is already working in our communities. It's important to step back, to know what is happening and what is changing

Question from Lorna Kelly

Has the Financial Inclusion Partnership the opportunity to look at some of those connections a bit more?

Answer from Lesley Haddow

Under the modernisation agenda we're reviewing all the referral pathways, to find out what the customer, patient, citizen actually need and to make sure they're referred on to the right route. Keeping up to date is a challenge. What we would like to do under the modernisation agenda is to make sure there's one point of contact for everybody, to self-assess and see what information and advice they can get. Hopefully, that's where we can include employability advice because we work closely with Jobs and Business Glasgow. That's something that GPs could maybe make use of and we will engage

with GPs as well as our other partners in Health when we're looking at that area of the partnership.

Question from James Egan

There was a question around the Inverse Care Law which a lot of people in primary care are well versed in. It would be good to get the panels view on whether or not we have an inverse care challenge when it comes to the advice landscape in the city, in terms of are we really making sure that those who the most vulnerable and the most in need of advice are actually getting access to it?

Answer from Sharon McIntyre

The people who most need welfare support tend not to approach their landlord first. One of the positive developments which we are leading on is the Young Person's Financial Inclusion Development Partnership. We know that young people do not take up traditional means of information and advice, especially vulnerable young people who are coming out of care, or from chaotic backgrounds. Our aims through this group are to provide that desperately needed financial information and advice and also housing advice and health advice in a joined up holistic way. We're pleased that the Financial Inclusion Partnership has centred on a few priority groups which as a landlord we will benefit from reaching.

It's young people who are hard to reach, and us – partners/services - who are hard to reach. We need to do more together to serve collectively our most disadvantaged residents and communities.

Answer from Lesley Haddow

What we've done is create a group of specialist work streams and each of us has an opportunity to lead in those. The Wheatley Group are leading on under twenty fives. There are also groups on Domestic Violence, BME, Mental Well-being, In Work Poverty, Homelessness and Housing Options and Financial Capability. The Groups involve not only funders and providers but also stakeholders such as young people. Also, one of the thematic groups is Service User Engagement, so if any business case goes up for approval, in terms of developing a new service, we ask for young people's views, in terms of what they think should be delivered. We also push everything through the Service User Engagement Groups to bring in an even wider group of stakeholders, such as community groups, to make sure that we are developing the right service for the right people.

Answer from Jackie Erdman

I think this was why there was a lot of interest in engaging the Health Service in Financial Inclusion and Employability Advice because a lot of vulnerable people that maybe don't engage with other services have a GP and that's where the issues will come up. It's a cross over between universal and targeted approaches. We're all talking about targeting but we're also in the world where lots of people that weren't at risk of poverty before are now at risk. There's been a lot of work in Glasgow to make sure Financial Inclusion Services are more evenly distributed in the city but if you go too far down the targeting route then there's the whole gradient of health with people falling down to the bottom. So yes, targeting and reaching the right people is important but the beauty of health services are that they're universal and they can pick up people who might not obviously be at risk.

Answer from Petra Samable

The best services are the services that take into account how vulnerable our patients are. We often forget that that it might be easy for me to go into a CAB office and see a worker. What I didn't know is that at the CAB office you see each time a different worker but what my patients need is developing trust because they've been knocked off so many times that if they don't get a chance to build up continuity and trust with the worker they won't come back.

This morning for example, our GP trainee went out to visit an elderly patient with cancer and asked who could help fill out a form to get extra benefits. The patient didn't want to ask his family, but he has a tremor and can't write properly himself, so he asked our doctor to do it, but again we don't have the time. So we were discussing how to get him quickly into the system. Following patients through, making sure that the whole journey is covered and providing continuity is the only way we get the most vulnerable on board, accepting that they might not attend but following them up assertively. That is what we need and that is quite often what falls down because our resources are so stretched that I'm quite glad if I have somebody who doesn't turn up, because I can catch up, but at the end of the day these are the most vulnerable patients and we need to help them.

CLOSING COMMENTS

Paul Pearson

We're all interested in the same thing, about patients, or clients, and how do we move people forward? I think for a lot of us it's so big and there's so much pressure on the system, but with a will and meetings like this we can try and smooth over a lot of the issues. Simply meeting and talking can lead to improvements between services. So again, where's the will, there's a way. Think positive because we're going to have to work better together.

Jackie Erdman

There is an opportunity with the health and social care integration. A lot of the discussion this afternoon has been about better coordination. I think we need to use the current changes as an opportunity to get more people around the table, more people from health, including district nurses, practice nurses, pharmacists and so on to get that wider primary care team supporting the agenda.

Maria Duffy

Although GPs may not be able to do the work we might be able to facilitate the work being done by others, so that might be a way forward.

Lesley Haddow

What we can take away on behalf of the Partnership under the modernisation agenda is hopefully that we can provide clearer pathways into the service. Also I'm keen to look into the model of information sharing if there is a secure way of doing it. Even if we only do it as a pilot exercise, it would be interesting to look at.

Sharon McIntyre

In terms of the Wheatley Housing Group we are interested in how we develop better relationships with health, at a local level because Deep End practices are where a lot of our tenants are. We and many RSLs across Glasgow have our own welfare provision that serve tenants in those communities – we are keen to see how we can be more cohesive in what we offer in terms of welfare advice to benefit our tenants, patients, residents. We have already developed local tools (welfare benefit GP template) to help streamline information required by GP's for our tenants with PIP applications/appeal etc. We are looking at ways in which we could have a direct dialogue. People who may be afraid to approach their landlord will go and trust a GP, so how can we work together to provide the best positive results for our tenants, patients, residents?

CLOSING REMARKS

Graham Watt

When we met last year, I remember looking at the room, with probably more people last time than this time. Then and now, I'm seeing a lot of people with public sector salaries, in comfortable positions. It was our responsibility then to do a good job for the citizens of Glasgow who are facing financial calamity and I think that's still true, especially with PIP looming. In a years' time how will we have done in relation to PIP? How will we know, not just individually but collectively?

It's been a very interesting year and we've rather stuttered through it. As with anything that starts uncertainly, there have been good things and not so good things. We learn by trial and error, that's how systems develop, not by grand design.

After a slow start, progress has picked up, as reported at this meeting. The Glasgow Centre for Population Health has been absolutely key, providing the continuity that's allowed us to survive the stuttering start. I hope the Centre will continue to provide the coordination and continuity that's needed for what we're engaged on, which is a complicated exercise in joint working. It's difficult. Everyone is working in particular circumstances often with imperatives and lines of accountability that are powerful in themselves but also in perverse ways a constraint and impediment to doing the right thing. That continues to be a challenge but we're in a stronger place than we were a year ago because relationships are growing.

In general practice there is quite a sophisticated understanding of relationships and how you make them productive, based on mutual understanding and respect. With good experiences and with confidence you develop trust and you move on to the next thing. That's beginning to appear in the relationships between the various parties here. I think we have a better understanding of each other and that is a better basis for joint work.

I'm coming at it from a Deep End point of view and have to observe that there are many fewer GPs here than last year. I think that's because the system is under more pressure than it was last year. So we have representative GPs, just two here today, and one of the challenges is to consider how to spread what's been said here to the wider group of GPs so that they are aware of what's happening.

A key message today was that embedding advice, whether in libraries or in practices, seems for some people to be a pre-requisite for services that are acceptable and

accessible. That ties in with a lot of Deep End experience and is a very important message.

Access to records is not going to happen unless there's trust established between people who know each other. That has to come first.

One of the consequences of getting to know people better is that you can disagree in the nicest possible way. I respect the argument for centralisation but I'm also concerned about it. In General Practice we are dealing the whole time with centralised services which do very good work to their own standards but leave lots to be done elsewhere.

We talk about services being patient centred, but what is the patient the centre of? Sometimes it's a professional conceit. Often the patient is not in the centre but in the middle of a whole lot of centres, each of which have got to be accessed and requires skills to do so.

The Inverse Care Law is important. You can't tell by simply being busy that you're being busy with the right things, or with the right people. There is the question of patient agency and whether people will access and use services. Our experience in the Deep End is that many patients require services to be near at hand, to be available quickly and to be familiar for them to be taken up. I'm sure that's true for financial advice as well.

There's an argument for centralisation for people who can access centralised services but there's another category of person who won't do that and for whom we need the embedding of advice and support within practices. If we can't do it overnight and everywhere why can't we do some experiments and see whether it works or not?

There were some familiar messages today. There's a lot of information around and the challenge is to spread it. There's variation between practices that needs to be addressed through improved information and the establishment of norms that people feel uncomfortable being different from.

The comments from Housing about linking with general practices are well taken and I look forward to that.

It was great to learn what has been happening in Edinburgh. Our experience in the Deep End is that there is often lots to learn from that direction. The Christmas party test is an interesting new yard stick of the quality of joint working relationships.

Finally, there is DWP engagement and making our voice heard. If we have experience of working in the front line, that other people don't have, there's a responsibility to find our voice is and make it heard.

Abuilding project is required but not the big one at the Southern General, based on bricks and mortar. Our building programme is based on relationships, on the human resource. We need to produce something as ambitious as the new hospital but which is based on how we work together collectively across organisations to make the system work better for the citizens of Glasgow.

In summary, the report card after one year is that we've made good progress, we've made good relationships and we're moving in the right direction but these things are only important if we continue to do them and to be more productive next year. Otherwise we've made just a small start. We've gone too far to go back, so we have to go forward now.

ANNEX A PARTICIPANTS AT THE MEETING IN JUNE 2015

Breannon	Babbel	<i>University of Glasgow</i>
Sandra	Barber	<i>NHS GG&C</i>
Jane	Beresford	<i>NHS GG&C</i>
Kate	Burton	<i>NHS Lothian</i>
Mark	Charlton	<i>The ALLIANCE</i>
Geraldine	Cotter	<i>Money Matters</i>
Linda	de Caestecker	<i>NHS GG&C</i>
Maria	Duffy	<i>Pollok Health Centre</i>
James	Egan	<i>Glasgow Centre for Population Health</i>
Jackie	Erdman	<i>NHS GG&C</i>
Helen	Fallowell	<i>Maryhill & Possilpark CAB</i>
Edwina	Fitz-Williams	<i>Glasgow City CHP - South Sector</i>
Chris	Gourlay	<i>The ALLIANCE</i>
Alan	Gow	<i>Glasgow Carers Forum</i>
Dr Richard	Groden	<i>Tollcross Medical Centre</i>
Lesley	Haddow	<i>Glasgow City Council</i>
Claire	Hardie	<i>Jobs & Business Glasgow</i>
Greig	Inglis	<i>Glasgow Centre for Population Health</i>
Rukhsanna	Jabbar	<i>Jobs & Business Glasgow</i>
Lorna	Kelly	<i>Glasgow Centre for Population Health</i>
Alison	Linyard	<i>Glasgow Centre for Population Health</i>
Sarah	Littler	<i>University of Edinburgh</i>
Emily	McCurrie	<i>Glasgow City CHP - North West Sector</i>
Carol	McGurin	<i>Eastbank Conference & Training Centre</i>
Margaret	McIntyre	<i>Greater Pollok CAB</i>
Sharon	McIntyre	<i>Wheatley Group</i>
Laura	McMahon	<i>Drumchapel CAB</i>
Claire	Montgomery	<i>Maryhill & Possilpark CAB</i>

Frank	Mosson	<i>Bridgeton CAB</i>
Kelly	Mulhern	<i>Possilpark Health & Care Centre</i>
Lynn	Naven	<i>Glasgow Centre for Population Health</i>
Hugh	O'Neill	<i>Drumchapel CAB</i>
Cathy	Rice	<i>NHS GG&C</i>
Lyn	Ryden	<i>Carr Gomm</i>
Petra	Sambale	<i>Keppoch Medical Practice</i>
Roddy	Samson	<i>Granton Information Centre</i>
Noreen	Shields	<i>NHS GG&C</i>
Jamie	Sinclair	<i>Glasgow City Council</i>
Hazel	Smith	<i>Glasgow Housing Association</i>
John	Thomson	<i>Glasgow City CHP - North West Sector</i>
Graham	Watt	<i>University of Glasgow</i>

ANNEX B SAMPLE TOOLKIT FOR GENERAL PRACTICES

Benefits toolkit for the Keppoch Practice

1. The Local Money Advice Service

Maryhill and Possilpark Citizen's Advice Bureau, Possilpark branch
160-162 Saracen Street Possilpark Glasgow G22 5AS.
General enquires telephone: 0141 xxx yyyy

Drop-in times Tuesdays and Thursdays 10.00–15.30

Advise patients to attend as early as possible to secure appointment, 09.30 by the latest

Drop-in sessions take place at the Maryhill office:
25 Avenuepark Street
Glasgow G20 8TS
Telephone: 0141 xxx yyyy

Please note In the case of financial emergency, direct patient to the CAB drop-in session, or complete money advice referral form (see below) and telephone the CAB administration team to inform them that this patient requires an urgent appointment.

Admin team telephone: 0141 xxx yyyy

2. Money Advice referral procedure

Money Advice referral form is available on DOCMAN in practice documents under 'money advice.'

Paper form is completed by the GP, and picked up from reception by the local CAB. Patients should be seen in approximately 2 weeks following referral to this service.

3. The benefits system and GPs: an overview

The Benefits System; A short guide for GPs (DWP, 2013). Available from:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/249923/gp-benefitguide.pdf

See also http://www.gla.ac.uk/media/media_419088_en.pdf

4. Benefits teaching resource for GP trainees

See http://www.gla.ac.uk/media/media_419088_en.pdf

5. Templates for benefits forms

Templates for ESA and PIP forms – See
http://www.gla.ac.uk/media/media_419088_en.pdf

6. Welfare reforms notices for patients

PIP waiting room notice – See
http://www.gla.ac.uk/media/media_419088_en.pdf

ANNEX C CASE STUDIES

Case study 1

Embedded advice worker at Possilpark Health Centre

This particular client was one of the earliest referrals that I received on this project, and she was referred to me because she had multiple debts and was really struggling financially. Simply meeting the basic needs of life was incredibly difficult when I first saw her; she was struggling to pay her rent, and did not have enough money for food. She has two young children, so she was particularly distressed at being unable to provide for them. As you can imagine, her mood was very low, she wasn't sleeping properly, and she was very tearful.

The main things we did were to maximise the client's income, which was quite time-consuming and complex in this particular case, because her immigration status changed after she was referred to me. However, she's now getting everything she's entitled to, which has significantly increased her income and made life a lot easier. We also arranged token payments to her creditors, which means there's no longer a large chunk of her income going out every month to meet high repayments. The client's creditors are satisfied with this arrangement, so the client benefits because she's no longer getting letters all the time, she's no longer getting phone calls from creditors, and the peace of mind that that gives a lot of clients is really quite significant.

She now has a realistic budget, so she knows that she can meet the basics, she knows that her family is going to be OK, and that she can afford to feed them. She has more income now, so she's paying back her rent arrears which is a top priority, and something that was really worrying her, understandably. Her mood has lifted and she's now planning for the future.

She's actually still a client of mine because she's had some other changes of circumstances recently, so we're looking at doing some budgeting sessions now, one to one, so that with her changed circumstances she can financially plan for those and hopefully not get into difficulties in the future.

Case study 2

Embedded welfare advisor in Lothian

This case study is a thirty nine year old man who has been homeless for the last two years. So he's been sofa surfing. He was made homeless because of rent arrears, he's got mental health problems, he's been in and out of work, usually in low paid insecure employment and he also has substance use problems. He's also had a medical history of head injury, epilepsy, personality disorder, depression and COPD. His current medication is methadone treatment, antiepileptic drugs, antidepressants and inhalers. That's a fairly typical patient for the sort of person that we're supporting through this project. He was on employment support allowance, he was in the Work Related Activity Group, the WRAG Group, but unfortunately in December 2014 he had aspiration pneumonia and also went into status epilepticus which meant he had to be admitted to intensive care within the Royal Infirmary in Edinburgh. His ESA was being reassessed,

so after he'd been discharged from hospital he went for his work capability assessment, which many of you will be familiar with and he was found fit for work, despite clearly being very ill. This caused him huge concern because the decision maker with the DWP advised him that he now had to claim Job Seekers Allowance or else he wouldn't be entitled to any benefit at all. He saw the GP again, when he was extremely distressed, agitated, terrified about the conditionality that was now applied to his Job Seekers Allowance, and petrified about the sanctions that may be imposed on him because he felt he couldn't comply with the claimant commitment that he'd filled in with the DWP. He was suicidal and the GP was incredibly concerned about this patient's feeling of hopelessness and his feeling that he wanted to end his life. The GP was so concerned that he gave the patient a list of crisis support agencies and also started him on antipsychotic medication for his agitation. He also referred him to the Welfare Rights Advisor who was based at the practice. The way that we provide access to the Welfare Rights Advice is by appointment only, making appointments with the receptionist at the practice, in the same way as making an appointment to see the practice nurse after a GP has referred you to see a practice nurse. So that's what the patient did, he made his appointment to see the Welfare Rights Advisor and she was able to see him the following week. Within two days of her seeing him she submitted on his behalf a mandatory reconsideration letter. She was able to download from his electronic records all the necessary medical information, hospital letters which she was able to submit with his mandatory reconsideration letter as supporting evidence. He won his mandatory reconsideration and has now been put in the ESA Support Group, which means he's not going to be reassessed for ESA for some time. That's the type of case that our Welfare Advisors are working in every day. I asked the GP what he thought the impact on the patient was and he said "this patient's mental health has significantly improved, he didn't require to attend any crisis, or emergency services, the patient was so well that he's now managed to secure a tenancy and he's managing to hold down his budgeting with his ESA benefit and is thinking perhaps in the future about moving into employment. This is just one of many cases that I could have brought along but it shows how beneficial putting the advisors in the GP practices can be.