



A NEW FUTURE FOR SOCIAL SECURITY

CONSULTATION ON SOCIAL SECURITY IN SCOTLAND

RESPONSE BY GENERAL PRACTITIONERS AT THE DEEP END

We are pleased to contribute to this consultation, and do so on the basis of 7 previous reports from General Practitioners at the Deep End on the subject of welfare changes, their impact on patients and practices, and joint working between general practices and financial advice services, mainly in Glasgow. (1-7, Annex A)

We welcome the spirit and principles underlying the consultation, although these are unremarkable in themselves. The challenge is to devise new arrangements which are genuinely client-centred with high uptake rates and broad coverage. It needs to be clear by whom and by what criteria the performance of the new arrangements will be assessed, as a whole system and especially at a local level and where roles and responsibilities are widely distributed. It is currently a lottery whether people get the advice and support they need.

General practice is the main public service with regular contact with the general population and provides unconditional care, based on whatever problems a person may have. Although other services may be better placed to help people with specific conditions, general practice is the main contact point for people who do not meet specific criteria, who are not good at accessing services and who for one reason or another have “fallen through the net”.

GPs interact with the benefits system at various stages, referring to money advice services, completing disability benefit reports for the DWP, supporting patients who appeal against DWP decisions, or who have been sanctioned, and treating the health consequences for patients, and their carers, at each stage. Most of what follows also applies to medical reports for non-devolved work capability assessments.

Resources and information

Insofar as the new Scottish social security arrangements involve a role for general practice, account must be taken of the fact that the general practices most likely to be involved in helping patients with financial problems are least able to do so, as a consequence of inequitable funding arrangements. This is not a strong foundation on which to build.

Whether general practitioners can identify and help with patients' financial problems is complicated in socio-economically deprived areas by the general shortage of time within consultations and the high prevalence of physical, psychological and social problems that patients may bring.(8) Both are features of the Inverse Care Law in Scottish general practice,

whereby funding is generally flat across the social spectrum, in contrast to the prevalence of health and financial problems for which there are steep social gradients.

General practices in deprived areas are keen to help patients with financial problems but not at the expense of clinical care. Additional support is required. An important first step should be to review the social patterning of welfare benefits, to identify where benefit recipients are concentrated and to resource the new arrangements accordingly.

When the prevalence of financial problems is high, it is not difficult for advice services to be busy, especially when they are under-resourced, but this can leave some groups under-served, especially when they lack literacy and confidence in contacting unfamiliar services, or have disabling physical and/or mental health problems.

It should not be assumed that additional resources will provide “more of the same”. Services which require self-help, self-management and agency systematically exclude people who struggle to respond in this way. General practice is well placed to help patients whom other services find “hard to reach”.

The new social security arrangements should be supported by shared learning across the system, so that the “best anywhere” can become the “standard everywhere”. This will require an information system which records not only activity but also the “measurement of omission”, allowing the identification of people who may be eligible for welfare benefits but who have not so far applied or who have found the process too daunting. Comparisons of observed and expected activity in particular areas can help to monitor coverage and target excluded groups.

First contact

Although financial problems are seldom patient’s presenting complaint, it is often the case, especially in deprived areas, that financial problems are not far below the surface.

For general practitioners and other members of the primary care team to be helpful to patients, they need reliable, bespoke information on available advice services in their locality (i.e. names, contact information, times – see Benefits Toolkit on Reference 5, page 17).

Experience shows, however, that simply providing such information, even if kept up to date, may not be sufficient. Nor is the geographical proximity of advice services a guarantee of joint working. The key ingredient is a trusted relationship between the primary care team and the advisory service, often based on a named individual, working as part of the primary care team and who can be relied upon to respond to referrals quickly and effectively. A consistent feature of reports from General Practitioners at the Deep End is that referral services in deprived areas have to be prompt, reliable, flexible, local and, above all, trusted, if they are to work well for often vulnerable patients.

Patients report that the anonymity of accessing such advice within the general practice setting (“where nobody knows who you are going to see, or what for”) is a key determinant of acceptability and use.

The most helpful front line financial advisors are those who can work across a broad range of issues, either dealing with issues themselves or linking patients to other services. There are

good and bad examples of local arrangements, from which lessons should be learned, the key yardsticks being acceptability and use, rather than administrative convenience or efficiency.

For example, while advice for Citizen's Advice Centres can be of high quality, its availability is unreliable, as patients turning up for drop-in sessions can be seen by staff with varying knowledge and expertise. Lack of continuity is a problem. Seeing different advisors on different occasions can be demoralising, while serial encounters with the same person can build understanding and trust.

The Parkhead Project in Glasgow provides a striking example of the effect of embedding a financial advisor within two general practices, which has resulted not only in more referrals to the Greater Easterhouse Money Advice Project (GEMAP) than from the other 42 practices in the Glasgow NE Sector combined, but also a high proportion of first-time applicants and an average financial advantage per applicant of over £2000 per year. (7)

It should be noted that the previously successful long term example of an attached financial advisor at Craigmillar Health Centre in Edinburgh involved a practice with nearly 10,000 patients, with an advisor being present on two days per week. The 76 Deep End practices in Glasgow have a combined list size of about 320,000 patients. Applying the Edinburgh formula suggests the need for 32 advisors working on two days per week (i.e. 13 WTE). As practice list sizes in Glasgow are, on average, less than half that in the 4 Edinburgh Deep End practices, different local arrangements are needed in Glasgow, probably based on the newly established general practice clusters.

Simple feedback on whether and by how much patients' financial situations have been improved can encourage practice teams to refer more patients.

Providing medical information

General practitioners are often asked to provide information as part of a welfare benefit claim. While it is straightforward to provide information on medical diagnoses, GPs are seldom the best person to ask for information on how medical conditions affect disability and daily living. Such information is generally not recorded in patients' notes, so that while others, such as approved financial advisors, might access medical notes, subject to individual patient consent the information they can then access may not be sufficient.

Some simplification may be possible for life long conditions, whose severity and associated disabilities are not in doubt, leaving more detailed assessments for complicated cases e.g. the cumulative impact of multiple problems. The prevalence of multimorbidity should not be underestimated, especially in deprived areas where its onset begins 10-15 years earlier than in affluent areas.

In marked contrast to their relationships, contacts and communication with specialists in hospital services, GPs have virtually no contact with decision-makers in the DWP. Both groups have much to learn from each other.

Appeals

GPs are often asked to provide letters of support when patients are appealing against DWP decisions. GPs may also have to cope with the mental health problems, such as anxiety and

depression, which the appeals procedure can trigger. It is essential, in the new Scottish social security arrangements, that delays in the appeals process are kept to a minimum and that the processing time for appeals is a quality indicator.

GPs are not best placed to advise on disabilities in daily living, but their knowledge of patients, often extending over several years, can provide useful information on the genuineness of patient circumstances. They can also comment on issues which may be difficult to detect or assess on single occasions, such as fluctuating conditions and mental health status.

Writing letters of this sort is often done by GPs in the evenings, catching up on paper work after a busy clinical day. Some practices charge patients for such letters, while other practices decline to write letters at all. Consistency is unlikely to be achieved until routine general practice in deprived areas is adequately resourced and/or supported to address patients' problems (See above, Reference 8). Providing a fee per letter does not provide GPs with the necessary time.

Our experience of practice-attached benefit workers at Parkhead and Possilpark Health Centres, who know what information will best help a patient's case, is that they can be very effective in preparing letters on behalf of patients, based on reviewing patients' records, exploring the functional implications of diagnoses and checking with GPs for additional information, but this only works when the attached worker is known and trusted by the practice team. An impersonal bureaucratic approach would not achieve the same results.

Conclusion

Essential features of the new Scottish social security arrangements should be :-

- A whole system approach, including general practice
- Maximising uptake based on entitlement
- Strengthening the general practice contribution
- Bespoke local information and feedback for general practices
- Financial advisors working with groups of general practices on a named basis
- Resources (e.g. advisors) distributed pro rata according to need
- An information system to monitor activity and identify gaps
- Effective monitoring of joint working, involving all parties
- Professional development activities to ensure consistency and spread best practice
- The time taken to process applications and appeals should be a quality marker
- Clear accountability arrangements, to avoid fragmentation, inefficiency and gaps

These measures are needed especially in Glasgow, where three quarters of the 100 most socio-economically deprived general practice populations in Scotland are based.

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ANNEX A

DEEP END SUMMARY 27

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

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.

- 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).

“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>

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