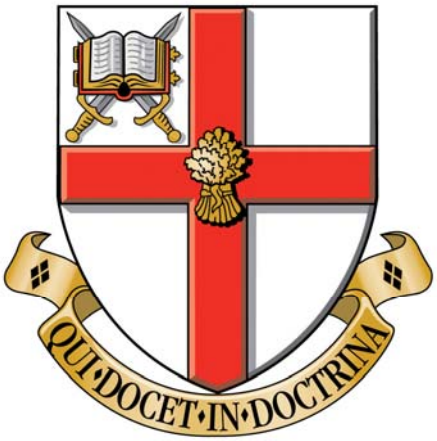

University of Chester

Evaluation of the Warrington District CAB GP Outreach Project

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Summary

Introduction

It is widely acknowledged that social deprivation is associated with ill-health (Acheson, 1998; Davey-Smith, Dorling & Shaw, 2001; Farmer, 1999; Marmot & Wilkinson, 1999). If social problems associated with deprivation are addressed, health among those living in deprived areas should, in theory, be improved. The Warrington District CAB GP Outreach Project was developed in order to address the wider determinants of health, and limit the impact that social welfare problems may have upon health.

Aims

The Centre for Public Health Research (CPHR), University College Chester was commissioned to undertake research to establish how successfully the project had met its objectives as stated in the original bid. The following outcome measures were used:

- access to the service, as reflected in service usage data on number of client referrals and contacts generated;
- reductions in self-reported anxiety following contact with the service;
- improvements in the financial situation of referred clients;
- improvements in health as measured by the SF-12 instrument;
- experience of the service from different stakeholder perspectives.

Study design and methods

A combination of both qualitative and quantitative research methods were used in order to meet the aims of the study. These included:

- routine monitoring data collected by the CAB (333 referrals to the service);

- a pre- and post-service intervention questionnaire (96 research participants);
- pre- and post-service intervention health status measurement, using the SF-12 instrument (90 research participants pre-service intervention, and 84 research participants post-intervention);
- semi-structured interviews with six service users, seven primary health care professionals and three CAB advisers.

Main findings

- Between August 2003 and September 2004, 333 clients accessed the service, an average of 28 per month.
- GPs made the highest number of referrals, making 120 (36%) in total.
- Clients had 1,603 contacts (face-to-face, letter or telephone) with the service, an average of just under five contacts per client.
- Of research participants who answered, 78% (69) reported feeling less anxious after seeing the CAB adviser, 2% (2) stated that they felt more anxious and 20% (18) stated that they felt the same as usual.
- A total of £356,753.95 was generated on behalf of clients in benefits, or financial assistance, as a result of accessing the service.
- Clients accessing the service had below average physical and mental health status as measured by the SF-12.
- No significant improvements in physical or mental health were observed as a result of clients accessing the service.

In the semi-structured interviews, service users reported that they found the service to be accessible (particularly those who were elderly, disabled or had been suffering with severe depression). Access to specialist advice, and help with filling out long and often complicated forms relating to benefit access, was also highlighted as a particular advantage for service users.

Primary health care professionals reported that they found the service a useful resource to utilise when dealing with patients presenting with social welfare issues, and that it provided them with a referral pathway to manage such patients. Health care professionals also reported that they were able to spend time more productively with patients. Health care professionals received positive feedback from patients whom they had referred to the service.

CAB advisers reported that many of the clients who had been referred to the service were having difficulties with debt, and were on a low income. Some clients had lost benefits or were not claiming benefits that they were entitled to, due to not being able to 'navigate' themselves through the welfare system without assistance. Advisers also reported observing 'real' improvements in clients as a result of accessing the service, but were also realistic in their expectations of improving health among those with severe mental illness or disability.

Discussion and conclusion

The Warrington CAB GP Outreach Project is meeting the needs of the people with whom it comes into contact. It has improved access to social welfare advice services for a vulnerable section of the local population, and has created an opportunity to work within primary care using a social model of health.

Chapter 1
Introduction

1.1 Social deprivation and ill health

In the UK, and internationally, it is widely acknowledged that social deprivation is associated with ill-health (Acheson, 1998; Farmer, 1999; Davey-Smith, Dorling & Shaw, 2001; Marmot & Wilkinson, 1999). Socio-economic deprivation has been linked to an increased risk of exposure to disease causing factors such as smoking, chemical hazards, poor nutrition, and lower standards of housing. However, it is not simply this direct exposure to disease causing factors that can be detrimental to health. Living in poor housing conditions and economically deprived areas can also generate social welfare problems. Indeed, Hoskins and Carter (2000) argue that increasing inequality leads to social isolation and chronic stress, which can impact on psycho-social pathways and damage life expectancy. Quick and Wilkinson (1991) suggest that income inequality also leads to individual stresses such as not being able to afford to pay bills, to buy new clothes, to send children on a school trip, or reciprocate the acts of kindness vital to the continuation of friendships. Furthermore, they argue that it is this kind of chronic stress that leads to the social isolation of the poor. Perhaps more importantly, it is the psycho-social effects of this chronic stress that is said to act on the endocrine and immune systems and result in more rapid ageing, susceptibility to infections and premature death from cardiovascular disease (Wilkinson, 1996).

It is widely acknowledged that if social problems and deprivation are addressed, health among those living in deprived areas should, in theory, be improved. Programmes that provide benefits advice in primary care settings aim to alleviate social welfare problems in order to produce better health outcomes within deprived communities.

1.2 Welfare advice in primary care facilities

Since the 1980s a number of programmes have delivered welfare and benefits advice in primary care facilities (Paris & Player, 1993). These programmes are based upon the underlying principle that people on low incomes should be able to access the benefits that they are entitled to, and that benefit advice should be provided in settings convenient to the client (Abbott & Hobby, 2002). Benefits advice delivered within primary care facilities also allows health professionals to refer patients directly if they have been identified as being in need of advice.

Anecdotal evidence suggests that many people, especially the elderly, are reluctant to seek advice from a high street Citizens Advice Bureau (CAB) (Hobby, 2001). This is often because they are embarrassed about seeking help with income (Frost, 1998). Furthermore, Frost also argues that there is strong evidence to suggest that it is the most disadvantaged sections of the population that do not claim all their social security entitlements. Reasons for this include fear of stigma, lack of understanding of the benefits system and difficulty in filling in forms. CAB services based in primary health care settings, with referral or recommendation from a health care professional, may help those who are not claiming benefits to which they are entitled, to feel that their claim is more legitimate (Veitch, 1995).

It is not uncommon for welfare benefits advice agencies to offer services in primary care settings and the impact of this is well documented (Abbott & Hobby, 2000, 2002). Studies have also assessed the impact of offering debt advice to patients in a primary care setting (Bundy, 2001). The effect of housing intervention on health has also been examined (Austin, Rao & Middleton, 1993; Blackman, Anderson & Pye, 2003).

1.3 The Citizens Advice Bureau

Since its inception in 1939 as an emergency service during World War II, the CAB has evolved into a professional, national agency (CAB, 2003). The CAB states that it provides free, confidential, impartial and independent advice on a variety of issues. These issues include debt, benefits, housing, legal matters, employment, immigration and consumer issues.

Each CAB is an independent, registered charity, relying on funding from the local authority and from local businesses, charitable trusts and individual donations (CAB, 2003). The CAB has over 2,800 different sites in England, Wales and Northern Ireland where advice is available. Each Bureau belongs to 'Citizens Advice', formerly the National Association of Citizens Advice Bureaux (NACAB), which sets standards for advice, training, equal opportunities and accessibility. Citizens Advice also contributes to the co-ordinating of social policy, media, publicity and parliamentary work (CAB, 2003).

Nationally there are 25,000 people working for the CAB, of which 79% are volunteers (CAB, 2003). These volunteers include trained advisers who can help fill out forms, write letters, negotiate with creditors and represent clients at court or tribunal; administrators; and, trustee board members.

1.4 The Warrington District CAB GP Outreach Project

The Warrington District CAB GP Outreach Project was developed in order to address the wider determinants of health (such as high levels of stress and anxiety caused by debt or housing problems), and limit the impact that social welfare problems may have upon health.

It was envisaged that the project would provide alternative resources for patients who attend primary care services with stress or anxiety-related illness associated with social welfare problems. The Warrington District CAB GP

Outreach Project seeks to address the root cause of stress and anxiety-related illness (that is, social welfare problems) rather than treating the symptoms (such as depression) through medication.

The Warrington District CAB GP Outreach Project is able to provide advice and support in a number of different areas which are listed below.

Benefits

- Appeals; eligibility; help completing forms; appeal representation.

Financial

- Managing debt; income maximisation; negotiating with creditors; bankruptcy; financial literacy and basic skills.

Employment

- Employment rights; contracts; redundancy payments; fair and unfair dismissal; sick pay; maternity rights; back to work training.

Housing

- Applications and eligibility for re-housing; housing conditions; residential care; avoiding re-possession; care home fees; transfers; tenancy agreements.

Health

- Disability rights; community care; industrial injuries; prescription charges and health costs.

Relationships

- Deaths; separation; child maintenance; childcare.

Legal

- Court action; compensation; legal aid; consumer rights.

The CAB GP Outreach Project provides a referral pathway (into the service) for a number of different health professionals. Among these are the following: GPs; health visitors; nurses; community mental health teams, and GP practice

receptionists. It is also possible for patients to refer themselves, for example, if they have seen an advertisement in their GP surgery.

Primary care staff identify patients who they think could benefit from a non-medical advice or support service in response to health problems arising from social welfare problems. These patients are then advised to book an appointment with the CAB GP Outreach Project via their surgery reception, or in some cases an appointment is made for them by the primary health care professional making the referral. An initial needs assessment will then take place between the patient and the CAB adviser at their local GP surgery at the appointed time. By assessing their needs, the CAB workers identify what action to take in order to address those needs. The patient is then invited to attend sessions for follow-up help and given further advice or updates if necessary, until the issue is resolved.

The project provides trained CAB workers, for one morning and one afternoon session per week, within primary care facilities in the eight most deprived inner wards of Warrington, which comprise the following: Poplars; Fairfield and Howley; Bewsey and Whitecross; Hulme; Orford; Poulton North; Latchford, and Westy. All practices within these wards are able to refer patients into the service, with each ward containing between one to four GP practices, numbering 17 in total.

The project objectives, as stated in the original bid, were as follows:

- to provide patients who attend Health Centres frequently with non-medical problems, alternative resources and referrals, which may appropriately meet their needs;
- to provide primary care staff with an effective non-medical intervention for patients;

- to demonstrate a reduction in frequent patient attendance for non-medical issues;
- to improve the physical and mental health of frequently attending patients;
- to make CAB advice accessible to patients in the primary care setting;
- to coordinate services between the patients, primary care staff, the CAB GP Outreach Project, the Consumer Support Network, Community Legal Services, other alternative referral agencies, and health promotion.

1.5 Aims and objectives of the study

This study is an evaluation of the Warrington District CAB GP Outreach Project. It aims to assess the extent to which the project achieved its stated objectives.

1.6 Structure of the report

This report is organised into a number of chapters. Chapter 2 presents a review of the relevant literature concerning previous projects that have incorporated a welfare advice service into a primary care facility. Chapter 3 details the study design and methods used during this investigation. Chapter 4 presents the findings and Chapter 5 discusses these findings in the context of relevant literature.

Chapter 2
Literature Review

2.1 Health inequality and primary care

Evidence suggests that there is a strong relationship between income distribution and health outcome (Wilkinson, 1996). The Black Report (Townsend & Davidson, 1982), and more recently the Acheson Report (1998), the Wanless Report (2002) and the White Paper on public health (Department of Health, 2004) identified that poverty-induced ill health still remains an important social problem. However, it is not simply how rich a nation is that determines the overall health of its inhabitants, but how *equitably* its wealth is distributed. Hoskins and Carter (2000) argue that countries which have narrow income differentials tend to have better health and that increasing income inequality leads to social isolation, chronic stress and poor health.

Low income and poverty have long been recognised as being key determinates of an individual's health. This link has been found to be consistent across studies, and universal access to health care does not seem to reduce health inequalities (Marmot, Ryff, Bumpass, Shipley, & Marks, 1997).

The influence of socio-economic deprivation may become apparent in primary care and therefore the provision of a welfare benefits referral service may help to provide a way of addressing welfare issues. Ennals (1990, p. 1321) argues that:

> *"Primary health care workers are in a uniquely influential position in relation to patients' access to benefits as they have a statutory role in the benefit system, that of providing medical evidence in support of certain claims."*

Hoskins and Carter (2000) argue that community nurses in particular may wish to more readily consider referring patients into welfare benefits advice services. Many aspects of the benefit system, such as incapacity benefit, disability living allowance (DLA) and attendance allowance are directly related to poor health and disability. Hoskins and Carter (2000) contend that it is very likely that a high proportion of a community nurse's caseload will include the mentally ill, the chronically sick, the elderly, low income families and ethnic minority groups, all of whom have a history of not claiming benefits to which they are entitled (Oppenheim & Harker, 1996).

However, it is unrealistic to expect primary care staff to maintain an accurate knowledge of the welfare benefits system since the range, eligibility criteria and value of benefits are constantly changing (Ennals, 1990). Therefore, the specialist provision of welfare rights may be needed in primary care settings.

Mechanic (2001) argues that although the time spent with patients in consultation is increasing, the pressures caused by increased roles (for example, health promotion) create extra demands on GPs, which can only be relieved through the reconfiguration of practice services. The introduction of CAB services in primary care has, according to Galvin, Sharples and Jackson (2000, p. 281), "created an opportunity to work within a social model of health by addressing poverty, bad housing or poor working conditions".

Advocates of providing such services may be encouraged by the change in government policy and willingness of agencies such as the CAB to provide them. However, Harding, Sherr, Singh, Sherr, and Moorhead (2002) warn that provider goodwill, endorsement and backing are crucial if extended welfare service provision is to be made available. Furthermore, that unless providers are committed to the concept of welfare provision and see the primary care surgery

as a venue for such provision and as an appropriate referral point, the links and solutions to welfare provision and health may not occur.

2.2 Citizens advice in primary care

Services that offer citizens advice in a primary care setting have been available (albeit somewhat sporadically) for over a decade (Paris & Player, 1993), and there is a good deal of interest in providing such services.

CAB within primary health care centres complement high street CAB services and provide access to its services and trained advisers. Despite much interest and research evidence linking poverty to poor health there is limited published literature about the CAB and, in particular, its role in primary health care. In 1998, Syme speculated that interventions aiming to reduce health inequalities may be difficult to undertake and that, to date, there have been few practical interventions.

There is however, increasing evidence that the provision of benefit advice within primary care facilities has a positive impact on health. Veitch (1995) reported a trend towards improvement in almost all fields of the Nottingham Health Profile among participants who received CAB advice in primary care facilities. Administering the Nottingham Health Profile to 52 patients however, Veitch found that the sample size was too small to show statistical significance, the instrument was not sufficiently sensitive, the experiment did not control for extraneous factors and the length of the experience may have been insufficient to show any effects. Generally, there has been concern about the small sample sizes used in these studies (Emanuel & Begum, 2000) and the difficulty of isolating the effects of CAB intervention from other factors.

A study by Abbott and Hobby (1999) reported that participants who received an increase in income as a direct result of a CAB in primary care programme had

significant improvements in three aspects of the SF-36: vitality, role functioning and mental health, (the SF-36 provides a score of functional health and well-being as well as physical and mental health). However, after 12 months these improvements had not been maintained. Among those whose income increased, 69% stated they believed that this had improved their health-related quality of life. Among those whose income increased as a result of the programme, Abbott and Hobby (1999) also reported a trend towards reduced GP consultation rates and first time prescribing. Another CAB in primary care study by Abbott and Hobby (2002) reported that participants whose income had increased had sustained improvements in mental health domains of the SF-36.

Previous evaluations of projects similar to the Warrington District CAB GP Outreach Project have focused, in part, on the statistical returns of the number of patients using the service, the number of enquiries they made and the income generated as a result of welfare benefit gains (Coppel, Packham & Varman, 1999; Emanuel, 2002; Emanuel & Begum, 2000; Galvin et al., 2000; Middlesbrough Welfare Rights Unit, 1999; Paris & Player, 1993; Veitch, 1995). Generally, these studies reported that most enquires made by patients related to welfare benefits. However, Galvin et al. (2000, p. 281) pointed out that the "majority of consultations related to financial and social problems, they were not dominated by benefit claims alone". These studies, as well as those of Pacitti and Dimmick (1996); Warden (1996); Bird (1998); NACAB (1999); Abbott and Hobby (1999), found considerable under-claiming particularly by those people suffering from mental health problems and significant increases in benefit claims when patients were given advice in these settings.

In a recent qualitative study, Moffatt, White, Stacy, Downey and Hudson (2004) found that welfare advice resulted in increased financial benefits for some clients. However, they also reported that among those interviewed, respondents reported a range of other benefits that cannot be measured purely

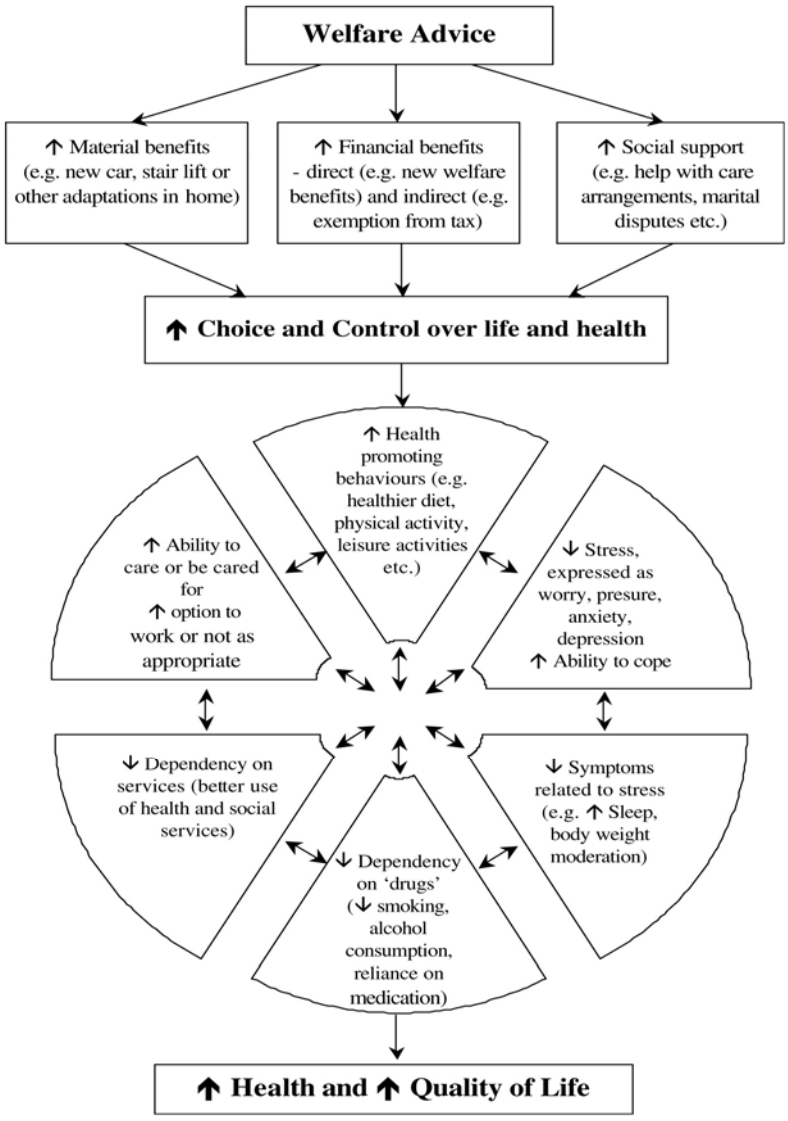
in monetary terms and relate more closely to quality of life. For example, material benefits such as exemption from council tax, free prescriptions or home adaptations, and social benefits, such as help with care arrangements and improvements in family relationships. As well as these, respondents in the study reported reduced stress and anxiety, better sleeping patterns, reversal of weight loss, reduction or cessation of smoking and improved diet and physical activity. Moffatt et al. (2004) suggest that respondents' narratives emphasised the importance of biographical, social and cultural factors as explanations for health status and behaviour.

Moffatt et al. (2004) also used what they describe as recurrent themes that emerged from participants' accounts, to develop a theoretical model (Figure 2.2.1) for understanding the relationship between welfare advice and improved health-related quality of life. According to Moffatt et al. (2004) these themes support existing elements of theory concerning the relationship between socio-economic position and health. The model highlights the complex web of interactions between financial and material resources on the one hand, and a range of social, behavioural and health outcomes on the other. Its central premise is that recipients of increased financial resources gain greater choice and control over their lives, which in turn, results in greater self-esteem (Charlton & White, 1995).

Another important concern since the introduction of services that offered welfare advice to patients in primary care was the way in which these may affect patients' use of health care services (Abbott & Davidson, 2000; Abbott & Hobby, 1999, 2000; Emanuel & Begum, 2000). Impact in this regard was less than expected. Generally, there were no significant differences reported in the use made of the health service between those receiving advice and those who did not. The one exception was in a study by Abbott and Davidson (2000) who

reported a significant reduction in the number of GP consultations and new prescriptions for those followed up after 12 months.

Figure 2.2.1 Theoretical model for understanding the relationship between welfare advice and improved health-related quality of life (Moffatt et al. 2004, p. 305) (Reproduced courtesy of Taylor and Francis Ltd, see: http://www.tandf.co.uk/journals)



The reports on patients' experience of the service and the attitude of GPs and practice staff to the service are less well documented and yet these are critical to the establishment of a successful service. It is likely that unless patients feel comfortable in seeking advice in these circumstances they will not use the

service, and unless a GP, or other member of the primary health care team thinks that an advice service will benefit their patients, and that an advice worker will fit within their practice 'team', they may be unlikely to make the referrals required to establish the service successfully.

As with the impact on patients, the reports of the perceptions of GPs and other primary health care staff are somewhat ambiguous. Early studies suggested that doctors and practice staff welcomed the presence of an advice worker into their surgery, and that access to a trained adviser had proved a valuable resource to practices that could subsequently make non-medical referrals (Veitch & Terry, 1993). However, not all studies agreed. Chaggar (1993, p. 261) reported that the provision of such services may lead to the view that GPs are "responsible for, and indeed expert on, every welfare, social and medical issue that effects their patients."

2.3 Conclusion

The literature examined in this chapter illustrates that there is an increasing provision of social welfare advice services in primary care. It also shows that the majority of people accessing such services do so for benefit, debt or other financial advice. Indeed, given the assumption that poverty affects the health of populations, then it seems to follow that increasing the income of low-income individuals should improve their health in some, albeit possibly small ways. However, the causal pathways that link socio-economic status and health at both population and individual levels could be considered at best to be 'very complex'. For this reason it may be difficult to define the exact potential for social welfare advice services to impact on health and health improvement.

The next chapter tackles this issue, and indeed the questions this raises regarding appropriate indicators of success in evaluation.

Chapter 3
Study Design and Methods

3.1 Introduction

This was a case study designed to evaluate the Warrington District CAB GP Outreach Project. A combination of qualitative and quantitative research methods were used. It is often useful to combine these methods in social research, particularly when the study seeks to provide a description of a service and the extent to which it is utilised (Kumar, 1999).

This study aimed to assess the extent to which the project achieved its stated objectives. The following outcome measures were used:

- access to the service, as reflected in service usage data on number of client referrals and contacts generated (CAB routine monitoring data);
- reductions in self-reported anxiety following contact with the service (pre- and post-service intervention questionnaire);
- improvements in the financial situation of referred clients (CAB routine monitoring data);
- improvements in health as measured by the SF-12 instrument (pre- and post-service intervention questionnaire);
- experience of the service from different stakeholder perspectives (qualitative semi-structured interview data).

3.2 Ethical approval

The ethical issues inherent in this project were considered and scrutinised by South Cheshire Local Research Ethics Committee. The Committee approved the study in April 2004.

3.3 CAB data

Routine monitoring data collected by the Warrington District CAB GP Outreach Project, were included in the study and used for analysis. These data are derived from 333 referrals that were made to the service between September 2003 and August 2004. These 333 service users generated 1,603 contacts. The data collected here relate to the number of individuals referred into the service from the eight inner wards of Warrington, referral details, such as the surgery from which a client was referred, outcome information (such as improvements in a client's housing situation) and details of any successful benefit application or financial gains awarded as a result of contact with the service.

Three detailed, anonymised case studies of clients' contacts with the service were also obtained from the CAB GP Outreach Project; this was in order to gain an insight into the workload generated by a typical referral.

3.4 Measuring health improvement

The study utilised a cohort design with pre- and post-intervention measures using the following:

- SF-12 instrument (Appendix 1) collected at pre- and post-intervention;
- evaluation questionnaire (Appendix 2) collected at pre- and post-intervention.

The evaluation study did not draw upon a sample of participants from the Warrington District CAB GP Outreach Project. Instead, the cohort included all participants who were referred to the service and consented to take part in the study during the evaluation period. This resulted in a sample of 96 research participants. Clients were invited to participate in the study when attending their first appointment with a CAB adviser and given an evaluation study 'participant information sheet' (Appendix 3). Only participants over the age of 16, and with sufficient cognitive functioning to understand the consent process

were invited to participate in the study. Once the clients had agreed to take part in the study they were asked to sign a consent form (Appendix 4).

The instrument used to measure health status was the Short Form 12 (SF-12) (see Appendix 1). It produces a 'health score' of between 0-100 with higher scores indicating a better state of health (Ware, Kosinski, Turner-Bowker, & Gandek, 2004). The SF-12 has previously been used to measure health gain as a result of using some kind of primary care-based welfare service in similar evaluation studies. Evidence suggests that the SF-12 is both sensitive to detecting change in psychosocial health dimensions, as well as being appropriate for a general practice-based population (see for example, Abbott & Hobby, 2002).

The SF-12 instrument was administered to clients of the CAB GP Outreach Project at two intervals. The first instance was at the client's first contact with the CAB adviser (pre-intervention) and the second instance was after the client had used the service and their case file had been closed (post-intervention). This was done in order to be able to make a comparison between scores pre- and post-intervention. Scores for each individual included a Physical Component Score (PCS), a Mental Component Score (MCS) and a total score. All component scores were aggregated pre- and post-intervention to allow an overall comparison to be made.

The SF-12 is a shorter version of the Short Form 36 (SF-36). Many studies have found the SF-36 to have good levels of reliability. High coefficients have been reported for inter-item correlations, internal consistency, test- re-test consistency and alternate form reliability (Bowling, 1997; McDowell & Newall, 1996; Ware, 2000). The SF-36 has been found to have moderate to high levels of correlation with other health measures, indicating good criterion validity (Bowling, 1997; Jenkinson et al., 1997; McDowell & Newell, 1996; Ware, 2000).

In the UK, studies of the SF-36 have found the instrument to be more sensitive in gradients of poor health than the Nottingham Health Profile (Hunt et al., 1986 cited in Bowling, 1997). It has also been reported that the SF-36 is a sensitive measure of change in health status in the general population.

The SF-12 measures the same eight dimensions as the SF-36, although in less detail and with less precision. Testing of the SF-12 has reported that the tool is able to reproduce 90 percent of the variance in sub-scale measures that the SF-36 achieves (Ware et al., 1996 cited in Bowling, 1997). Jenkinson et al., (1997) suggest that the SF-12 provides an almost identical measure of ill-health compared to the SF-36. Given this finding the authors agreed that the shorter SF-12 was preferable to the SF-36 as it is considerably shorter and therefore requires less time for completion, approximately 3-4 minutes (Ware, 2000).

The twelve items on the questionnaire measure eight dimensions of health. These include physical functioning, role limitations from physical problems, role limitations from emotional problems, mental health, vitality, pain, general health perception and perception of changes in general health (McDowell & Newell, 1996). Respondents are typically asked questions about their health during the last month. The response format is either yes/no or a single response selected from a six-point scale of 'none' to 'very severe' (Bowling, 1997).

The SF-12 instrument was embedded within the pre- and post-evaluation questionnaires (Appendix 2).

3.5 The pre- and post-intervention questionnaire

The pre-intervention questionnaire (Appendix 2) was used to collect demographic data as well as data regarding why/how service users had been referred to the service and whether or not they had been suffering from any stress-related symptoms of anxiety. The post-intervention questionnaire

(Appendix 2) was used to collect service evaluation data, including the outcome of the respondent's contact with the service, together with the respondent's views of the service more generally.

3.6 Stakeholders' views of the Warrington District CAB GP Outreach Project: semi-structured interviews

Semi-structured interviews were carried out with a variety of stakeholders involved with the Warrington District CAB GP Outreach Project. Seven health professionals, three CAB advisers and six service users were interviewed. Interview schedules can be found in Appendix 5.

Semi-structured interviews were selected because this method provides a loose structure, which utilizes open-ended questions that define the area to be investigated, but which will allow the interviewer or the interviewee to deviate in order to pursue particular areas in more detail (Bryman, 2001). This type of interview focuses strongly on the interviewee's point of view, going off on tangents is often encouraged as this gives insight into what the interviewee deems as relevant and significant (Bryman, 2001). This approach to questioning is not restricted to particular questions, rather it allows the opportunity to ask new questions that follow up interviewees' replies and is therefore increasingly flexible.

The sampling method for all interviews was purposive. Purposive sampling is a deliberately non-random method which is often used in qualitative work. It seeks to select people who have knowledge of a subject which is of value to the research process (Bowling, 2002). Purposive sampling constitutes a judgement by the researcher as to who can provide the best information to achieve the objectives of the study. This type of sample is considered extremely useful where it is desirable to construct a historical reality, describe an event, or expand upon something about which only a little is known (Kumar, 1999).

3.6.1 Interviews with health professionals

In order to achieve a detailed picture of the programme and to obtain a range of perspectives, seven health professionals were interviewed. These were a general practitioner (GP), two practice nurses, a health visitor, a GP receptionist, a community psychiatric nurse and a practice administrator. Health professionals were selected from the participating practices within the eight inner wards of Warrington. They were specifically selected from different practices and drawn from a variety of professional backgrounds in order to capture any variation, and to represent the range of health professionals that are present in the primary care setting. Not all of the health professionals interviewed had referred patients into the service.

Health professionals were selected on the basis of being 'key informants'. They were initially approached by staff from Warrington Primary Care Trust (PCT) to ask if they would be willing for the researcher to contact them by telephone to arrange an interview. Each interviewee was given a Participant Information Sheet (Appendix 3) and was asked to sign a consent form (Appendix 4). These were posted to each interviewee approximately one week prior to the interview taking place. None of the health professionals approached declined to be interviewed.

3.6.2 Interviews with CAB advisers

CAB advisers were also selected on the basis of being 'key informants', and were interviewed for a number of reasons. Firstly, very little literature exists regarding the fundamental differences between the high street CAB service and the service provided by a project such as the Warrington CAB GP Outreach Project. It was the intention of this evaluation study to explore, and reveal the complexity of work being undertaken by the CAB GP Outreach advisers, and how the service differs from the high street service. Secondly, the purpose of the interviews was to explore the advisers' perceptions of benefits to both clients

and the health service more generally. It is helpful for evaluation purposes to examine not only the views and perceived outcomes of those who use and are referred to the CAB GP Outreach Service, but also to consider how the service is perceived by those who provide it.

It was envisaged that these interviews would be conducted until a point of data saturation was met. This was reached after three interviews had been conducted. Qualitative research theory supports the determination of interview sample size by data saturation analysis (Bowling, 1997).

Although the CAB advisers who were interviewed were all working as part of the Warrington CAB GP Outreach Project, advisers were selected from different participating practices within the eight inner wards of Warrington. This was done to obtain a range of perspectives, particularly in relation to the 'types' of cases that advisers were dealing with on a day to day basis.

The project co-ordinator for the Warrington District CAB GP Outreach Project was contacted by the researcher and asked to approach a number of CAB advisers on the researcher's behalf. Once advisers had agreed to take part in the study, an interview was arranged between the researcher and CAB adviser. Once again each interviewee was given a Participant Information Sheet (Appendix 3) and asked to sign a consent form (Appendix 4).

3.6.3 Interviews with service users

Six service users were interviewed about how, and in what ways, the service had helped them, focusing specifically on feelings of the alleviation of stress and anxiety. The interviews also explored their views on the service that they had received. All interviewees had been through the process of referral (or self-referral), and had had one or more consultations with an adviser (as well as any number of other correspondences). Four service users had reached an outcome

regarding their particular case and according to project procedures were classified as 'case closed'. This point of case closure had been reached by these interviewees between 4 and 12 weeks prior to the interview taking place. One service user had resolved some of the social welfare issues for which they had originally been referred to the CAB GP Outreach Project, but was still receiving help and advice for subsequent issues.

Service users were approached and asked to take part in the study by the CAB adviser who had dealt with their case, and as such already had an established rapport with them. This was done in order to maximise participation in the study by allowing CAB advisers to explain the purpose of the study. Once service users had agreed to take part in the study an interview was arranged between the researcher and the service user.

Of the six interviews that were conducted with service users, five were telephone interviews and one was conducted face-to-face with the service user. Telephone interviews were conducted due to transport difficulties for service users. Also, due to the status of some service users being one of 'case closed' they did not require any further consultations with the CAB adviser and thus it was not possible to combine the interviews with consultations. It was not considered appropriate to request that service users should make a trip to their surgery for the exclusive purpose of being interviewed. Telephone interviewees were asked to give verbal consent to take part in the interview and were sent a Participant Information Sheet (Appendix 3).

The interview that was conducted face-to-face was carried out at the Warrington CAB GP Outreach office and the service user was able to combine the interview with a consultation with the CAB adviser. Although the service user would normally have consultations at the local surgery, it was not possible to combine both a consultation and an interview due to rooms only being available

for limited periods of time at the surgery. In this instance, appropriate travel expenses were paid by the CAB GP Outreach Project on behalf of the service user. The interviewee was given a Participant Information Sheet (Appendix 3) and asked to sign a consent form (Appendix 4).

The service user who was interviewed face-to-face was asked for permission to record the interview onto audiotape. After the interview the audiotape was transcribed. It was not possible to record the telephone interviews, therefore notes were taken during the interview and then written up in full immediately afterwards. A thematic analysis was carried out, with data being coded by theme.

Chapter 4
Results

4.1 Introduction

This Chapter presents the findings in relation to:

- access to the service, as reflected in service usage data on number of client referrals and contacts generated (CAB routine monitoring data);
- reductions in self-reported anxiety following contact with the service (pre- and post-service intervention questionnaire);
- improvements in the financial situation of referred clients (CAB routine monitoring data);
- improvements in health as measured by the SF-12 instrument (pre- and post-service intervention questionnaire);
- experience of the service from different stakeholder perspectives (qualitative semi-structured interview data).

4.2 Study cohort

Routine monitoring data presented in this report is derived from the 333 referrals to the service between September 2003 and August 2004. These 333 service users generated 1,603 contacts. Data were also collected from a sub-sample of 96 research study participants who gave their informed consent to participate in the pre- and post-service intervention evaluation. Semi-structured interviews with six clients, seven health professionals and three CAB advisers were also carried out.

4.3 Service use by age, sex and ethnicity

Of the 333 referrals between September 2003 and August 2004, 36% (119) were male and 64% (214) were female. These proportions correspond with average GP consultations and attendance (Office of National Statistics, 2002).

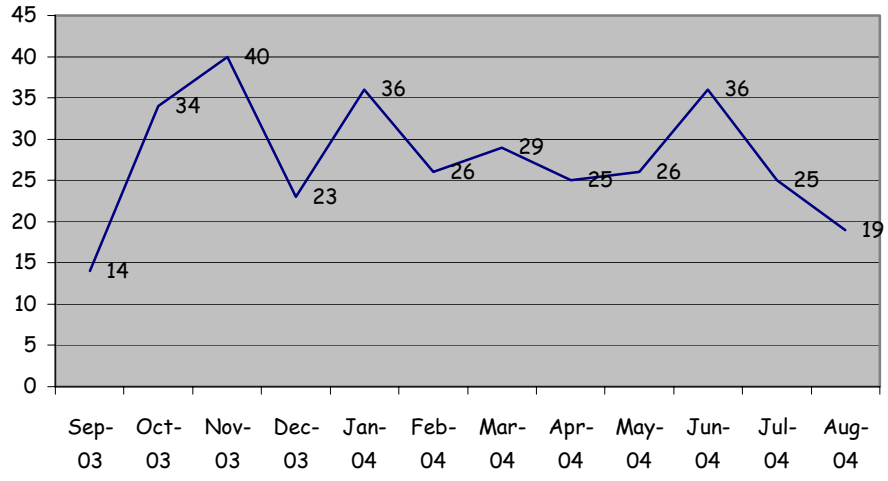
Clients aged between 19 and over 75 accessed the service. Of these, those aged between 55-64 accessed the service with the highest frequency (76, 23%), followed by clients between the ages of 25-34 (68, 20%).

Ninety-eight per cent of service users accessing the service during this period described their ethnic group as 'white'. This corresponds to the resident population in Warrington (Warrington Borough Council, 2001).

4.4 Referrals

Figure 4.4.1 below illustrates the trend in referrals from primary health care professionals between September 2003 and August 2004. Referrals were at their peak in November 2003 when the figure reached 40 referrals. The lowest recorded number of referrals was in September 2003 when the total number of referrals was 14. The average number of referrals made each month over the 12-month period was 28, while the total number of referrals made was 333. Seasonal variation in referrals is expected and in part reflects varying needs at different points in time, for example, greater need for debt advice after Christmas, as well as the general pattern of primary care usage throughout the year.

Figure 4.4.1 Number of referrals between September 2003 and August 2004



All primary health care professionals working in the participating practices can refer clients into the service. Table 4.4.1 (below) shows the total number of referrals made by primary health care professionals between September 2003 and August 2004. GPs made the highest number of referrals, making 120 (36%) in total. Overall, the highest number of referrals came from clients themselves, with 125 (37.5%) clients self-referring in total.

Table 4.4.1 Number of referrals made by primary health care professionals between September 2003 and August 2004

	Number	Percent
Self-referral	125	37.5
General Practitioner	120	36.0
Health Visitor	28	8.4
Mental Health Worker	17	5.1
Other	11	3.3
GP/Self	9	2.7
Receptionist	6	1.8
Nurse	5	1.5
Practice Nurses	3	0.9
Citizens Advice Bureau	3	0.9
Practice Manager	2	0.6
Social Worker	2	0.6
Midwife	1	0.3
District Nurse	1	0.3
Total	333	100

Table 4.4.2 shows referrals made by each GP surgery in the eight inner wards of Warrington in which the CAB GP Outreach Service is available. The number of referrals varies markedly, with Surgery 'A' making the most referrals (58, 17%), while Surgery 'L' was recorded as making the least referrals (2, 1%). It should be noted that Surgery 'A' was one of the first practices to be involved with the project.

Table 4.4.2 Referrals made by participating GP surgeries between September 2003 and August 2004

	Number	Percent
Surgery A	58	17
Surgery B	43	13
Surgery C	38	11
Surgery D	36	11
Surgery E	34	10
Surgery F	33	10
Surgery G	28	8
Surgery H	20	6
Surgery I	17	5
Surgery J	16	5
Surgery K	8	2
Surgery L	2	1
Total	333	100

Figure 4.4.2 shows the number of referrals made by GPs, and the number of self-referrals over time from September 2003 to August 2004. Anecdotal evidence from the service provider suggests that the initial high number of self-referrals was as a result of 'inappropriate' referrals. GP referrals vary from month to month ranging from a minimum of 4 in September 2003 to a maximum of 16 in June 2004. As awareness of the service increases over time, it is possible that the number of referrals from all primary health care professionals would increase. However, it should be noted that all referrals made by primary health care professionals (apart from those made by GPs) remained between 0-6 per month over the twelve-month period. This suggests that primary health care professionals were not referring to full capacity.

Figure 4.4.2 Number of self-referrals and referrals made by GPs over time between September 2003 and August 2004

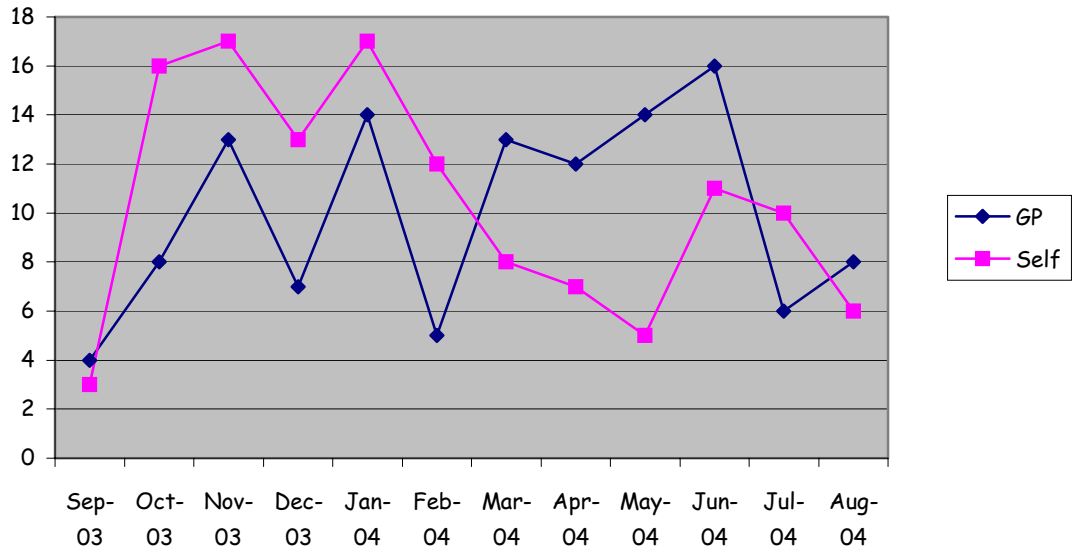
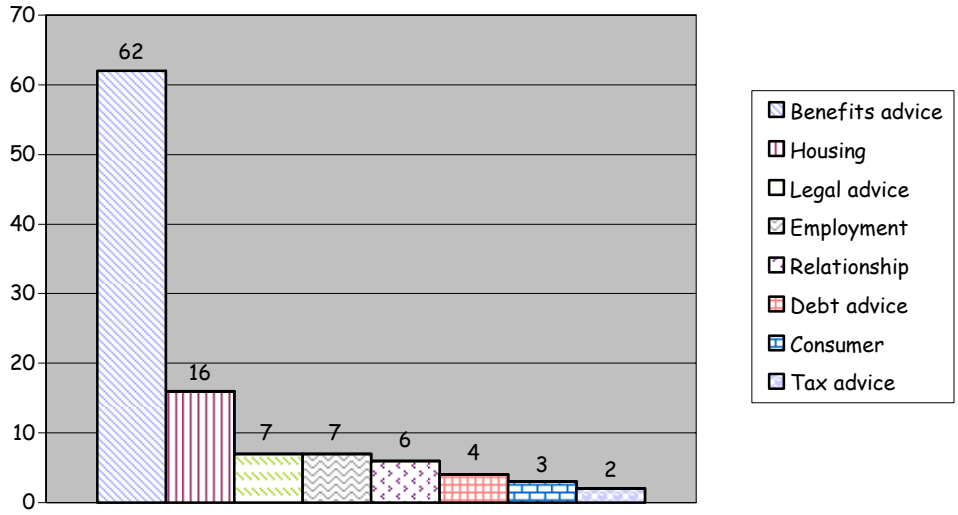


Figure 4.4.3 shows the reasons given by research participants (96) who consented to take part in the evaluation study, regarding the social welfare issue on which they were seeking advice. Research participants may have been seeking advice regarding one or more social welfare issues and therefore the values given here do not total 96.

Sixty-two people stated that they were seeking benefits advice, 16 people stated that they were seeking advice regarding housing, while two people were seeking social welfare advice related to taxation. Anecdotal evidence from the CAB GP Outreach Project suggests that many clients seek advice regarding debt issues, however, figure 4.4.3 shows only a small number (four) who stated that they were seeking advice regarding debt. It is possible that those seeking advice regarding benefits may have been doing so due to problems they were facing with debt, and may account for the low number of research participants seeking debt-related advice.

Figure 4.4.3 Types of social welfare issues on which research participants sought advice

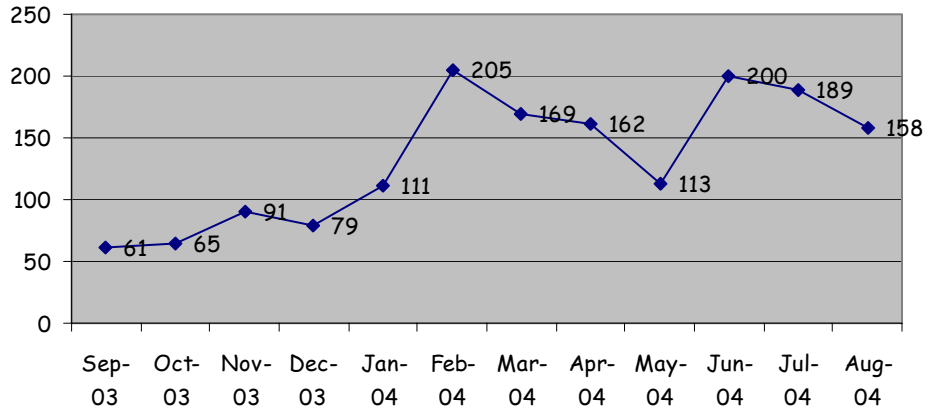


4.5 Contacts

The initial appointment with each client can generate several subsequent contacts in order to resolve the presenting issue(s). (A client contact here is defined as a face-to-face contact, a telephone call or a letter written to the client or on the client's behalf). Figure 4.5.1 below shows the number of contacts between September 2003 and August 2004. The 333 referred clients generated a total of 1,603 contacts in the 12-month period, an average of just

under five contacts per client. The number of contacts per month varied from a minimum of 61 (September 2003) to a maximum of 205 (February 2004).

Figure 4.5.1 Number of client contacts from September 2003 to August 2004



4.6 Workload generated by a typical referral

Table 4.6.1 summarises the work associated with a typical referral. Case 1 consumed a total of 6 hours and 40 minutes of the caseworker's time while Case 2 consumed 16 hours and 20 minutes.

Table 4.6.1 Case studies

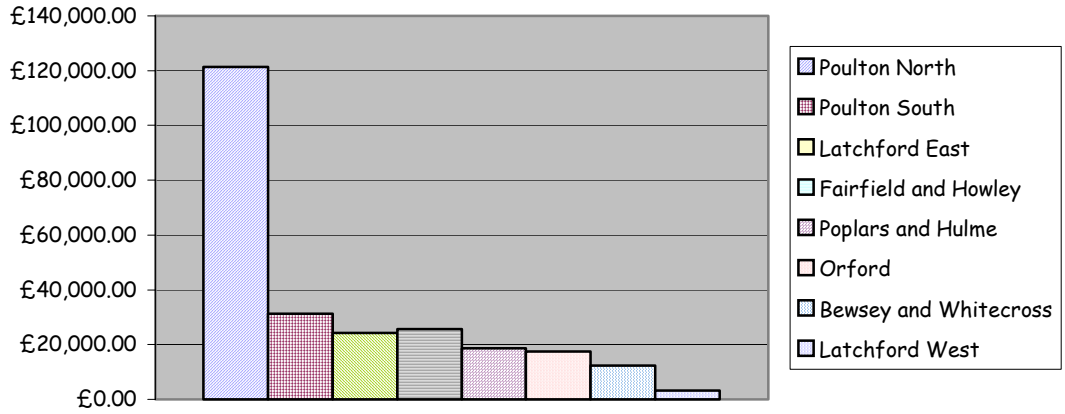
	Case 1 - Welfare Benefits Issue	Case 2 - Multiple Debt Issue
Total Interview Time	140 Minutes	560 Minutes
Total Casework Time	260 Minutes	420 Minutes
Letters Written	8	8
Telephone Calls Made	3	9
Other	Tribunal attended	County court attended

This indicates that the CAB GP Outreach Service provides in-depth support and specialist advice that would not otherwise be available to clients either in primary care or within the high street CAB service.

4.7 Finance generated for the eight inner wards of Warrington

It was agreed that the service would initially focus on the inner (most deprived) wards in Warrington. Figure 4.7.1 shows the amount of money generated by the CAB GP Outreach Project on behalf of clients living in the eight inner wards of Warrington between September 2003 and August 2004. Despite having the smallest population (6,640) (Warrington Borough Council, 2004), the ward that received the second highest amount of income generated by the CAB GP Outreach Project was Poulton South. Surgery 'A' is situated in this ward, and made the highest number of referrals which may account for the highest amount of money gained per capita. Poulton North received by far the highest amount of income generated by the CAB GP Outreach Service. This ward has only the third highest population (10,800) and contains Surgery 'E', which made the fifth highest number of referrals. The amount of financial gains for the client group generated as a result of this service indicates that income is going to those who live in the most deprived wards in the Borough of Warrington.

Figure 4.7.1 Finance generated for eight inner wards of Warrington



4.8 Clients' prior use of CAB services

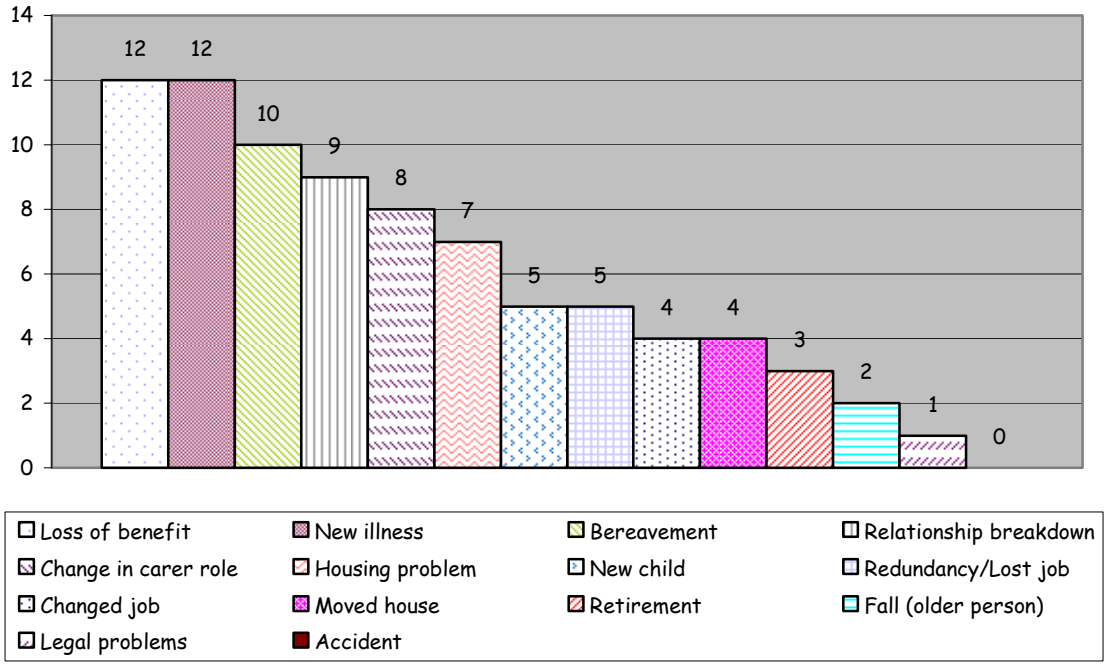
Of the total number of research participants (96) who consented to take part in the evaluation study, 21 (22%) service users had used a high street CAB service previously, while 64 (67%) had not. Eleven respondents did not declare whether they had previously used a CAB service or not. These data suggest that the

CAB GP Outreach Project is improving access to appropriate sources of specialist advice for those in need. The service also has the potential to capture or connect with those clients for whom a trip to a high street bureau is impractical, for example, due to mobility difficulties.

4.9 Life events as a precipitating factor in consulting the CAB GP Outreach Project

Figure 4.9.1 shows the number of individuals who stated that they had experienced one or more of the following life events during the previous six months: bereavement; moved house; redundancy/lost job; retirement; changed job; loss of benefit; legal problems; new illness; an accident; fall; relationship breakdown; taken on the role of carer or had had a child.

Figure 4.9.1 Number of individuals who stated they had experienced one or more life events during the previous six months



Twelve people stated that they had been diagnosed with a new illness while another 12 people stated that they had suffered a loss of benefit. Seven people had suffered bereavement in the previous six months. In total, 82 life events

had occurred among the study population of 96. Sixty-one respondents (64%) reported that they had experienced at least one life event.

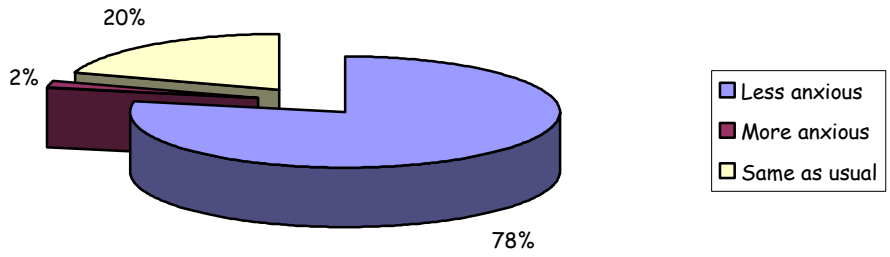
Sixty-nine per cent of research participants (66) stated that they felt anxious or stressed as a result of life events that had occurred in the previous six months, whilst 15% (14) said they did not. Three per cent (3) said it was not applicable and 14% (13) failed to respond to the question.

Research participants were asked if they had visited the doctor due to stress or anxiety during the past six months. Forty-six percent of research participants (44) reported that they had visited their GP due to stress-related problems, while 42% (40) stated that they had not. Fourteen per cent (12) failed to respond. This indicates that improving access to CAB services by locating them within primary care facilities can be a vehicle for more appropriately addressing stress and anxiety generated by life events.

4.10 Improvements in anxiety

Figure 4.10.1 shows the percentage of research participants who reported feeling less anxious, more anxious or the same as usual *after* seeing the CAB adviser. Seventy-eight per cent (69) of respondents who answered, stated that they felt less anxious after seeing the CAB adviser, 2% (2) stated that they felt more anxious and 20% (18) stated that they felt the same as usual. This indicates that addressing social welfare issues through contact with the CAB service can lead to reductions in anxiety for clients.

Figure 4.10.1 Research participants' self-reported anxiety levels after seeing the CAB advice worker



4.11 Improvements in financial situation

Table 4.11.1 shows the total amount of money gained from single (lump sum) payments for the 333 clients who accessed the service between September 2003 and August 2004. It also shows financial gains derived from annual benefits, for example, housing benefit applied for and granted, for this group of clients.

Table 4.11.1 shows that the highest amount of single payment sums was gained from DLA benefit. A total of £22,186.38 was gained in lump sum payments by the CAB GP Outreach Project on clients' behalf. The highest amount of money gained on an annual basis as a result of successful applications for clients to receive DLA was £92,901.20. The total amount gained from single payment sums was £33,868.60, while the total amount gained from annual gains was £118,111.86.

Table 4.11.1 Benefits gained on behalf of clients by the CAB GP Outreach Project from August 2003 to September 2004

	Single Payment Sums	Annual Gains	Total
Debt written off (bankruptcy)			£141,773.49
Disability Living Allowance	£22,186.38	£92,901.20	£115,087.58
Sickness Benefit	£5,084.13	£43,229.20	£48,313.33
Income Support	£2,540.54	£28,140.86	£30,681.40
Other	£1,063.24	£6,699.52	£7,762.76
Council Tax Benefit	£643.30	£6,998.46	£7,641.76
Housing Benefit	£892.13	£3,142.62	£4,034.75
Maternity Grant	£1,458.88	£0.00	£1,458.88
Total	£33,868.60	£181,111.86	£356,753.95

Table 4.11.1 also shows that the total amount of debt written off (due to bankruptcy) was £141,773.49. The total gain made by all clients who gained financially as a result of contact with the CAB GP Outreach Project, who used the service between August 2003 and September 2004, was £356,753.95.

4.12 Improvements in housing situation

Among the 333 cases dealt with by the CAB GP Outreach Project between September 2003 and August 2004, twelve required urgent action due to the client being in danger of being made homeless. This led to the following outcomes: client offered alternative accommodation; housing benefit issues resolved and back dated lump sum awarded; client received housing benefit award and possession order suspended; client offered more suitable accommodation by Warrington Borough Council; client received discretionary housing award and threat of eviction retracted; client advanced to priority band on housing list. Housing and poor accommodation conditions relate directly to health while the threat of homelessness can cause high levels of stress and anxiety. In these cases the service was able to support clients, prevent homelessness and reduce levels of stress and anxiety.

4.13 Health Improvement

The Short Form 12 (SF-12) instrument was used to assess health improvement in research participants who used the service. It produces a 'health score' of between 0-100 with higher scores indicating a better state of health. The SF-12 has previously been used to measure health gain as a result of using some kind of primary care-based welfare service in similar evaluation studies.

Eight measured dimensions of health are used to calculate a Physical Component Score (PCS) to measure physical well-being and a Mental Component Score (MCS) to measure mental well-being, which together constitute the total health score. A score of 50 would indicate an average 'normal' state of health, while a score above 50 would indicate above average health status and a score below 50 would indicate below average health status.

Table 4.13.1 shows the mean SF-12 scores for research participants who answered baseline and follow up SF-12 questionnaires (n=81). For the physical component score (PCS) the mean score for research participants pre-service use was 38.75, which indicates a 'below average' physical health status. The mean PCS score for research participants post-service use was 39.52, still indicating a below average physical health status but showing an increase of 0.76 when compared to the mean PCS pre-service use score. Despite this increase, no significant changes in physical health status have occurred (P = 0.523).

For the mental component score (MCS) the mean score for research participants pre-service use was 34.07, which indicates a 'below average' mental health status. The mean MCS score for research participants post-service use was 35.55, still indicating a below average mental health status but showing an increase of 1.47 when compared to the mean MCS pre-service use score. Once again it is not possible to observe any significant change (P = 0.335).

The mean total score for research participants pre-service use was 36.41, indicating a 'below average' health status, while the mean total score for research participants post service use was 37.53, still indicating a below average health status and resulting in a total increase of 1.12 when compared to the mean total pre-service use score. Despite this increase in total scores it is not possible to observe any significant change in health status (P = 0.165). However, it is evident that the CAB Outreach Project is reaching those clients who have below average physical and mental health. It is also important to note that the sample size was relatively small (96).

Table 4.13.1 Mean SF-12 scores for research participants' pre- and post-service use

	Pre service use score (Mean)	Post service use score (Mean)	Score difference post service use
Physical Component Score (PCS)	38.75	39.52	0.76
Mental Component Score (MCS)	34.07	35.55	1.47
Total Score	36.41	37.53	1.12

It is also important to note that the follow-up questionnaires were completed at the time of case closure. At this stage clients accessing the CAB GP Outreach Project may still be suffering from high levels of stress, anxiety, or be in a state of relatively 'poor health'. To gain a greater insight into any effects on health as a result of access to the CAB GP Outreach Service, follow-up data collected three months after case closure may be more insightful with regard to changes in health.

The next section presents the qualitative data collected from the interviews conducted as part of the study. All interviews were analysed thematically with data being coded by theme.

4.14 Clients' views on the CAB GP Outreach Service

This section presents the findings in relation to clients' experiences of using the service. Each client was allocated a client number in order to remain anonymous.

4.14.1 Improving access to CAB services

It is important to note that the possible benefits for clients who use a service such as the CAB GP Outreach Project, are not exclusively financial or benefit-related. Indeed, many clients who are referred will not, as a result, receive an increase in their annual income. However, as shown earlier, benefits to service users can take the form of, for example, ease of access to specialist advice and support.

> *"…especially for older people like me who have trouble walking and everything. Because it's at the surgery so you know, it's not far and it's easy to get to because you know where you are. You don't need to go all the way into town and everything"* (Client 1).

In relation to access, it was not only the issue of location that was highlighted as a benefit of using the GP Outreach Project rather than a high street bureau, but waiting time was also an important issue. The CAB GP Outreach Project allows service users to book an appointment with the CAB adviser, whereas high street bureaux are operated predominantly as drop-in centres that allow open access to anyone who may need to use the service.

> *"…yes, I've popped my head in from time to time [high street bureau], but they're always so busy, and I'm disabled you see and I can't wait around all that time, it becomes very uncomfortable and…well painful really"* (Client 3).

4.14.2 Access to specialist advice required to resolve complex issues

Another theme identified in the interviews with clients was the help that they were able to obtain regarding filling out long and often complicated forms:

> *"It did make me feel much better. Before I didn't understand what was going on but [adviser] explained everything to me and then everything seemed so much clearer. I had all these forms to fill in and to be honest I just felt like throwing them out the window and saying 'sod it', but then 3 weeks later it was all sorted"* (Client 1).

Another interviewee had a similar view stating:

> *"I felt a lot better because [adviser] has helped me out with a lot of things, even simple things like these daft forms"* (Client 2).

This indicates that clients can access specific, specialist help from which they themselves directly benefit.

The specialist advice that clients receive from the CAB GP Outreach advisers is unlikely to be available to them from a GP or other health professional. Indeed this was commented on by clients, and cited as one reason why it was preferable to discuss social welfare issues with the CAB adviser, essentially because more time was available. This also has repercussions for primary health care professionals as their time is freed up for addressing more appropriate matters.

> *"Well you know that the doctor doesn't have very much time and you know that you're on a time limit…It was a lot easier talking to the CAB people, you didn't feel like you were wasting the doctor's time, and you feel that they have the time to give you"* (Client 1).

It was also stated by clients that the specialist advice given by the GP Outreach Project takes a different, more thorough form than that which is available at a high street branch.

> *"She takes time to talk to you as opposed to the one in town. When you're there it's a case of 'what's your problem? Oh sorry we can't deal with that – go on'"* (Client 2).

4.15 Primary health care professionals' views on the CAB GP Outreach Project

One of the primary objectives of the CAB GP Outreach Project is to provide a referral pathway for primary health care professionals who have patients with social welfare problems. The majority of feedback from the interviews was positive with most negative comments made relating to a lack of space in the surgeries themselves. Finding somewhere adequate to house the CAB adviser, even for one afternoon a week, was often a struggle.

> *"We are a very small practice and we just haven't got the room. So we literally have to put the CAB where we can find a room"* (Practice Administrator).

With regard to referring clients to the CAB GP Outreach Project, many health professionals stated that they would refer when they felt that the patient had approached them or was seeking advice regarding 'inappropriate' issues that they were not trained to deal with, or did not know the correct answers or advice to give to the patient. For example, one health professional said:

> *"… I think, well I have not got the experience or the knowledge to be able to recommend or tell them what to do. So it tends to be I know where they can go to get it… then there is another avenue to go down as well as social services"* (Practice Nurse).

Many health professionals stated that they received positive feedback from clients whom they had referred into the CAB GP Outreach Project:

> "*Yes, it's all been very good and positive. Someone I referred recently to the service because they were on a low income and it was making them very stressed, depressed - have now increased their income by around £40 a week and when I see them they are much more able to cope with the other things, such as post-natal depression*" (Health Visitor).

Health professionals themselves also had a positive view of the project and the purpose of the project in general. Indeed, many appreciated the fact that such

support was available to them and were aware of the potential of the project to benefit their clients. One health professional commented:

> *"I think it's a very good project, I don't really see how it could be anything but good really. Anything that's going to help people be less stressed and anxious has to be good"* (Health Visitor).

Some criticism did stem from a lack of awareness of the project. A number of health professionals commented that they would like to see the project raise its profile in order to reach a greater proportion of the local population who may benefit from the service.

> *"I'd say it doesn't have a very high profile…Personally I think they could do with a bigger sign, more advertising for the project really. I'm sure a lot of people don't consult the doctors about problems because they know it's not appropriate. And they may or may not know about the CAB. General awareness of the CAB sessions in the surgery isn't that high really"* (GP).

However, despite the numbers of self-referrals into the service, promotion and advertising to potential service users within the surgeries was kept to a minimum in order to discourage large numbers of patients from inappropriately self-referring. It was anticipated that promotion of the service to potential users within the surgeries may result in an extremely high demand for appointments with the CAB adviser. This in turn may have resulted in time with the adviser being oversubscribed and due to a lack of resource, a large backlog of clients waiting to be seen by the adviser. GPs referring patients with an urgent need would not have been able to receive the attention that they required, and thus somewhat negate the aim of the service to provide easy access to specialist help and advice. This is supported by the initial high number of self-referrals into the service.

When discussing the kind of support that the CAB GP Outreach Project was able to provide, it was difficult for health professionals to identify specific outcomes for their patients (that is, resolving specific health problems) that

they could attribute directly to the CAB project. However, it was apparent that health professionals were able to call upon help and assistance when presented with social welfare issues that they themselves were unable to manage, or provide advice for.

> *"I don't know whether I would be able to discharge anybody because of it. I have certainly seen differences in them but I am not sure I would be able to discharge anybody because often they will get their financial problems resolved and then you will work with the other problems. But it is certainly one less problem for me to have to work with. I don't fill forms in. I haven't got that sort of time or training. It is not my area at all"* (Community Psychiatric Nurse).

Similarly, some health professionals were unable at this stage to notice a significant reduction in patients visiting the surgery.

> *"Probably because some of the patients that we see that we would refer, it tends to be a chronic illness rather than an acute thing so that wouldn't actually change and we would probably still see them a lot"* (Practice Nurse).

Once again however, the potential for the service to reduce workload, and therefore provide a support link for health professionals to utilise, was expressed.

> *"Yes I'd say potentially it could reduce some of my workload. And it probably does. I mean when they mention problems like that I suggest the CAB so it actually cuts short that bit of the consultation"* (GP).

This was also the case when commenting on the potential for the project to reduce medical prescribing.

> *"I don't know. I expect that it does change things because with problems giving medication isn't the only answer. And there will be situations where solving a person's or helping a person's social problems will be an alternative to medication. But I wouldn't be able to quantify that"* (GP).

4.16 Interviews with CAB advisers

Interviews with CAB advisers were also analysed thematically and a number of themes were identified. Four major themes emerged from conducting the interviews, these included: the types of social welfare issues presented to advisers; differences between the GP Outreach Project and the high street bureau; improvements for clients; the extent of the adviser's involvement with clients.

4.16.1 Social welfare issues presented to advisers

It is apparent from the interviews that the advisers are approached with a range of social welfare issues relating to disability (both physical and mental), and subsequent benefit claims, debt and finance problems. Advisers stated that these often lead to emotional problems such as stress, anxiety and depression. Social welfare issues emerging from consumer and relationship problems however, seemed to be dealt with less frequently.

> *"Lot of the problems are debt problems that they're coming to us now, which is obviously causing a great deal of stress, they might have the bailiffs about to call, they're in rent arrears, they're in debt with other people … they haven't enough money to live on, they have a disability situation which they probably haven't realised they can get help with…mainly financial and debt problems"* (Adviser 1).

When discussing the origin of clients' social welfare issues, advisers viewed many of these issues as stemming from a misunderstanding of, or lack of awareness and knowledge, regarding how *"the system"* works. Clients were then, it was explained, in a disadvantaged position and in danger of *"slipping through the welfare net"* due to the nature of an illness or disability they may be living with. One adviser described the majority of clients they see as:

> *"Predominantly people with a lot of mental health issues who are falling foul of the benefits system because it's so complex and because they're not able to work within it"* (Adviser 2).

The adviser also went on to describe how this may happen, for example, to someone who had mental health problems.

> *"A paranoid schizophrenic may have their benefit reviewed, but due to the nature of their illness they don't complete the forms correctly, and so it's taken away from them"* (Adviser 2).

The adviser also described the type of social welfare issues that arise in a case such as this:

> *"There's a knock on effect you see, I mean an appeal might take six months but the client has to live in those six months, and on what money now that their benefit has been taken away from them?"* (Adviser 2).

Another adviser explained that some clients are simply not physically able to follow the correct procedures that they need to, in order to gain the benefits to which they are entitled. This may be due to a disability which, for example, inhibits someone from being able to write. This is made more difficult for those who do not have carers or family members who are able to take on a caring role.

> *"For some of our clients…the disability is such that you've got to get them in, in order to actually complete things for them, they're just not capable of actually doing manual forms and that's their main problem"* (Adviser 1).

Another theme that emerged from the adviser interviews was the multitude of social welfare issues that many clients found themselves having to deal with. Despite many clients being referred to the service for assistance with one specific enquiry, CAB advisers commented that this was often the *"tip of the iceberg"* and that other, related, and sometimes more serious issues would emerge at the time of consultation.

> *"They usually come in with what they see as their main problem, but sometimes that isn't the problem, the presenting problem isn't the main problem at all when you get down to it, there's lots of things going on"* (Adviser 3).

It is possible that once an adviser has established a rapport with their client and created an atmosphere of trust, clients may feel able to discuss issues of a particularly personal nature more openly. Clients interviewed also suggested that the familiar and friendly surroundings in which consultations take place can also help them to feel more at ease with discussing sensitive issues.

4.16.2 Differences between the high street bureau and the CAB GP Outreach Project

Some clients of the CAB GP Outreach Project who had had previous experiences and contact with the CAB via a high street bureau, observed differences between the two services. The differences between a high street bureau and the CAB GP Outreach Service from the perspective of the advisers themselves can be summarised by one adviser's comments:

> *"Basically a high street bureau, they ring in, you answer the question you write to them, draft a letter but really then the client is perhaps left on their own to a certain extent, because we've signposted them where to contact. The difference with the PCT is that we take the client from cradle to grave all the way through the process, we're talking to them all the time, we're writing letters to them, we're following them up, so we're taking on a caseload as opposed to outside in the bureau where you don't as such have a caseload, you're just dealing with either public at the door or a phone conversation and taking them up to a level. So we're spending far more quality time with the client and making sure they're ok"* (Adviser 1).

4.16.3 Improvements for clients

All the advisers for the CAB GP Outreach Project regarded their roles and involvement with clients as having a significant, positive effect on the lives of their clients. An example can be seen from an account which details one adviser's involvement with a client:

> *"On the DLA side I managed to get it for a lady and she was overjoyed because she could then buy in a service which totally improved her health situation, whereas before she just couldn't afford it, and with the help she got through the system, she could*

afford to buy in a health service which she desperately needed" (Adviser 1).

However, advisers seemed to express a view of 'realism' with regard to the 'effect' that they can expect to have on some clients' health and general well-being.

> *"[In relation to a client suffering from a psychotic illness] I'm not going to help his health by fixing his benefit, but his mother who is his carer will tell me that what…by having a carer and the benefits, what I will do is stop him going to A&E, stop the police having to be called, stop social services having to be involved. So they're not actually tangible to me, but in the wider picture …"* (Adviser 2).

4.16.4 Extent of advisers' involvement with clients

Service activity can also be understood in terms of the amount of work that advisers undertake in order to assist clients with their social welfare issues. A typical debt-related case is described briefly below by one adviser:

> "*Once I'd seen the client, I wrote to all the creditors, once I'd got the info from the client. That was ten letters, and then I was waiting for 10 replies and responding to those. Once you contact creditors of course they then feel the need to contact you to see when they're going to get their money… you've got to manage those calls…but those calls are going to me [adviser] and not to the client so it's less stress for them and they can rest a bit easier"* (Adviser 2).

Advisers felt that they were *"taking the strain"* for many of their clients and that this in turn was helping to reduce stress and anxiety, and was one of the first steps in helping those clients suffering from depression.

Chapter 5
Discussion

5.1 Introduction

The findings of this evaluation are discussed here in relation to the objectives of the study and in the light of the literature reviewed in Chapter 2. They are also discussed within the context of health inequalities in Warrington and the outcomes for service users who were referred to the CAB GP Outreach Project. In particular, consideration is given to the provision of a support network for primary health care professionals, access to advice services among GP patients living within the deprived inner wards of Warrington, and benefits to service users. Specifically within this, attention is centred on improvements in health-related quality of life.

5.2 Supporting primary health care professionals

The literature reviewed as part of this study suggests that bringing primary health care and citizens advice services together, not only has the potential to benefit the health and quality of life of patients but also to benefit and support primary health care professionals and improve primary care. While CAB services can provide expertise in social welfare issues, primary health care workers are also in a unique position where they can influence patients' access to such services.

Findings from this show that the CAB GP Outreach Project has created an opportunity to work within primary care using a social model of health by addressing social welfare issues such as poor housing. By using the CAB GP Outreach Project, primary health care professionals are able to make immediate referrals into a service that can provide specific expertise in social welfare issues. It provides an alternative referral pathway to support primary health

care professionals to manage patients who visit GP surgeries with social welfare issues.

GPs made the highest number of referrals out of all primary health care professionals, making 120 in total. Although encouraging, and indicating support from GPs, referrals from other primary health care professionals were lower and may indicate that these were not referring to full capacity. This may reflect the larger number of GPs than any other health professional within the general practices, or a lack of awareness of the service on the part of others. Alternatively, GPs may be in a better position to ascertain whether or not a client may benefit from being referred into the service.

5.3 Access to services: closing the net

Studies show that people considerably under-claim benefits to which they are entitled. This was particularly the case where patients were suffering from mental health problems.

Twenty six per cent of research participants (18) stated that they had previously used a CAB service while 59% (41) had not. This suggests that the location of a CAB service within primary care facilities has resulted in greater and improved access for patients in the eight inner wards of Warrington, particularly for elderly, disabled and mentally ill clients. The CAB service provides specialist advice to a client base that would otherwise be unlikely to access support from a high street bureau due to, for example, mobility difficulties or mental illness. Therefore, the service is addressing the issue of people under claiming benefits to which they are entitled.

This point is further supported by the qualitative interview data from both service users and CAB advisers. Service users indicated that due to the service being accessible at the local surgery, it was much easier to attend the sessions,

particularly for those with mobility difficulties. As well as this, service users cited the fact that they did not have to *"wait around"* to be seen, as is the case in the high street bureau due to their drop in nature. Waiting in such an environment can also become very uncomfortable and even impossible for someone suffering with a severe disability. The CAB GP Outreach Project uses an appointment-based system and enables clients to 'double up' appointments with a primary health care professional and the CAB adviser.

During the interviews, health care professionals expressed concern that their patients were not aware that the service existed. They also remarked that they would like to see the project assume a higher profile, to encourage an increased proportion of the local population who may benefit from social welfare advice, to access the service. However, the number of referrals into the service may also be largely dependent upon awareness by primary health care professionals, particularly considering that a number of self-referrals may be regarded as 'inappropriate'. To achieve this, high profiling by the CAB is required, in order to ensure that potential referrers (primary health care workers) to whom the service provides a support network, are aware that they are able to refer patients into the service. Health care professionals can thereafter continue to refer patients into the service and integrate it into their repertoire of support.

During the interviews, CAB advisers described how their role was, in many ways, one of catching those who slip through the 'social welfare net'. Advisers viewed these clients as those who benefit most of all from the CAB GP Outreach Project; those who are unable (due to physical or mental disability or illness) to navigate themselves through the processes of the welfare benefit system.

5.4 The nature of the service: from start to finish

It is arguably the nature of the service that results in this *"closing of the social welfare net"*. The engaging and *"handholding"* characteristic of the service has

enabled a number of clients to complete welfare benefits applications and, as a result, gain financial support that they would not otherwise have been able to claim.

The service grants substantially more time and resource to each client than a high street bureau is able to, enabling the caseworker/adviser to present the client with a number of options, and, subsequently, to work through those options providing assistance where necessary. This also includes accompanying clients on necessary visits, as well as considerable liaison work.

5.5 Benefits to service users: improvements in health-related quality of life

Evidence suggests that improvements in health-related quality of life may indeed be mediated by a reduction in stress (Moffatt et al., 2004). Seventy eight per cent of research participants said that they felt less anxious after seeing the CAB advice worker. This indicates that contact with the service did indeed reduce self-reported anxiety for the majority of clients.

It was anticipated that many of those accessing the service would be under-claiming benefits to which they were entitled, the uptake of tax-free disability entitlements in particular were expected to increase. For some clients this was indeed found to be the case and the total amount gained on behalf of clients by the CAB GP Outreach Project reached £356,753.95 over a period of 12 months. From this it is possible to observe a more tangible benefit for clients who were referred to the service and achieved financial gains.

Perhaps more difficult to observe are changes in health for clients accessing the service. Previous studies (Abbott & Hobby, 2002), highlighted in the literature, have reported that participants whose income had increased, had sustained improvements in some domains of the SF-36 after six months.

However, another study by the same authors (Abbott & Hobby, 1999) showed that after 12 months such improvements had not been maintained.

This study did not reveal any significant change in SF-12 scores. However, evident in the literature are concerns that evaluations of services similar to the CAB GP Outreach Project contain relatively small sample sizes, and also that it is difficult to isolate the effects of the intervention from other factors. One of the limitations of this study, as in many similar studies, is its relatively small sample size. However, what can be observed from the SF-12 measurements is that the CAB GP Outreach Project is reaching those clients with below average physical and mental health.

It is evident from the data presented in this report and the detailed description of the service, that the CAB GP Outreach Project focuses directly on addressing social welfare issues that adversely affect quality of life, rather than simply attempting to treat the symptoms (such as depression and acute anxiety) medically. As such it is directly addressing inequalities in health in inner Warrington.

5.6 Conclusion

This report has provided a detailed description of the Warrington District CAB GP Outreach Project and analysed available data about service usage. The report has also identified the key benefits to service users and analysed how the service is meeting the project objectives.

Respondents in the study reported a number of benefits that cannot be measured purely in monetary terms and relate more closely to quality of life. Supporting the model illustrated by Moffatt et al. (2004), this study shows some evidence of increased benefit and social support contributing to reducing self-reported stress among clients (expressed as worry, pressure, anxiety or

depression). This in turn has the potential to lead to an increased ability to cope with pressing social welfare problems and reduce symptoms related to stress.

It is apparent that for those people involved with the Warrington CAB GP Project, it has been a positive experience. This applies to staff involved in service provision, primary health care professionals and service users alike. However, it is evident that the evaluation has not been able to show improvements in health as measured by the SF-12 instrument. What the evaluation has shown is that the Project is able to contribute towards gains in health-related quality of life for its clients. Increased income and benefit uptake, reductions in stress and improved housing situation are relevant to addressing health inequalities in Warrington and improving peoples' health-related quality of life. Furthermore, by promoting the health of its clients, the CAB GP Outreach Project captures the public health spirit which underpins the Government's commitment to reduce inequalities in health.

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Appendix 1

Short Form 12 (SF-12)

SF-12 (Short Form)

Question 1	In general, would you say your health is excellent, very good, good, fair, or poor?	Excellent ...	☐
		Very Good ...	☐
		Good ...	☐
		Fair ...	☐
		Poor ...	☐
Question 2	The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? First, moderate activities such as moving a table, pushing a vacuum cleaner, bowling or playing golf. Does your health now limit you a lot, limit you a little, or not limit you at all.	Limited a lot ...	☐
		Limited a little ...	☐
		Not limited at all ...	☐
Question 3	Climbing several flights of stairs. Does your health now limit you a lot, limit you a little, or not limit you at all?	Limited a lot ...	☐
		Limited a little ...	☐
		Not limited at all ...	☐
Question 4	During the past four weeks, have you accomplished less than you would like as a result of your physical health?	No ...	☐
		Yes ...	☐
Question 5	During the past four weeks, were you limited in the kind of work or other regular activities you do as a result of your physical health?	No ...	☐
		Yes ...	☐
Question 6	During the past four weeks, have you accomplished less than you would like to as a result of any emotional problems, such as feeling depressed or anxious?	No ...	☐
		Yes ...	☐
Question 7	During the past four weeks, did you not do work or other regular activities as carefully as usual as a result of any emotional problems such as feeling depressed or anxious?	No ...	☐
		Yes ...	☐
Question 8	During the past four weeks, how much did pain interfere with your normal work, including both work outside the home and housework? Did it interfere not at all, slightly, moderately, quite a bit, or extremely?	Not at all ...	☐
		Slightly ...	☐
		Moderately ...	☐
		Quite a bit ...	☐
		Extremely ...	☐

Question 9	These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much time during the past 4 weeks have you felt calm and peaceful? All of the time, most of the time, a good bit of the time, some of the time, a little of the time, or none of the time?	All of the time ... ☐ Most of the time ... ☐ A good bit of the time ... ☐ Some of the time ... ☐ A little of the time ... ☐ None of the time ... ☐
Question 10	How much of the time during the past 4 weeks did you have a lot of energy? All of the time, most of the time, a good bit of the time, some of the time, a little of the time, or none of the time?	All of the time ... ☐ Most of the time ... ☐ A good bit of the time ... ☐ Some of the time ... ☐ A little of the time ... ☐ None of the time ... ☐
Question 11	How much time during the past 4 weeks have you felt down? All of the time, most of the time, a good bit of the time, some of the time, a little of the time, or none of the time?	All of the time ... ☐ Most of the time ... ☐ A good bit of the time ... ☐ Some of the time ... ☐ A little of the time ... ☐ None of the time ... ☐
Question 12	During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities like visiting with friends, relatives etc? All of the time, most of the time, some of the time, a little of the time, or none of the time?	All of the time ... ☐ Most of the time ... ☐ Some of the time ... ☐ A little of the time ... ☐ None of the time ... ☐

Appendix 2

Pre- and Post-intervention questionnaires

CAB in Primary Care Evaluation Study
Baseline Questionnaire

Participant's initials | | |

Participant's date of birth | | | | | | |

Date of first appointment | | | | | | |

Section 1 - Demographics

1. Age | | |

2. Sex | |

3. Employment status (please circle more than one if necessary)

Employed — Please state job title ……
Unemployed
Retired
Carer
Other

If not employed please state title of last job ……

If none, please state employment of spouse, or parent etc. ……..

4. Current housing status (please circle)

Owner occupier/mortgage
Rented LA/HA
Private rented
Other — Please state ……

5. Ethnic background

White
- White British
- White Irish
- Any other White background

Mixed
- White and Black Caribbean
- White and Black African
- White and Asian
- Any other mixed background

Asian or British Asian
- Indian
- Pakistani
- Bangladeshi
- Any other Asian background

Black or Black British
- Caribbean
- African
- Any other Black background

Other ethnic categories
- Chinese
- Any other background

6. Household composition (circle all that apply)

Live alone
Couple
Single parent
Children Please state number of children …….. ……..…….
Living with parents
Living with flatmates
Other people living with you. Specify ……

Section 2 - CAB Service use

7. How did you hear about the CAB service at the GP Practice?

GP
Primary health care team
Receptionist
CAB/Welfare Rights
Friend or relative
Poster or flier
Other Please specify ……..

8. Why did you contact the CAB service at the GP Practice (i.e. presenting problem)?

Benefits advice
Debt advice
Legal advice
Tax advice
Housing advice
Employment advice
Consumer issues
Family/relationship issues
Other advice Please specify ……

9. Were any other issues identified? (please circle all that apply)

Benefits advice
Debt advice
Legal advice
Tax advice
Housing advice
Employment advice
Consumer issues
Family/relationship issues
Other advice Please specify ……

10. How many days did you have to wait for an appointment? ……..

11. Which benefits (if any) are you already receiving (prior to advice)?

Disability Living Allowance
Care Allowance
Mobility Allowance
Attendance Allowance
Income Support
Incapacity benefit
Housing benefit
Council Tax Benefit
Industrial Injuries Benefit
Other Please state ……

12. Have you used CAB anywhere else?

Yes No

13. If yes, where? ……

14. What made you attend this CAB service (at the GP surgery) rather than the high street this time?
…….
……
……....

15. Are there any advantages to seeing a CAB worker at the GP?

Yes No

Please explain: …….
……
……
……

Section 3 - Health questions

16. Do you have any of the following long-standing illnesses that limit your daily activity?

Arthritis/rheumatism
High blood pressure
Heart trouble/angina
Stroke
Diabetes
Asthma
Physical disability Please specify……..
Sensory impairment Please specify …….
Psychiatric illness

17. Have any of these illnesses got worse in the last six months?

Yes No

18. If yes, please specify which illnesses have got worse ..…….
……
……
……

19. Have you had any of the following experiences in the last six months?

Bereavement
Moved house
Housing problem (e.g. eviction, sub-standard housing, problems with neighbours, etc)
Redundancy/lost job
Retirement
Changed job
Loss of benefit
Legal problems
New illness diagnosed, operations, Please specify …….……...….
……
Accident
Fall (older person)
Relationship breakdown
Change in caring responsibilities
Change in household composition (e.g. new child). Please specify……..
……..……..
Other ……...…….
……

20. Have any of these things had any effect on your health?

Yes No

Please explain ……
……
……
……

21. As a result, has this led to any change in GP visits?

Yes No

If yes, please explain ……
……
……
……

22. Have these problems made you feel stressed or anxious?

Yes No

23. Have you visited your doctor because of stress or anxiety in the last six months?

Yes No

24. If yes, did the doctor prescribe any medication for your stress or anxiety?

Yes No Not sure

25. Have there been any changes in any medication you take over the last six months?

Yes No

If yes, please explain ……
……
……
……

CAB in Primary Care Evaluation Study
Follow-up Questionnaire

Initials of participant | | |

Date of birth | | | | | | | | |

Date of interview | | | | | | |

Section 1 - Demographics

1. Current employment status (please circle more than one if necessary)

Employed Please state job title ……
Unemployed
Retired
Other

If not employed please state title of last job ……

If none, please state employment of spouse, or parent etc. ……..

2. Current housing status (please circle)

Owner occupier/mortgage
Rented LA/HA
Private rented
Other Please state ……

3. Household composition

Live alone
Couple
Single parent
Children Please state number of children …….. ……..……..
Living with parents
Living with flatmates
Other people living with you. Specify ……..

Section 2 - CAB Service use

4. What advice were you given? (please circle more than one if necessary)

To claim a new benefit
To appeal against a loss of benefit
Debt rescheduling
General benefits advice
Debt advice
Legal advice
Other Please state ……

Tax advice
Housing advice
Employment advice
Consumer advice
Family/relationship advice

5. Do you think the options that you were given helped to improve your situation?

Yes No Not sure

Please explain:……
……
……

6. Were you able to follow these options?

Yes No

If no, why not? ……..
……
……
……

7. What was the outcome? ……
……
……
……

8. How did you feel after seeing the advice worker? (Please circle one)

Less anxious
Same as usual
More anxious

Please explain: …….....
……
……
……

9. If this service had not been available through GP surgeries would you have visited a high street CAB office?

Yes No Not sure

10. If no or not sure, why wouldn't you visit a high street office? ……...
……..…
……..

Section 3 - Health

11. Do you have any of the following long-term illnesses that limit your daily activity? (please circle all that apply)

Arthritis/rheumatism
High blood pressure
Heart trouble/angina
Stroke
Diabetes
Asthma
Physical disability Please specify……..
Sensory impairment Please specify …….
Psychiatric illness

12. If any of the above are circled, have you noticed any change in these conditions since visiting the CAB Advisor?

Yes No

If yes, please describe: …….....
……
……
……
……

13. Have you noticed any change in the number of visits you have made to your GP in the last six months?

Yes No

14. If yes, have you been:

More often Less often

Please explain:……...
……
……
……

15. Have you visited your doctor because of stress or anxiety in the last six months?

Yes No

16. If yes, did the doctor prescribe any medication for your stress or anxiety?

Yes No Not sure

17. Have there been any changes in any medication that you take over the last six months?

Yes No

If yes, please explain: ……
……
……
……

18. Has your income increased through the assistance of the CAB in Primary Care Advisor?

Yes No

19. Do you think this increased income has had any affect on your health (mental and physical health)?

Yes No

Please describe:
……
……
……
……
……
……
……
……

Appendix 3

Participant information sheets

Participant Information Sheet

"Evaluation of Citizens Advice Bureau (CAB) in Primary Care"

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

The study aims to evaluate the implementation, delivery and effectiveness of the CAB in Primary Care project. This project provides CAB Advisors within GP surgeries in the inner wards of Warrington.

Why have I been chosen?

You are being asked to take part because you have had an appointment with a CAB in Primary Care Advisor. The evaluation study hopes to include every person who has been a client of the CAB in Primary Care project.

Do I have to take part?

It is up to you to decide whether or not to take part. Your decision whether or not to participate will not affect your relationship with the CAB in Primary Care project or access to services provided by the project. If you do decide to take part you will be given this information sheet to keep and will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time without giving a reason.

What will happen to me if I take part?

You will be asked to complete a general health questionnaire and a CAB in Primary Care project evaluation questionnaire during your first appointment with a CAB Advisor. During your last appointment with your CAB in Primary Care Advisor (or at the close of your case) you will be asked you to complete a follow-up general health questionnaire and a follow-up CAB in Primary Care project evaluation questionnaire. Your GP surgery will also provide the study with data relating to: your visits to the GP during the study, visits to secondary health services during the study and prescriptions given to you by your GP during the study. Your GP surgery will not provide the study with your medical history or any other information. We will not record your name, address or any other identifiable personal details on any study questionnaires or other data collection instruments. Your GP surgery will not give us your name, address, or any other details that may identify you, with your consultation and prescription data.

What are the possible disadvantages and risks of taking part?

The study involves questionnaires on your general health, basic demographics, and use of the CAB in Primary Care service. It is not expected that the questions contained in these questionnaires will cause any distress. However, if you become upset or are uncomfortable completing a questionnaire please tell the interviewer that you do not wish to answer specific a question, or that you wish to the leave the questionnaire incomplete.

What are the possible benefits of taking part?

A possible benefit of participating in the research is the opportunity to discuss your experiences and express your opinions about the CAB in Primary Care service.

What if something goes wrong?

It is not expected that you will suffer any harm from participating in the study, However, if you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for a legal action but you may have to pay for it. Regardless of this, if you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service complaints mechanisms will be available to you.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential. Any information about you which leaves your GP surgery will have your name and address removed so that you cannot be recognised from it.

If you consent, we will notify your GP of your participation in the CAB in Primary Care evaluation study.

What will happen to the results of the research study?

The research will be used to evaluate the CAB in Primary Care service and to inform the development of similar projects in the future. Individuals who participate will not be identified in any subsequent report or publication.

Who is organising and funding the research?

The Centre for Public Health Research, University College Chester will be organising the evaluation study of the Warrington CAB in Primary Care project.

Who may I contact for further information?

If you would like more information about the research before you decide whether or not you would be willing to take part, please contact:

Your CAB advisor or;

James Caiels (Researcher, Centre for Public Health Research on 01244 375444 ext.2058).

Thank you for your interest and co-operation in this research.

Interview Information Sheet

"Evaluation of Citizens Advice Bureau (CAB) in Primary Care"

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

The study aims to evaluate the implementation, delivery and effectiveness of the CAB in Primary Care project. This project provides CAB Advisors within GP surgeries in the inner wards of Warrington.

Why have I been chosen?

You are being asked to take part because you have had an appointment with a CAB in Primary Care Advisor. The evaluation study hopes to include every person who has been a client of the CAB in Primary Care project.

Do I have to take part?

It is up to you to decide whether or not to take part. Your decision whether or not to participate will not affect your relationship with the CAB in Primary Care project or access to services provided by the project. If you do decide to take part you will be given this information sheet to keep and will be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time without giving a reason.

What will happen to me if I take part?

You will be asked to participate in an audio-taped semi-structured interview with a researcher from the Centre for Public Health Research, University College Chester. We will we ask for your permission to audio-tape the interview prior to commencing recording. The audiotapes will be anonymously transcribed and the tapes subsequently erased of all data. The interview will take approximately ten to twenty minutes to complete and will involve questions about your experiences and opinions of the CAB in Primary Care project. We will not record your name, address or any other identifiable information during the interview or on any forms. We may quote you for the purposes of the evaluation but will not identify you in any way.

What are the possible disadvantages and risks of taking part?

The study involves an interview on your experiences and thoughts in relation to the CAB in Primary Care service. It is not expected that any questions will cause any distress. However, if you become upset or are uncomfortable completing a questionnaire please tell the interviewer that you do not wish to answer specific a question, or that you wish to terminate the interview.

What are the possible benefits of taking part?

A possible benefit of participating in the research is the opportunity to discuss your experiences and express your opinions about the CAB in Primary Care service. Your feedback may help shape the design and delivery of similar projects in the future.

What if something goes wrong?

It is not expected that you will suffer any harm from participating in the study, However, if you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for a legal action but you may have to pay for it. Regardless of this, if you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service complaints mechanisms will be available to you.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential.

What will happen to the results of the research study?

The research will be used to evaluate the CAB in Primary Care service and to inform the development of similar projects in the future. Individuals who participate will not be identified in any subsequent report or publication.

Who is organising and funding the research?

The Centre for Public Health Research, University College Chester will be organising the evaluation study of the Warrington CAB in Primary Care project.

Who may I contact for further information?

If you would like more information about the research before you decide whether or not you would be willing to take part, please contact:

James Caiels (Researcher, Centre for Public Health Research on 01244 375444 ext.2058).

Thank you for your interest and co-operation in this research.

Telephone Interview Information Sheet

"Evaluation of Citizens Advice Bureau (CAB) in Primary Care"

What is the purpose of the study?

The study aims to evaluate the implementation, delivery and effectiveness of the CAB in Primary Care project. This project provides CAB Advisors within GP surgeries in the inner wards of Warrington.

Why have I been chosen?

You have been asked to take part because you have had an appointment with a CAB in Primary Care Advisor. The evaluation study hopes to include every person who has been a client of the CAB in Primary Care project.

What are the possible benefits of taking part?

A possible benefit of participating in the research is the opportunity to discuss your experiences and express your opinions about the CAB in Primary Care service. Your feedback may help shape the design and delivery of similar projects in the future.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential. We may quote you for the purposes of the evaluation but will not identify you in any way.

What will happen to the results of the research study?

The research will be used to evaluate the CAB in Primary Care service and to inform the development of similar projects in the future. Individuals who participate will not be identified in any subsequent report or publication.

Who is organising and funding the research?

The Centre for Public Health Research, University College Chester will be organising the evaluation study of the Warrington CAB in Primary Care project.

Who may I contact for further information?

If you would like more information about the research please contact:

James Caiels (Researcher, Centre for Public Health Research on 01244 375444 ext.2058).

Thank you for your interest and co-operation in this research.

Professional Interview Information Sheet

"Evaluation of Citizens Advice Bureau (CAB) in Primary Care"

You are being invited to take part in a research study. Before you decide, it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Thank you for reading this.

What is the purpose of the study?

The study aims to evaluate the implementation, delivery and effectiveness of the CAB in Primary Care project. This project provides CAB Advisors within GP surgeries in the inner wards of Warrington.

Why have I been chosen?

You are being asked to take part because you either work in a GP practice where the CAB in Primary Care project is delivered, have referred patients to the CAB in Primary Care project, or you work as a staff member within the CAB in Primary Care service.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason.

What will I have to do if I take part?

You will be invited to participate in an individual semi-structured interview. We will ask you for your permission to audio-tape the interview. We will ask you questions relating to your experiences, views and thoughts on the CAB in Primary Care project. We will not ask you to provide your name or any personal details, or ask you to answer personal questions.

What are the possible disadvantages and risks of taking part?

While it is not expected that the interview will cause any distress, if you do become upset or are uncomfortable answering a question please tell the interviewer that you do not want to answer the question or would like the interview to end.

What are the possible benefits of taking part?

A possible benefit of participating in the interview is the opportunity to express your thoughts and perspectives on the CAB in Primary Care project. Your feedback may also influence the design of similar programmes in the future.

What if something goes wrong?

It is not expected that you will suffer any harm from participating in the study. However, if you are harmed by taking part in this research project, there are no special compensation arrangements. If you are harmed due to someone's negligence, then you may have grounds for a legal action but you may have to pay for it. Regardless of this, if you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service complaints mechanisms should be available to you.

Will my taking part in this study be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential. We will not record your name or address on any documents or audio-tapes.

What will happen to the results of the research study?

The research will be used to evaluate the CAB in Primary Care project and to inform the development of similar programmes in the future. Individuals who participate will not be identified in any subsequent report or publication.

Who is organising and funding the research?

The Centre for Public Health Research at University College Chester is organising and conducting the study for the Warrington CAB in Primary Care service.

Who may I contact for further information?

If you would like more information about the research before you decide whether or not you would be willing to take part, please contact:

James Caiels (Researcher, Centre for Public Health Research on 01244 375444 ext.2058).

Thank you for your interest and co-operation in this research.

Appendix 4

Consent forms

Centre for Public Health Research

UNIVERSITY COLLEGE CHESTER

CONSENT FORM

For research participants

Title of Project: Evaluation of Citizens Advice Bureau (CAB) in Primary Care

		Please tick box
1.	I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.	☐
2.	I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.	☐
3.	I understand that sections of any of my medical notes may be looked at by responsible individuals from my General Practice surgery or from regulatory authorities where it is relevant to my taking part in research. I give permission for these individuals to have access to my records.	☐
4.	I agree to take part in the above study.	☐

Name of Patient	Date	Signature

Name of Person taking consent (if different from researcher)	Date	Signature

Researcher	Date	Signature

1 for patient; 1 for researcher; 1 to be kept with CAB notes

University College Chester, Parkgate Road, Chester CH1 4BJ
Tel: 01244 375444 Fax: 01244 392820 www.chester.ac.uk

Centre for Public Health Research

UNIVERSITY COLLEGE CHESTER

CONSENT FORM

For interview participants

Title of Project: Evaluation of Citizens Advice Bureau (CAB) in Primary Care

Please tick box

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected. ☐
3. I agree to take part in the above study. ☐

Name of Interviewee	Date	Signature
Name of Person taking consent (if different from researcher)	Date	Signature
Researcher	Date	Signature

1 for interviewee; 1 for researcher; 1 to be kept with CAB notes

University College Chester, Parkgate Road, Chester CH1 4BJ
Tel: 01244 375444 Fax: 01244 392820 www.chester.ac.uk

Appendix 5

Interview schedules

Semi-structured Interview Guide for Interviews with GP Practice Staff Who Referred to the CAB in Primary Care Project

1) Introduction

The researcher will explain the purpose interview and ask the participant for permission to audio-tape the discussion.

2) Background

Can you please tell me a little about your professional role? (Eg. GP, Nurse, Receptionist etc.)

Which GP surgery are you employed by?

How long have you worked at this surgery?

How would you describe your relationship with patients?

3) CAB in Primary Care project

Are you aware of the CAB in Primary Care project?

How long has the CAB in Primary Care project been established at your GP surgery?

Have you referred any patients or carers to the service? Why or why not?

What kind of criteria do you use when referring someone to the CAB service – how would you identify that they might benefit from using the CAB?

Approximately how many people have you referred to the service?

Have you had any feedback from these people about the CAB in Primary Care Service? What kind of feedback have you received (please describe)?

What are your thoughts and opinions on the CAB in Primary Care project?

Do you think the project has helped patients? How and in what ways?

Do you think the CAB in primary care project has any impact on patients' health? How and in what ways?

Do you think the project has had any impact upon patients' stress and anxiety? If so, in what ways?

From your perspective, what are the benefits of having a CAB service in primary care? Are there any negative aspects about having the service located within the surgery? If yes, what are these?

Do you think the project has had any impact on consultation frequency of persons referred?

Do you think the project has had any impact on medication prescribing? If so how and in what ways?

4) Conclusion

Are there any final comments that you would like to make?

Thank you for your time.

Semi-structured interview guide for CAB in Primary Care Project Advisers

Introduction

The researcher will explain the purpose of the interview and ask the participant for permission to audiotape the discussion.

Background

Can you please tell me a little about your professional background?

Have you worked in CAB services within Primary Care previously?

How long have you been working for the CAB in Primary Care Project?

Delivery of the CAB in Primary Care Service

Could you please tell me a little about your position/job title and what your role is within the CAB in Primary Care project?

What type of clients do you work with?

What are the most common social welfare issues that you are presented with?

Do the clients that you see come to you with a single problem, or a multitude of problems?

Where and how often do you work with these clients?

Could you please describe the type work that you do with these clients?

Case study

Could you describe the process, from start to finish, of a case that you have dealt with?

Approximately how many hours would you say you spent working on this particular case?

Staff perspective

Is working in Primary Care different in any way from working in high street branches? - How

Are you seeing a different type of client to high street offices?

What is your view on how you think the service is working?

What kind of outcomes does this work lead to in your view?

GP visit frequency?

Medication?

Do you think the CAB in Primary Care service changes clients' lives? If so, how and in what ways?

In your opinion do you think that the services that you deliver have any impact on general and mental health of CAB in Primary Care project clients? If so, how and in what ways?

Do you see any disadvantages for clients, in locating CAB services within GP surgeries? Please describe these disadvantages.

Are there any parts of the CAB in Primary Care project that you would like to see improved? If so, what are they and how would you do this?

Conclusion

Are there any final comments you would like to make?

Thank you for your time.

Semi-structured Interview Guide for Interviews with Clients of the CAB in Primary Care Project

Introduction

The researcher will explain the purpose interview and ask the participant for permission to audiotape the discussion.

Background

We don't need to know your personal details but we would like just a bit of background information about you.

Have you ever visited a high street CAB office? Why or why not?

Would you prefer to see a CAB Advisor at your GP surgery compared to the high street office? Why/why not?

What did you expect from the CAB in Primary Care service? Did the service meet your expectations?

> Were you sceptical about the service / confident it could help you?

How do you feel now (physically / mentally), compared to how you felt when you were first referred to the service?

> Do you think the CAB in Primary Care project has had any effect on how you feel in terms of your overall health? If so, **how and in what ways**?
>
> *How* did it help you feel better?
>
> Why do you think your physical health has changed?
>
> Why do you think your stress levels / level of anxiety have changed?

Do you think the frequency of your visits to the GP has changed at all since your first appointment with the CAB in Primary Care Advisor? If so, in what ways? Why do you think this has happened?

Have you stopped or started taking any medications since your first visit to the CAB in Primary Care Advisor? If so, do you know why? Do you think seeing the CAB Advisor in Primary Care had anything to do with these medication changes?

What are your thoughts, perspectives and views in relation to the delivery of CAB services at GP surgeries?

Do you think that putting CAB services in your GPs practice is helpful to patients? Why / why not?

Why / how is it better talking to CAB staff as opposed to the doctor / nurse etc?

Better informed, less intimidating, more appropriate?

Would you recommend a friend or family member to visit a CAB Advisor at the GP? Why or why not?

Would you use the service again?

Is there anything else you'd like to say about the CAB service at your GP?

Conclusion

Are there any final comments that you would like to make?

Thank you for your time.