

# Liverpool Citizens Advice on Prescription

Interim evaluation report - January 2023



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## Table of Contents

<b>Executive Summary.</b> .....	3
List of abbreviations .....	6
List of Figures and Tables .....	7
Introduction and background .....	8
Scope and purpose of report.....	8
Overall Aims and Objectives of the evaluation. ....	8
Background.....	9
The Liverpool Citizens Advice on Prescription intervention.....	10
Timeline for implementation .....	11
Logic Model.....	11
WP1: Estimating the impact of Citizens Advice on Prescription on health outcomes and healthcare utilisation.....	12
<i>WP1. Methods</i> .....	12
<i>Outcome measurement.</i> ....	13
Work Package One: Results.....	15
<i>Use of CAP across types of service access.</i> .....	15
<i>The demographic profile of CAP clients</i> .....	17
<i>The profile of CAP clients by ethnicity</i> .....	18
<i>The health status of CAP clients</i> .....	19
<i>The socioeconomic profile of CAP clients.</i> .....	21
<i>Types of issues and support provided.</i> .....	24
Outcomes.....	25
EQ-5D follow up measures .....	28
Work Package Two: - Understanding service users' experience of the Citizens Advice on Prescription intervention .....	32
Work Package 2. Methods .....	32
Work Package 2. Findings.....	33
Conclusions.....	37
References .....	39

## Executive Summary.

### Background.

This report outlines initial findings from the evaluation by the University of Liverpool of the Citizens Advice on Prescription (CAP) service. Citizens Advice on Prescription is a service provided by Citizens Advice Liverpool and commissioned by the NHS. It provides a rapid response for people using primary health care services to social welfare advice and support. For secondary care patients, there is an added offer of wellbeing support helping patients connect to community activities and services. The service started in primary care in 2015 and has subsequently been rolled out across multiple health services, most recently the perinatal pathway. The evaluation includes several components, including analysis of data extracted from the services case management system, a quasi-experimental analysis using linked data and a matched control group, interviews with service users and stakeholders and an economic evaluation. This report only includes findings based on analysis of data extracted from the services case management system. Some of the interviews with service users and the other components have not yet collected and analysed sufficient data to draw conclusions. In the analysis we define a “client” as any individual who has accessed CAP at any point during this period, whilst a “case” is a referral to CAP for a specific set of issues. In other words, one client can result in multiple cases, if at separate time periods the same person has been referred multiple times.

### Main findings.

#### *Uptake*

- Between January 2018 and August 2022 there were approximately 50,000 referrals to CAP, from 25,000 people. Service use doubled during the pandemic and has remained 50% higher than pre-pandemic levels during 2022.
- A large majority of all clients (90%) using the service report having a long-term mental or physical health condition or disability.
- 45% of CAP clients reported that they were extremely or severely anxious or depressed, compared with 6% of the overall Liverpool population.
- 1 in 3 CAP clients live in the most deprived 20% of neighbourhoods in Liverpool, and this has increased slightly over time.
- Over the past 4 years, Jan 2018 through Aug 2022, the service has on average increased uptake in the most deprived areas though in some specific disadvantaged communities, Speke, Garston and Belle Vale, uptake has reduced.
- 70% of CAP clients are living in poverty, although when the service altered their model to support medically vulnerable groups during the pandemic, this reduced slightly.
- Most clients receive just welfare support (~500 clients per month), an increasing number of clients receive both welfare and wellbeing support (~ 180 clients per month in 2022), with only ~80 clients a month receiving just wellbeing support.

- Support for benefits continues to be the major welfare issue that is addressed by CAP, with housing issues being the most notable increasing trend in recent data.
- The numbers of clients accessing the service through secondary care is low when compared to referrals from GP practice teams.
- The numbers of clients accessing the service through the perinatal pathway is growing after a slow start, and if rates of increase continue, the pilot is expected to reach its target number of referrals by the end of the pilot phase.
- There has been a marked increase in the proportion of clients with children. Increasing from around 80 per month to 250 to 300 per month. Probably reflecting the work with the perinatal pathway. This is important as the benefits of income maximisation may be particularly important for children living in poverty.
- There has also been a marked increase in the proportion of clients from Black, Asian and Minority Ethnic groups, particularly through the perinatal pathway. This is the direct result of the service development collaboration identifying this as an issue and working with community groups and services to increase uptake in these groups.

### *Outcomes*

- Almost all clients (98%) report that the service has improved their psychological wellbeing (reduced anxiety, improved self-respect, improved choice and control, improved mental health).
- 40% of clients reported that the service had improved their material conditions (employment, housing, engagement in work/life activities).
- In general, clients living in more deprived areas and living in poverty were more likely to report these improvements – particularly those related to material conditions.
- In general, younger clients were more likely to report improvements, than older clients.
- For clients with available follow up data, overall health, as measured by EQ5D VAS, improved by 7% at 2 months after the intervention ( $p=0.05$ ) and by 17% at 6 months ( $p=0.002$ ).
- For clients with available follow up data, anxiety and depression had reduced by 17% at 2 months after the intervention ( $p=0.03$ ) and by 38% at 6 months ( $p=0.005$ ).
- There were no consistent differences in improvements between different routes into the service or based on whether clients received welfare support, wellbeing support or a combination of both.
- In general, improvements in overall health were greater in people living in the more deprived areas.
- The interaction between health problems, financial insecurity and negotiating the benefits system were a common theme driving need for the service among service-users interviewed.

- Service-users interviewed felt that particularly important components of the intervention were (1) the trusted nature of the provider, (2) easy and rapid access, (3) the sense that their concerns were being listened to, (4) practical support and increased knowledge, (5) continuity of support and follow up beyond an initial session, (5) the option to re-engage if needed.
- Issues driving need highlighted in interviews included: increased health problems due to the COVID-19 pandemic, the complexity of the sickness and disability benefits system, housing shortages, the increase in energy prices, and the asylum and immigration system.

## List of abbreviations

Acronym	Meaning
CAL	Citizen's Advice Liverpool is the Liverpool branch of Citizen's Advice that is providing services for the Citizens Advice on Prescription project.
COVID-19	Coronavirus disease 2019.
EQ-5D	EQ-5D is a standardised measure of health-related quality of life developed by the EuroQol Group to provide a simple, generic questionnaire for use in clinical and economic appraisal and population health surveys. EQ-5D assesses health status in terms of five dimensions of health and is considered a 'generic' questionnaire because these dimensions are not specific to any one patient group or health condition
GP	General Practitioner.
Logic model	A visual representation of the chain of causes and effects that describe how an intervention produces its outcomes.
NHS	National Health Service.
NIHR	National Institute for Health and Care Research.
Outcome	A descriptive summary of what has changed because of the initiative e.g., citizens feel more confident.
Scope	The boundary of what is included in the evaluation.
Stakeholder	People or organisations involved in or affected by the activities of the programme under evaluation.
Theory of change	A type of logic model which describes the relationship between inputs, outputs/mechanisms and outcomes and contexts.
UK	United Kingdom.
WP	Work package. The WPs identify the 4 different analytical approaches being taken in the Citizens Advice on Prescription research.
CAP	The Citizens Advice on Prescription. The Intervention being evaluated.

## List of Figures and Tables

Figure 1: Development of social prescribing model in Liverpool .....	11
Figure 2: Overview of the logic model derived from theory of change for Citizens Advice on Prescription.....	12
Figure 3. Flow diagram for collection of EQ-5D outcome data.....	14
Figure 4: Monthly number of clients by service access type.....	16
Figure 5: Monthly number of cases/ referrals by service access type.....	16
Figure 6: Monthly number of cases by type of referrers for the perinatal service .....	17
Figure 7: Number of referrals per 1000 population by age and sex (2022 data adjusted to reflect part year) .....	17
Figure 8: Monthly referrals for households with and without children.....	18
Figure 9: Proportions of yearly referrals by ethnicity .....	18
Figure 10: Number of referrals per 1000 population by ethnicity.....	19
Figure 11: Proportions of yearly referrals by ethnicity - perinatal service.....	19
Figure 12: Monthly referrals by long-term condition and disability status.....	20
Figure 13: % of CAP service users reporting severe or extreme difficulties in each of the domains of the EQ-5D compared with the overall Liverpool population (GP patient survey data 2017).....	20
Figure 14: Number of referrals per 1000 population by deprivation quintile .....	21
Figure 15: Proportions of yearly referrals by poverty status (in poverty if income is under £1300 pcm) .....	22
Figure 16: Proportions of yearly referrals by debt arrears .....	23
Figure 17: Geographic distribution of CAP clients and number of households with complex needs.....	23
Figure 18: Monthly referrals by intervention type – showing the number of cases who received welfare support, wellbeing support and both.....	24
Figure 19: Number of cases by type of issues .....	25
Figure 20: self-reported outcome set 1 by route of service access .....	25
Figure 21: self-reported outcome set 1 by deprivation.....	26
Figure 22: self-reported outcome set 2 by age group .....	27
Figure 23: self-reported outcome set 2 by deprivation.....	28
Figure 24: Trends in EQ-5D Index VAS and Anxiety/Depression at assessment, and follow-ups.....	29
Table 1: Summary of Work packages.....	8
Table 2: Change in outcomes between the assessment and first follow-up (2 months) (n=399).....	30
Table 3: Changes between assessment and first follow-up – VAS by service (n=399) .....	31
Table 4: Change in outcomes between the assessment and 6 months follow-up (n=103).....	31
Table 5: Changes between assessment and second follow-up – VAS by deprivation .....	32



## Introduction and background

### Scope and purpose of report

This is a research report outlining initial findings from the evaluation of Citizens Advice on Prescription. The evaluation is taking place over 36 months starting in May 2021. This report outlined findings from the assessment of the CAP service between January 2018 and August 2022.

### Overall Aims and Objectives of the evaluation.

The aims and objectives of the evaluation are:

1. To assess whether required uptake is achieved to effectively improve health and reduce health inequalities.
2. To quantify the health and economic impacts of different components of Liverpool Citizens Advice on Prescription when implemented in different parts of the health system and whether effects differ between different socioeconomic and demographic groups.
3. To understand how these different groups of participants experience the Citizens Advice on Prescription intervention.
4. To explore the mechanisms through which the intervention influences health and wellbeing.
5. To identify enablers and barriers to effective adaptation and embedding of Citizens Advice on Prescription within first level health services, including emerging link-worker schemes and the effective partnerships and pathways needed to ensure that anti-poverty interventions are at the core of improving health and wellbeing.
6. To estimate the cost-effectiveness of the intervention under alternative implementation assumptions and explore the public value and fiscal benefits generated.
7. To produce recommendations for action by engaging stakeholders and members of the public in synthesising findings and identifying the implications of these findings for implementing similar initiatives in other places and embedding learning so that delivery is adapted to improve health and reduce health inequalities.

Across the 7 objectives, the study has four work packages (see Table 1) below and described in depth below. The anticipated study duration is 36 months from May 2021 to April 2024.

*Table 1: Summary of Work packages.*

	<b>Work Package</b>
Objectives 1 and 2	<b>Work Package 1</b> – Assessing uptake and estimating the impact of Citizens Advice on Prescription on health outcomes and healthcare utilisation
Objectives 3, 4 and 5	<b>Work Package 2</b> – 2.1 Understanding how participants' experience of the Citizens Advice on Prescription intervention has influenced their health and wellbeing and 2.2 from a stakeholder perspective, identify enablers and barriers to effective implementation
Objective 6	<b>Work Package 3</b> – Economic evaluation
Objective 7	<b>Work package 4</b> - Synthesis across work packages, developing recommendations and embedding learning

This report only includes findings from Work Packages 1 & 2 as WPs 3 and 4 have not as yet collected and analysed sufficient data to draw conclusions.

## Background

Individuals living on low incomes have reduced access to resources that promote health<sup>1,2</sup>, leading to poor health outcomes<sup>3-5</sup>. This causes stark inequalities in health between socio-economic groups in the UK. These inequalities start early in life, with child health particularly sensitive to the adverse effects of poverty.<sup>6</sup>

We are currently facing the cumulation of multiple crises that are exacerbating poverty and driving increased and unequal poor health and demand for health services. Prior to the pandemic, austerity policies and welfare reforms increased the risk of poverty and poor health<sup>7</sup> for some groups, in particular children, increasing health inequalities<sup>8</sup> and costs to the health and social care system.<sup>9-14</sup>

The COVID-19 crisis has exacerbated these inequalities, hitting the most disadvantaged communities hardest, particularly Black, Asian and Minority Ethnic groups.<sup>15</sup> The public health emergency contributed to a financial shock which has resulted in increasing numbers of people relying on welfare benefits and at increased risk of poverty. The present cost of living crisis and second economic recession pose a further threat to the ability of those on the lowest incomes to improve the conditions in which they live, work and learn, to protect their health.

The NHS, along with local government and the third sector, has a potentially important role to play in addressing this increasing tide of need. One such response is through its approach to social prescribing and enabling access to social welfare support through health services. The NHS defines social prescribing as a means of enabling health and care professionals to refer people to a range of local, non-clinical services.<sup>16</sup> There are many examples of social prescribing in action, with interventions ranging from basic sign-posting through to holistic support.<sup>17</sup> Most models for social prescribing involve a link worker who works with people to identify 'what matters' to them and help them access local activities or sources of support, which are typically provided by voluntary and community sector organisations. Currently all Primary Care Networks are required to employ link workers in this role.<sup>18</sup> Social welfare advice has generally not been described as a component of social prescribing.<sup>16</sup> For some time, however, there have been scattered projects providing welfare advice in primary care across the UK.<sup>19,20,21</sup>

There is limited evidence on the health impact of different social prescribing models or the provision of social welfare advice, although there is growing evidence to support the role of the link worker.<sup>17,22-24</sup> Recent reviews have also described factors facilitating engagement of patients in social prescribing (both in the co-production of the social prescription and in the activities 'prescribed'). These include positive patient-held beliefs about benefits of social prescribing, trust in the referrer and link worker, the context of the social prescribing, the way in which activities are presented by the link worker, patient perception of the link worker and activities as supportive, accessibility of activities and availability of support to attend activities.<sup>17,23</sup> Barriers to engagement include fear of stigma, low patient expectations, and the short-term nature of social prescribing programmes.<sup>24</sup> The available evidence for welfare advice services suggests that these deliver measurable financial benefits for patients, mostly in the form of accessing unclaimed welfare benefits and help with managing debt.<sup>25,26</sup> Other studies have found that welfare advice can help with housing issues and relationship problems.<sup>26,27,28</sup> Qualitative studies report improvements in physical and mental health, improvements in living and working environments, and the increased ability to spend on assets which can improve health.<sup>29,30,31</sup> A major limitation of most studies has been small sample sizes, lack of longitudinal follow-up and control groups and insufficient analysis of equity in uptake to investigate the impact on health outcomes and health inequalities.<sup>26</sup>

Models that integrate social prescribing and social welfare and legal advice have the potential to create a wraparound service that responds to the needs of the individual, aiming to address

the social determinants of health in conjunction with health and wellbeing needs. An integrated approach can also enable proactive identification of issues that could be detrimental to health, potentially before the patients themselves are aware of them. There is increasing interest in how referrals or information sources can be targeted to those within certain clinical pathways e.g. new diagnosis, pregnancy, caring responsibilities.<sup>32</sup>

The Liverpool Citizens Advice on Prescription Service is novel in a number of ways: it combines community-focused social prescribing with welfare and legal advice; it is being implemented at a larger scale than previous schemes, and in more diverse settings than previous similar initiatives. Understanding how the intervention works, for whom, and its impact on health outcomes, is crucial for local service development to address growing health needs and demands on services and of national importance for the Department of Health and Social Care to achieve its aims to improve people's health and reduce inequalities.

### The Liverpool Citizens Advice on Prescription intervention.

The City of Liverpool has been developing the Citizens Advice on Prescription (CAP) to ensure that people using health services across the life course have access to advice and support that reduces financial insecurity and alleviates poverty, thereby modifying the health risk factors associated with deprivation.<sup>33</sup> CAP is a partnership between the NHS and Citizens Advice, providing a single 'gateway' from health services in Liverpool into social determinants of health offer. This involves a series of steps as outlined below:

#### Identifying those at risk of financial difficulties

- The Citizens Advice relationship manager liaises and collaborates with staff of frontline health services to raise awareness, provide training and encourage referrals
- People who are identified as at risk of financial and/or social hardship by frontline health professionals are referred to the CAP service.
- In addition, during the pandemic, households which were identified as vulnerable using Liverpool's integrated data systems (such as those shielding), were offered the opportunity to be referred to the service.

#### Assessment

- The CAP case worker then contacts referred patients within two working days. On contact they carry out a preliminary telephone assessment and arrange a face-to-face or telephone follow up.
- They conduct a holistic assessment with each client, to help them identify potential actions and prioritise changes they want to achieve.

#### Advice and Planning

- A tailored plan of support is developed, that may involve help with financial issues, welfare benefits, housing difficulties, debt, relationship breakdown, bereavement, domestic abuse, social isolation and fuel poverty, as well as signposting to local health and wellbeing services.

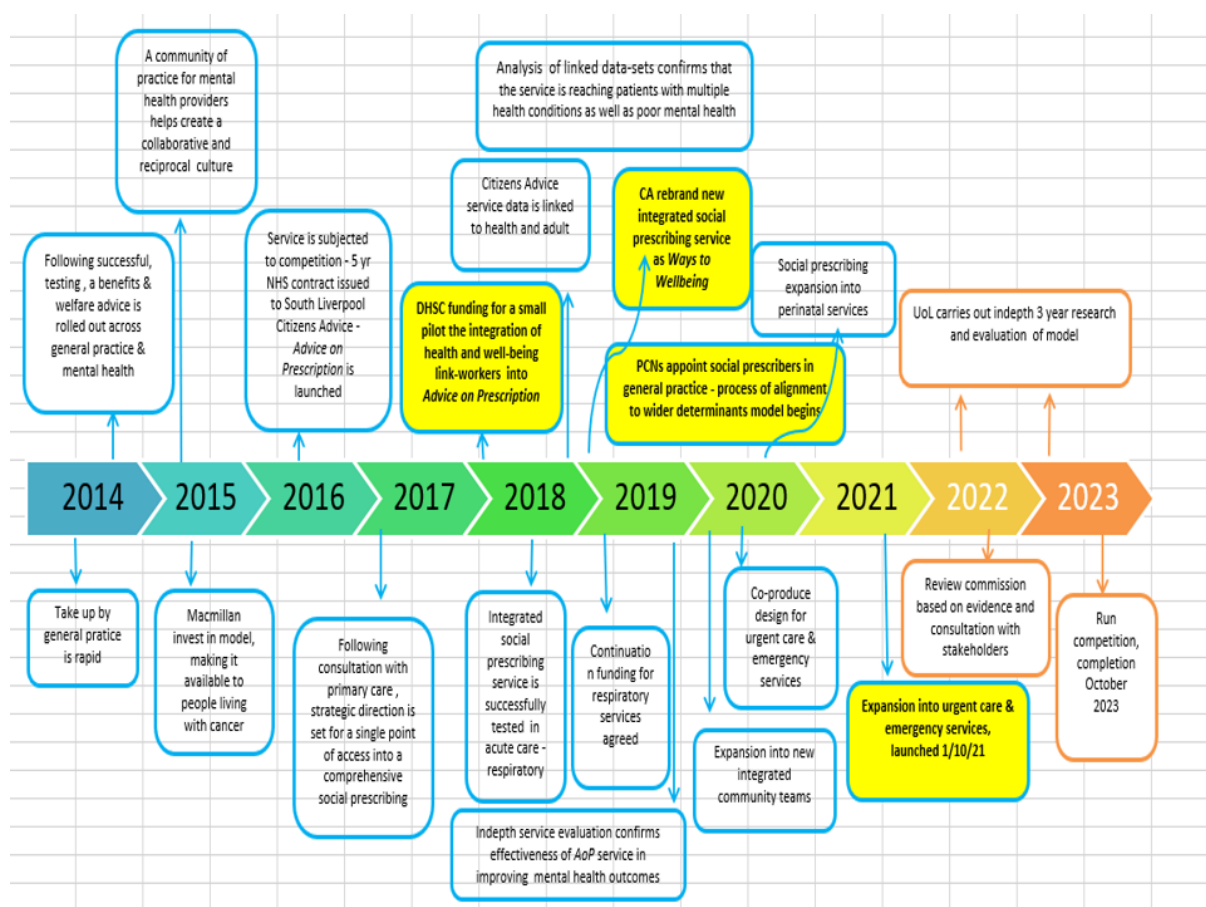
#### Follow-up

- The Citizens Advice CAP case workers contact clients at regular intervals to assess progress.
- After support and advice is given clients are offered the opportunity to re-contact the service if needed.

## Timeline for implementation

The approach was introduced in primary care in 2014 as a pilot covering 10% of the population. This was then extended to all GP practices in Liverpool in 2015 including a targeted offer for patients with severe mental illness and cancer. It was extended into respiratory services in 2018, and in 2020-21 into antenatal, health visiting, midwifery, integrated health and social care teams, and emergency services. CAP provides the link workers for some of the primary care networks in Liverpool, following NHS England's introduction of a social prescribing programme in 2020 requiring all primary care networks to employ at least one social prescribing link worker per population of 40,000 to facilitate the signposting of patients to a variety of activities and support options. From 2021, the service was extended into perinatal services, through the Health Foundation's Spreading Improvement Programme (see Figure 1).<sup>18</sup>

Figure 1: Development of social prescribing model in Liverpool



## Logic Model

We see the contact with the Citizens Advice on Prescription service as an event introduced into the lives of people who have multiple interrelated health and social problems, that has the potential to influence their material and psychosocial resources for health through multiple pathways.<sup>34</sup> These interactions can initiate a virtuous cycle of events, or alternatively, the complexity of people's lives can override any potential benefits from the intervention.

The Citizens Advice on Prescription is hypothesised to lead to (1) improved material circumstances through benefit maximisation and improved debt management, housing or

employment support, educational and training services, (2) increased access to local health and wellbeing activities. These interact, in that greater financial security may help people to participate in other activities, and these other activities (e.g. training) may increase income and financial security. This engagement and increase in financial security then potentially lead to health improvement through four main interacting mechanisms: reduced psychological stress, improved material conditions (e.g. housing, food etc.), improved social connections and reduced isolation, and improved health behaviours (e.g. increased physical activity, improved diet). There are potential feedback loops whereby improved health and wellbeing may enable greater engagement and financial security (see Figure 2).

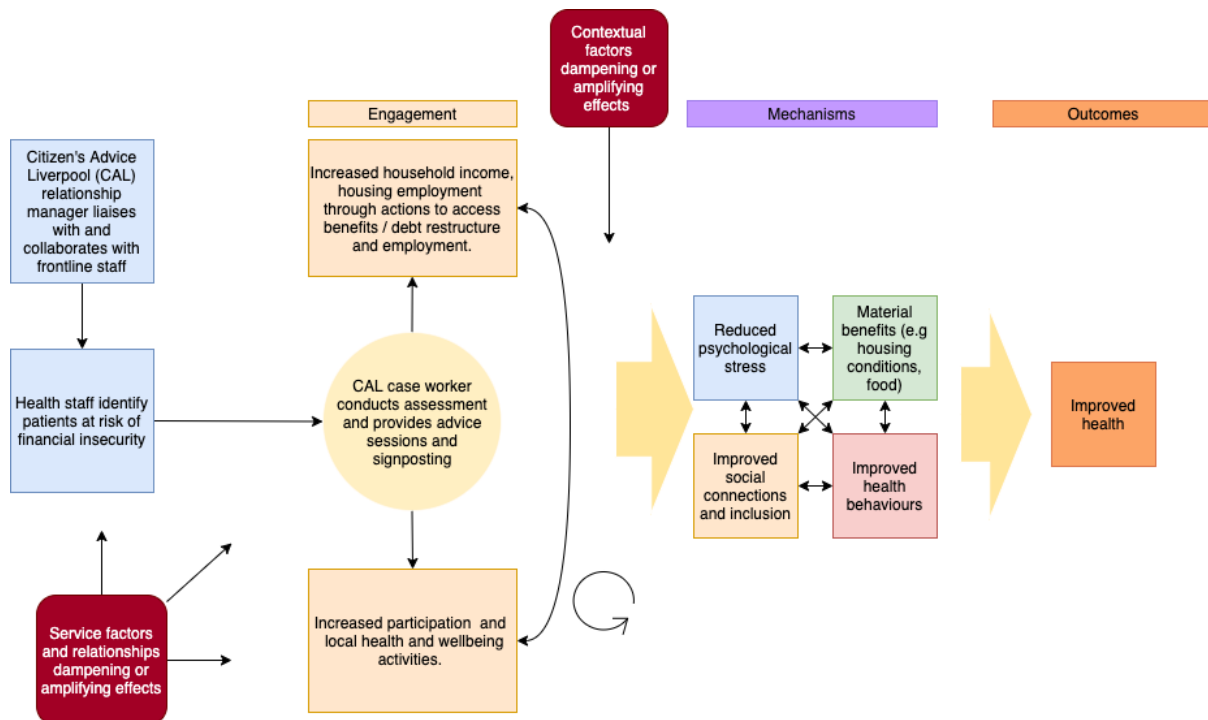


Figure 2: Overview of the logic model derived from theory of change for Citizens Advice on Prescription.

WP1: Estimating the impact of Citizens Advice on Prescription on health outcomes and healthcare utilisation.

### WP1. Methods

The planned analysis for WP 1 will use a unique dataset covering the whole population of Liverpool including linking health and social care datasets to Citizens Advice Casebook data. Analysis will use a quasi-experimental design matching CAP participants with a similar cohort that has not accessed the service enabling the robust estimate of the impact on health care utilisation. However, initial review of this data identified data linkage problems and a new data flow needed to be established under a new data sharing agreement. This has now been completed, however, linked data for this analysis was not available to inform this interim report.

Our analysis for this interim report therefore uses an unlinked extract of data from Citizens Advice Liverpool on all clients that have accessed the CAP service between January 2018 and August 2022. Within this data we define a *client* as any individual who has accessed CAP

at any point during this period, a case is a referral to CAP for a specific set of issues. In other words, one client can result in multiple cases, if at separate time periods the same person has been referred multiple times.

We define four main types of access into the service:

- CAP – General practice: largely welfare support accessed through or referred by GP practices.
- CAP – Secondary Care: a blended offer of social welfare and wellbeing support to any Liverpool patient in contact with secondary care, particularly patients referred from respiratory, mental health services, urgent care, cancer care, Macmillan.
- Link workers: who provide wellbeing support linked to primary care networks helping patients connect to enhanced community activities and services.
- Perinatal service which mainly provides social welfare support and advice, and wellbeing link work to women with babies and/or pregnant woman, taking referrals from health visiting, midwifery teams, mental health services and children's centres.

As outlined above, there are broadly two forms of support that people receive through CAP, welfare support and wider wellbeing support connecting people to community activities. Clients mainly receive social welfare support, while some clients receive a combination of both. The initial service linked to general practice and mental health in 2015 included only the welfare offer with the wellbeing offer being introduced alongside the link worker programme in 2018. We therefore define three intervention types: (1) People receiving casework for a welfare or legal issue, (2) people receiving wellbeing support, (3) people who have a record of a welfare or legal issue being addressed as well as social prescribing.

#### *Outcome measurement.*

CAL collect outcome data on each case whereby clients are asked at one point in time, usually at the end of the episode, if they have experienced an improvement in a set of outcomes. The outcomes assessed vary depending on the route into the service.

Those coming directly from general practice, secondary care and the perinatal service are asked if they were:

- Better able to manage their physical health
- Better able to manage their mental health
- Better able to participate in chosen activities
- Experienced greater choice, control or involvement in activities
- Established contacts that helped reduce social isolation.
- Secured or maintained accommodation.
- Increased feelings of safety and or reduced anxiety
- Improved or maintained self-respect
- Enabled to obtain maintain paid work
- increased budgeting skills awareness of affordable financial products and services.

Those coming through the link worker programme are asked if they were:

- Better connected to reduce social isolation.
- Increased physical activity and enabled to be active
- Engaged in creative activities (e.g arts, music, drama, choir, crafts)
- Connecting with others.
- Built personal confidence and resilience.
- Engaged in activities to support paid or unpaid employment

In addition to these outcomes CAL, since November 2021, have been collecting data using the EQ-5D<sup>35</sup> at assessment on all clients, then a snapshot of follow up at 2 and 6 months on clients referred between March and July 2022. The EQ-5D is a widely used instrument which evaluates health-related quality of life with one question for each of the five dimensions

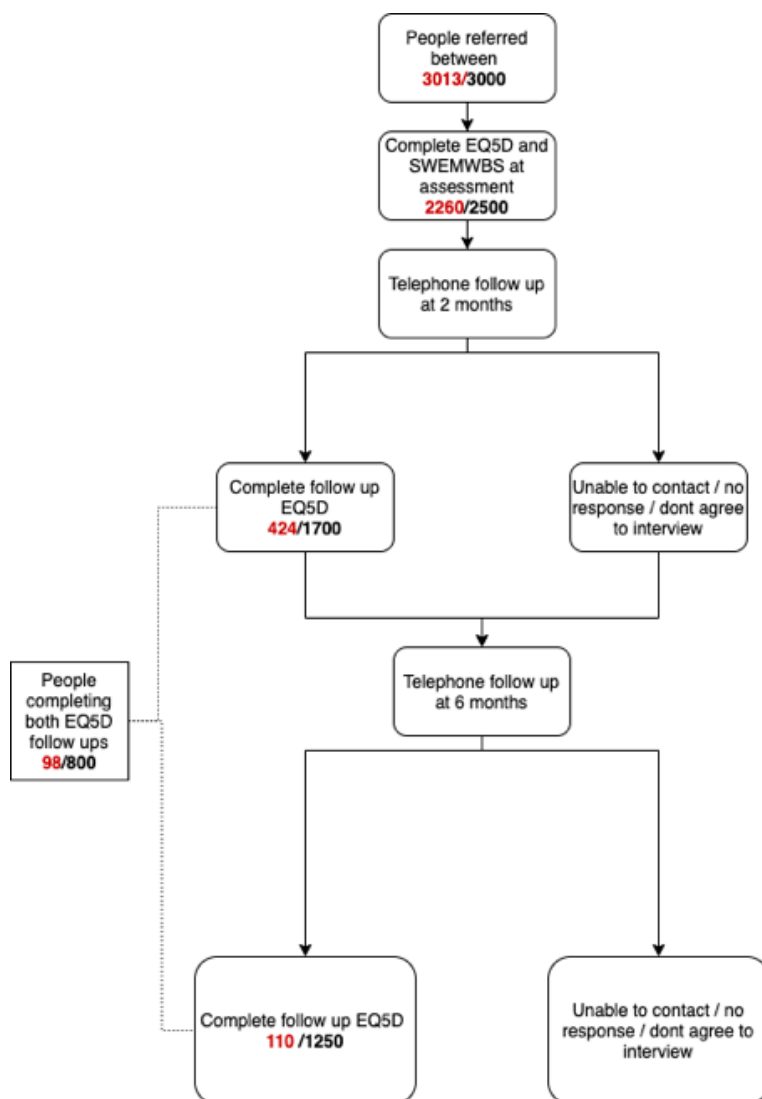


including mobility, self-care, usual activities, pain/discomfort, and anxiety/depression. In addition, clients are asked to rate their health on a visual analogue scale (VAS) from 0-100, with 100 indicating the best health status and 0 being the worst. The EQ5D-VAS measures patients' own overall assessment of their health and provides complementary information about the patients' view of their own health.

Training was provided to CAL case workers in the use of the EQ-5D instrument.

The target is to collect data on at least 800 people at all three measurement points, as shown in figure 3. At the time of this report, 2260 had complete data on the EQ-5D at assessment, 424 at 2 months and 110 at 6 months with 98 having measurements at all three time points.

Figure 3. Flow diagram for collection of EQ-5D outcome data.



We use three main outcomes derived from the EQ-5D instrument in this analysis.

**Outcome 1: EQ-5D index.** This index is derived from the answers across all five domains and provides a summary assessment of how good or bad a health state of service users is according to the general preference of the population. The index is computed by applying a formula that attaches value sets (weights) to the responses from each of the five dimensions. Where, the value sets are obtained from a standardised valuation exercise from a

representative sample of the general population in the UK. This gives an index between 0 and 1 (we might have some negative values as well) where value '1' is full health and '0' is a state as bad as being dead. And index values less than 0 represent health states regarded as worse than a state that is as bad as being dead.

**Outcome 2: Overall health.** We use the EQ-5D VAS score between 1 and 100.

**Outcome 3. Anxiety and depression.** The responses of clients to the anxiety/depression domain in the EQ-5D. Respondents are asked if they are: not anxious or depressed, slightly anxious or depressed, moderately anxious or depressed, severely anxious or depressed or extremely anxious or depressed. This domain has been found to be a valid screening tool for clinically relevant anxiety and depression as compared to the Patient Health Questionnaire 9 (PHQ9) and Generalized Anxiety Disorder 2-item questionnaires routinely used in general practice.<sup>36</sup>

We initially conducted a descriptive and graphical analysis assessing:

- The uptake of the service by ethnicity, deprivation, long term condition, age and gender and how this varies by service type and has changed over time.
- The profile of the clients in terms of income and levels of debt and how this has changed over time.
- The health profile of clients compared to the Liverpool population.
- The type of issues that clients receive support for through CAP and how this varies by ethnicity, deprivation, long term condition, age and gender and has changed over time.
- Self-reported outcomes and how these vary between client groups, including client reported improvements at the end of an episode and change in EQ-5D measures from baseline to 2 and 6 month follow up points.

To assess the change in each of our three outcomes we used regression models for longitudinal data comparing the change in outcomes between assessment and stage 2 (2 months) and between assessment and stage 3 (6 months). For EQ-5D index and VAS we used linear regression, and for anxiety and depression we used ordered logistic regression. Models accounted for the clustering of variance within individuals.

## Work Package One: Results.

### *Use of CAP across types of service access.*

Figure 4 and Figure 5 show the trends in the numbers of people and the number of referrals/cases by service access type. Between January 2018 and August 2022 there were approximately 50,000 referrals to CAP, from 25,000 people. On average, each person seen by the service over this time has had 2 referrals/cases.

The number of people accessing the service was steady prior to the pandemic at around 250 per month. There was a large increase during the pandemic, particularly through the link worker programme between April 2020 and April 2021. This in part reflects pro-active support provided to vulnerable people. At the beginning of the pandemic (April 2020 – July 2020), as part of Liverpool's Covid response in support of the clinically vulnerable, a list of vulnerable people was identified using clinical search criteria and these people were pro-actively contacted by CAP, Health Trainers and PCN SPLWs to identify those who needed additional support. Following the peak reached during the pandemic, utilisation of the service has remained higher than pre pandemic levels, with around 400 new people accessing the service each month. The numbers of clients accessing the service through secondary care remains low compared to other services such as GP practice and link worker and has reduced over time.



Figure 4: Monthly number of clients by service access type

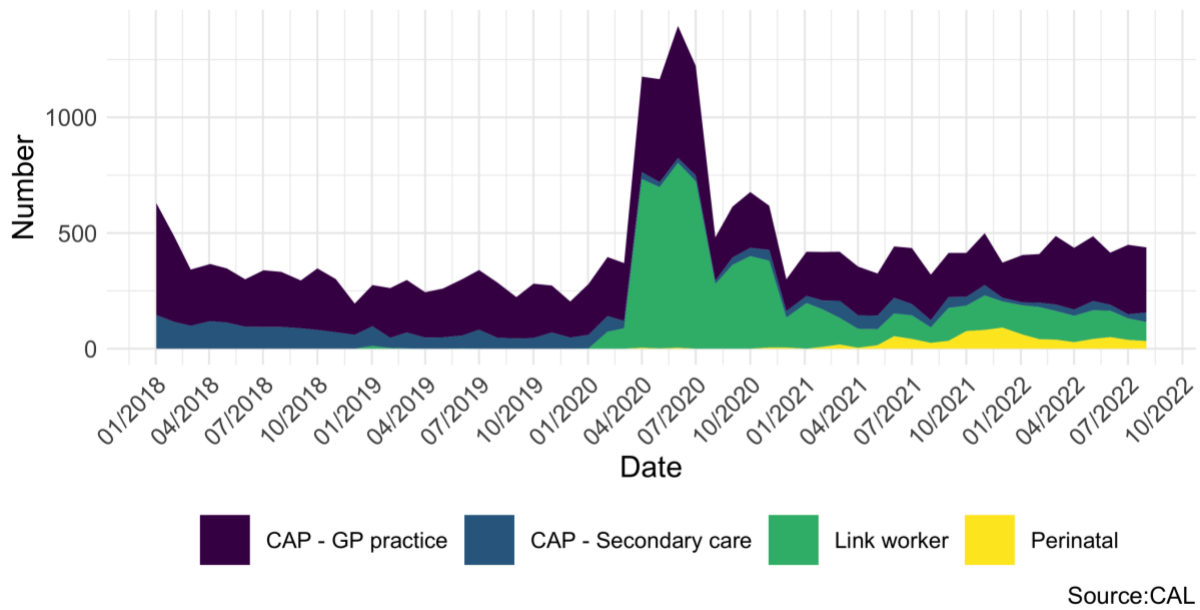


Figure 5: Monthly number of cases/ referrals by service access type

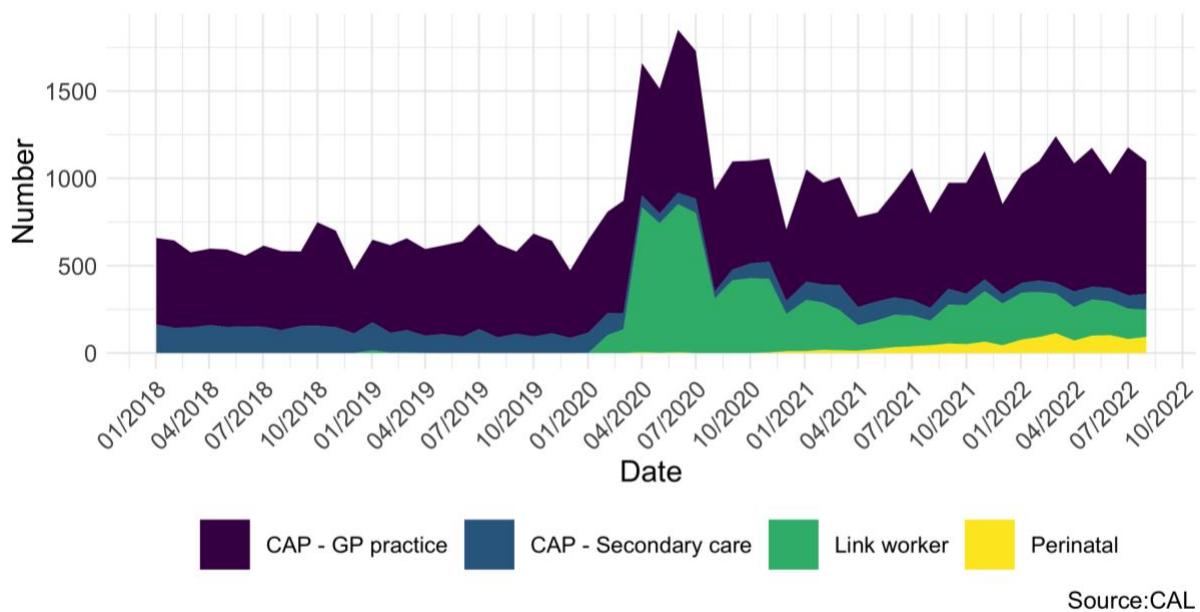
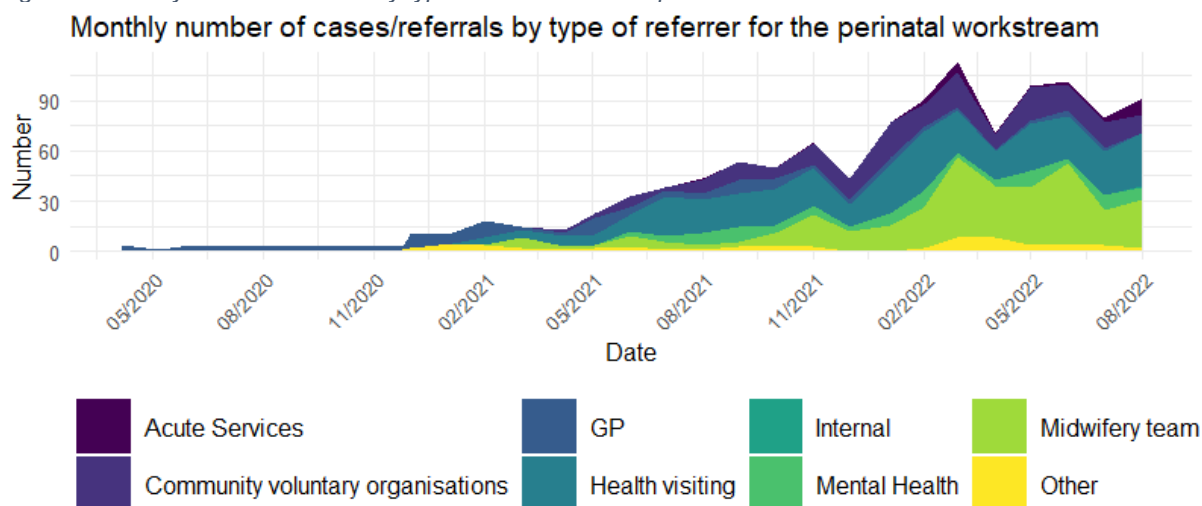


Figure 6 presents the service uptakes by type of referrals for the perinatal workstream. It shows that initially the number of referrals were low, but increase over time in 2021 and 2022, with an increase in the range of referrers including midwifery teams, health visiting, GPs and community organisations etc. Particularly, towards the end of 2021 and in 2022, we see an increased number of cases coming from all the referrers predominantly from midwifery team and health visiting referrers.

Figure 6: Monthly number of cases by type of referrers for the perinatal service

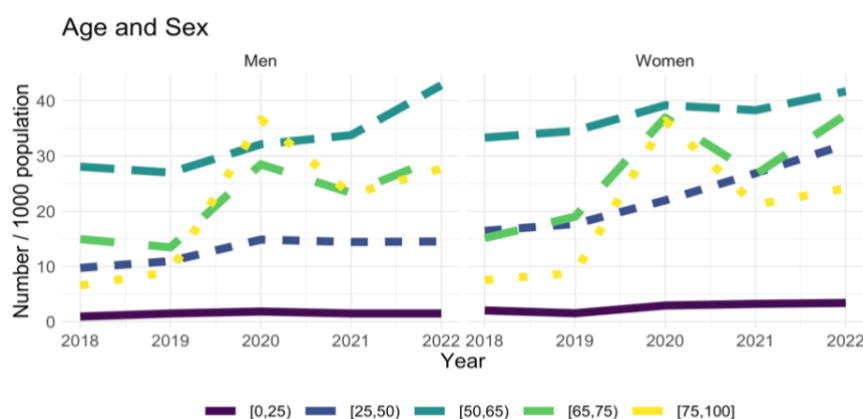


Source:CAL

### The demographic profile of CAP clients

Figure 7 shows the rate of service uptake per 1000 population each year by age group and sex. The 50 to 65 year-olds age group is the group most likely to use the service, although service use by older people (aged over 65) increased during and since the pandemic. The peak in the older age group during the pandemic reflects the targeted support that was provided to groups identified as vulnerable and on the shielding list. Use of the service by 25 to 50 year-olds has also increased, most markedly in women. This is important because women are generally poorer than men and more likely to have been adversely impacted by the cumulative impact of welfare changes since 2010. Women account for 65 percent of those hit by the Under Occupation Penalty and 60 percent of those affected by a cut in Council Tax Support. Besides, families with children were hit by the welfare changes such as a freeze in the child benefits, a reduction in housing benefits, the Under Occupation Penalty and the Benefit Cap.<sup>37</sup> Because of this, the service has actively sought to increase referrals for mothers with young children, particularly across the perinatal pathway.

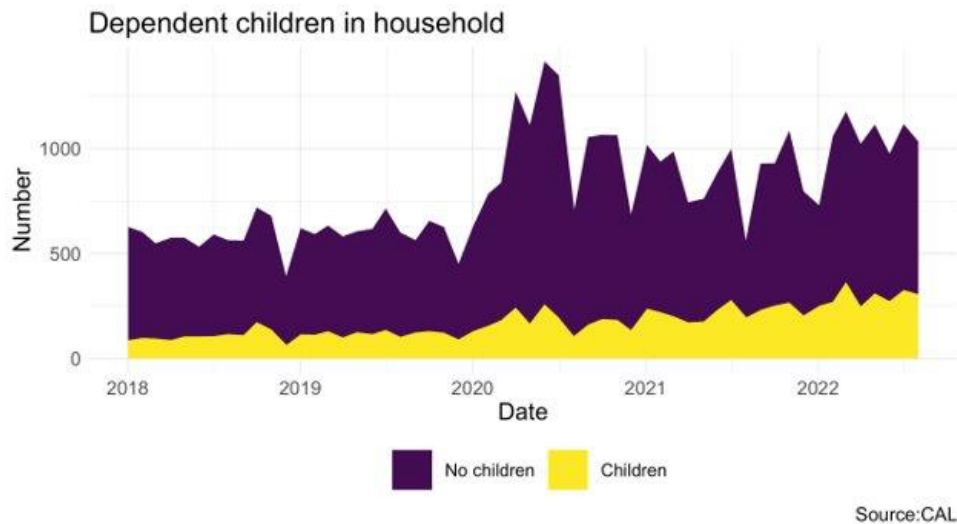
Figure 7: Number of referrals per 1000 population by age and sex (2022 data adjusted to reflect part year)



Source:CAL

Similarly, as Figure 8 shows – there has been a marked increase in the proportion of cases from households with dependent children, from around 80 to 250 - 300 per month. This is important, as the benefits of income maximisation may be particularly important for children living in poverty.

Figure 8: Monthly referrals for households with and without children



#### The profile of CAP clients by ethnicity

There has also been a marked increase in the proportion of clients from Black, Asian and Minority Ethnic groups (see Figure 9).

Figure 9: Proportions of yearly referrals by ethnicity

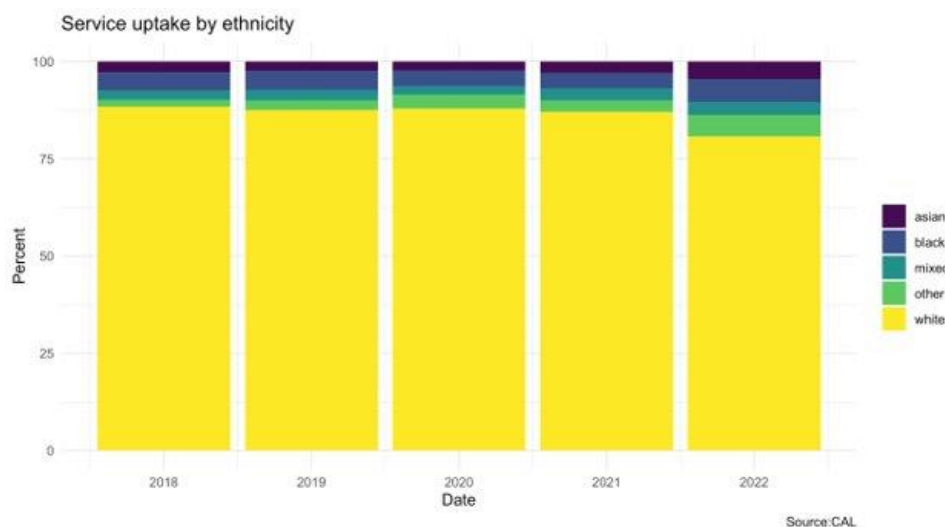
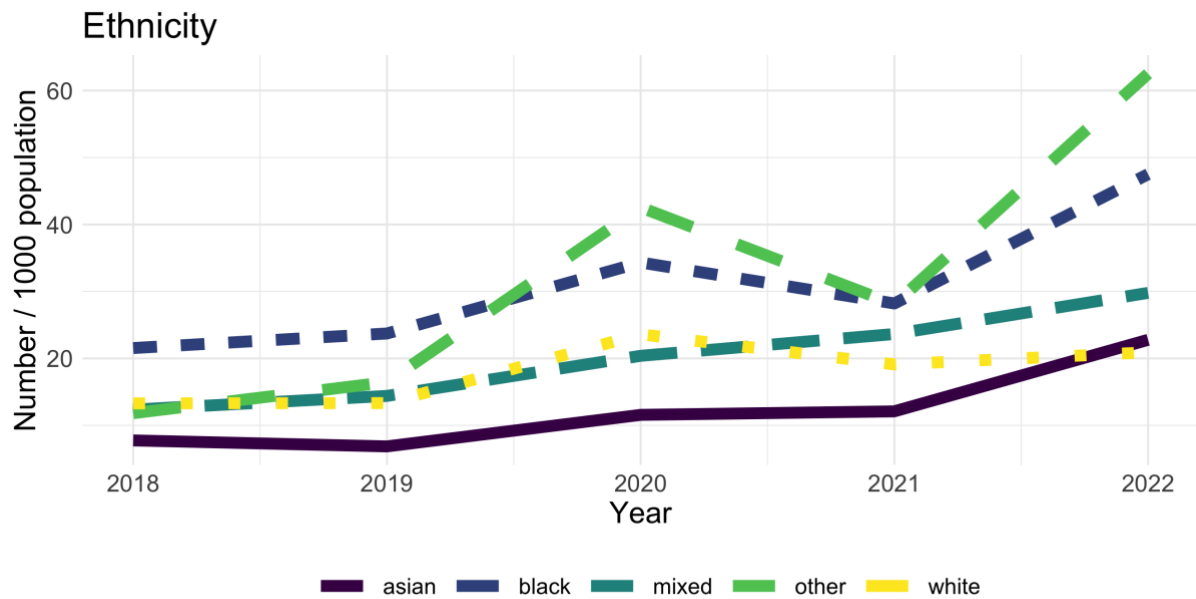


Figure 10 shows the uptake rate by ethnic group per 1000 population; taking account of the population size of each ethnic group (based on census data). We see that Black, Mixed and other ethnicities are more likely to use the service than the white population and this difference has increased over time. By 2022, the Asian group had the same likelihood of using the service as people of white ethnicity from previously low use. This reflects specific outreach activities that have sought to increase uptake in Black and ethnic minority groups with high levels of need.

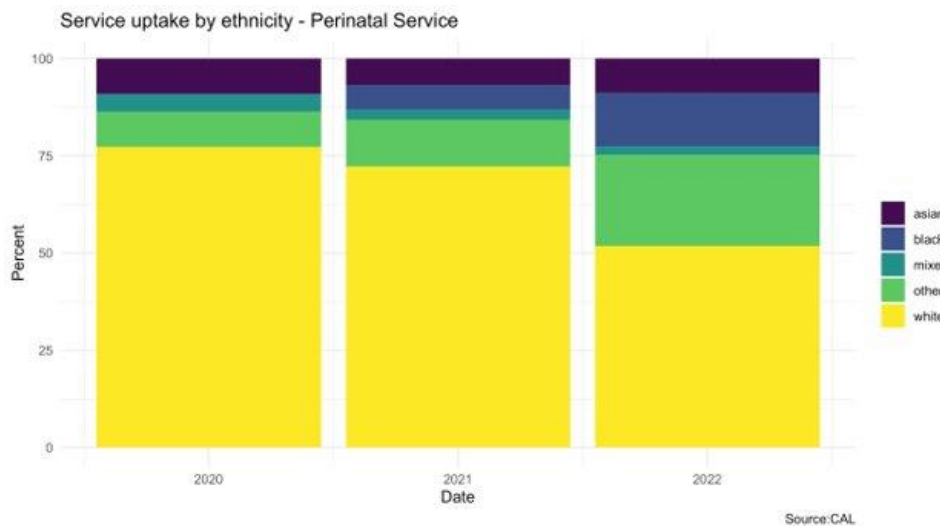
Figure 10: Number of referrals per 1000 population by ethnicity



Source:CAL

For the perinatal workstream in particular, we see a marked increase in black and ethnic minority group service use (see Figure 11), with people from black and ethnic minority groups making up nearly half of all cases.

Figure 11: Proportions of yearly referrals by ethnicity - perinatal service

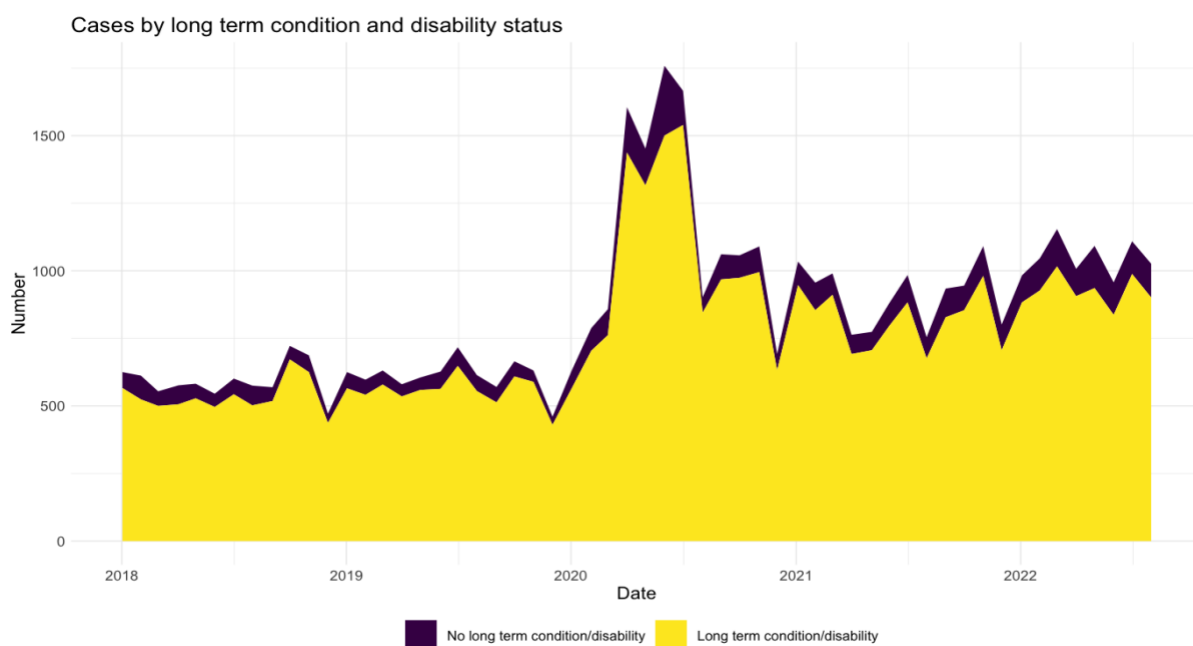


Source:CAL

A large majority of all clients (90%) using the service report having a long term mental or physical health condition or disability. Although this proportion decreases slightly to 88% in 2022, there is a large increase in the absolute numbers of people with long term conditions accessing the service (see Figure 12).

*The health status of CAP clients*

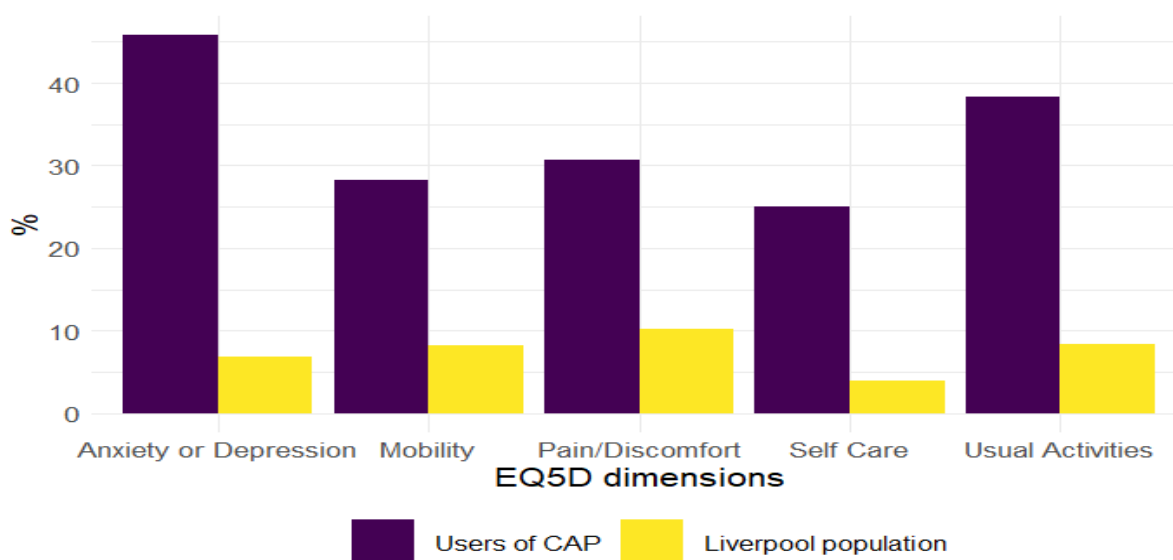
Figure 12: Monthly referrals by long-term condition and disability status



Source:CAL

Figure 13 shows the health profile of 2,500 clients who completed the EQ-5D in 2021-22 at assessment, compared with the overall Liverpool population, based on the responses from the GP patient survey in Liverpool in 2017. Forty-five percent of CAP clients reported that they were extremely or severely anxious or depressed. This compares with 6% of the overall Liverpool population based on the 2017 GP patient survey, the latest available data using the same EQ-5D measure. Across the five quality of life domains, the CAP client group has much more severe health problems compared with the Liverpool population; a high proportion having severe disability, with high limitations in ability to selfcare and undertake usual activities.

Figure 13: % of CAP service users reporting severe or extreme difficulties in each of the domains of the EQ-5D compared with the overall Liverpool population (GP patient survey data 2017).

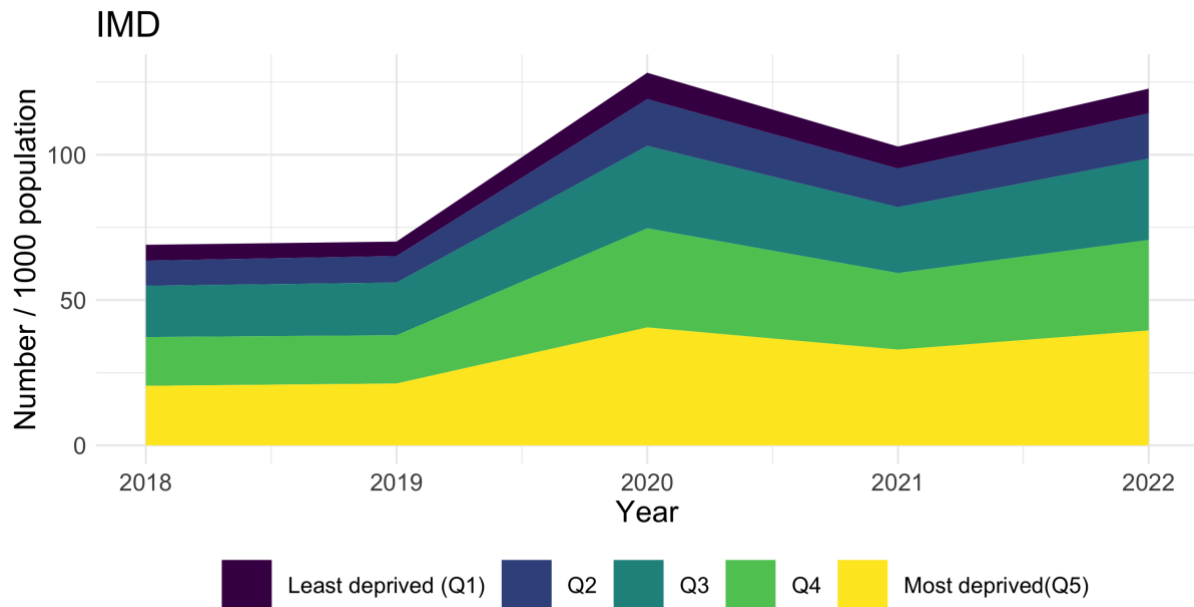


Source:CAL and GP patient survey 2017

*The socioeconomic profile of CAP clients*

Figure 14 shows service uptake by deprivation level. Uptake has increased most in the most deprived populations, with the share of clients coming from the most deprived areas in Liverpool increasing from 30% in 2018 to 32% in 2022.

Figure 14: Number of referrals per 1000 population by deprivation quintile



Source:CAL

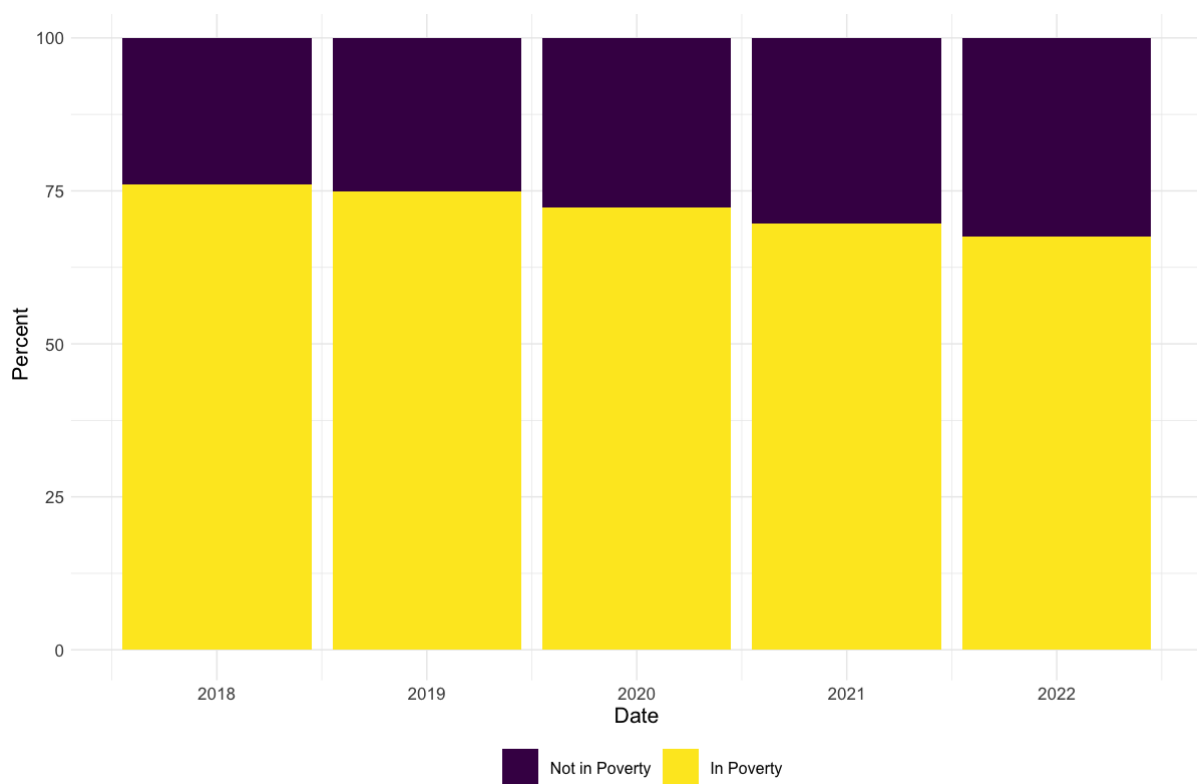
Figure 15 shows an estimate of the proportion of clients in poverty. This estimate is based on client reported income data recorded in casebook. We take the poverty threshold as being a monthly income of below £1300. This was the level that was 60% below the national median income in 2018, which is the measure of poverty used nationally by the Office for National Statistics.<sup>38</sup> There are a number of caveats in this estimate. Firstly, there is quite a lot missing data, 18% of records have no income recorded. Secondly self-reported income can often be inaccurate and may be biased,<sup>39</sup> particularly as in this case it is not clear if people are reporting household or individual income. As we do not have complete household income or data on the number of people in each household, we cannot calculate household income adjusted for household size, which is what official national poverty measures are based on. Nevertheless, this analysis gives an approximate indication of the proportion of households that are probably below the national poverty threshold.

We estimate that a large proportion of clients are probably living in poverty<sup>1</sup>. The proportion of clients estimated as living in poverty has however been declining over time. In 2018, 76% of clients were estimated as living in poverty, whilst in 2022 this had reduced to 69%. Overall poverty levels during this time in Liverpool have not been declining during this period and have actually increased. This could therefore reflect the change in emphasis of the service over time. In particular, during the pandemic, the service pivoted to supporting people with medical vulnerabilities to COVID-19 which included a wider segment of the population, less affected directly by poverty, also with the introduction of the link worker programme there has been an increased focus on the wellbeing offer as well as a welfare offer. Other reasons could include the widening out of the service into areas of service beyond mental health and general

<sup>1</sup> The poverty status is determined based on the income profile of the service users. People would be labelled as in poverty if their income is less than the average threshold of £1300pcm.

practice. However, it could also reflect limitations we have in the calculated poverty levels in this analysis. For example, it is likely that the household size of clients is greater in more recent years, given that we have an increase in the proportion of clients with children. If we able to take this into account, we may not see the same decline in poverty rates. Estimated poverty rates tended to vary considerably between routes into the service. The highest poverty rates are in people accessing the service through primary care (73%) and secondary care (78%), whilst poverty rates are lower in those accessing through link workers (68%) and the perinatal pathway (50%). This could in part be due to differences in household size of clients in these groups, but this is unlikely to explain all the difference. Clients living in poverty were slightly more likely to have a health condition or disability (90% vs 83%). They were nearly twice as likely to be experiencing severe anxiety and depression (50% vs 29%). Overall, the service is being used by a relatively large number of people who have a long-term condition and are living in poverty (16,000 people during the study time period).

Figure 15: Proportions of yearly referrals by poverty status (in poverty if income is under £1300 pcm)



Source:CAL

The number of people with some positive debt arrears has increased from an average about 107 referrals per month prior to the pandemic to about 150 per month during the pandemic and 167 referrals per month after the pandemic. However, the proportion of clients receiving debt advice appears to have reduced over this time, and the level of debt has also declined. This is shown in Figure 16. However, it is important to note that the type of debt is more important than the amount, as some debt, even relatively small amounts, if left unpaid, can lead to prosecution and loss of liberty. This aspect will be reviewed in greater detail in a future stage of the evaluation.



Figure 16: Proportions of yearly referrals by debt arrears

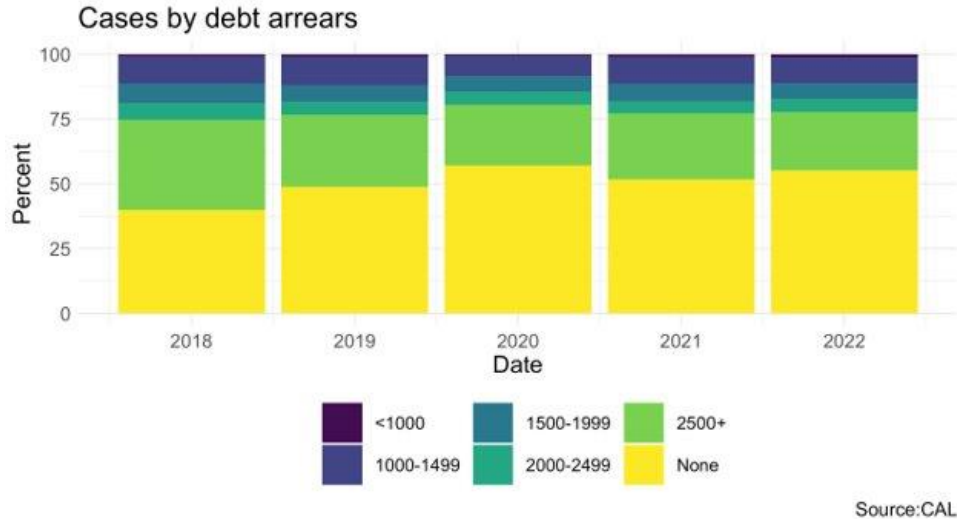
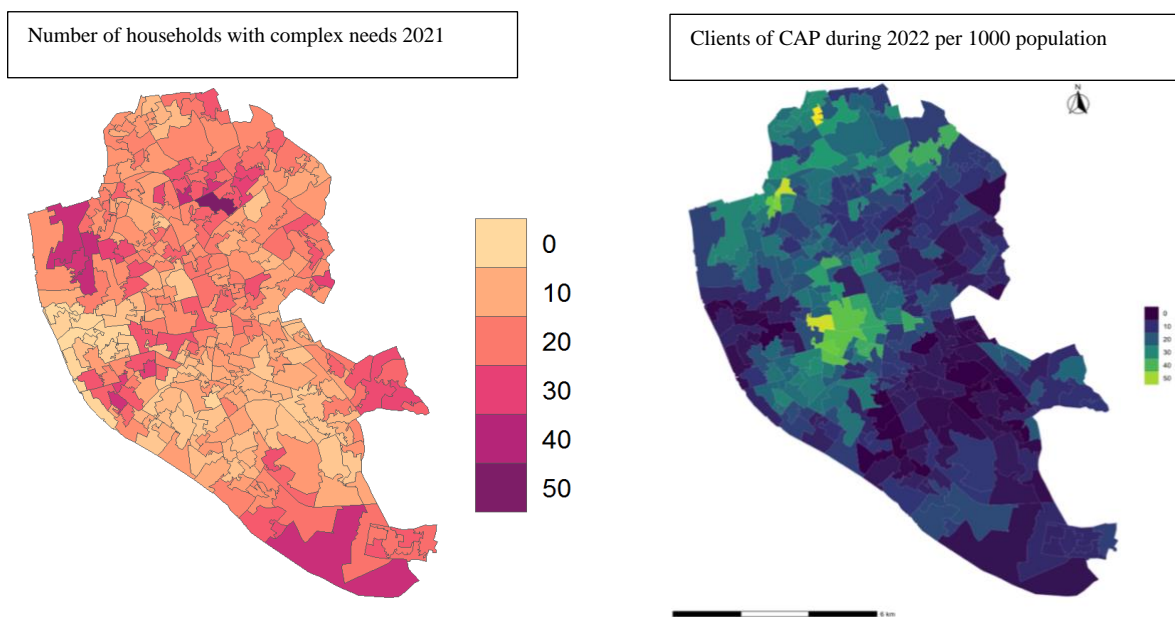


Figure 17 shows the geographical distribution of CAP clients in Liverpool on the right, compared with the distribution of households with complex needs (defined as those that have complex mental and physical health issues together with social and welfare problems), on the left. The comparison highlights the geographical distribution of need for CAP. In North Liverpool, the distribution of CAP clients seems to closely match the geographical pattern of need. This is less the case in South Liverpool. Whilst the south of Liverpool is on average more affluent than North Liverpool there are significant pockets of deprivation in Speke-Garston and Belle Vale. At present the communities in these places are not accessing the service as much as would be expected given their level of need. However, the average number of clients accessing the service per 1000 population in Speke-Garston and Belle Vale was not lower than the other areas in 2018. Similarly, it was not particularly lower in these areas as per the exploratory analysis from 2015 to 2018.

Figure 17: Geographic distribution of CAP clients and number of households with complex needs

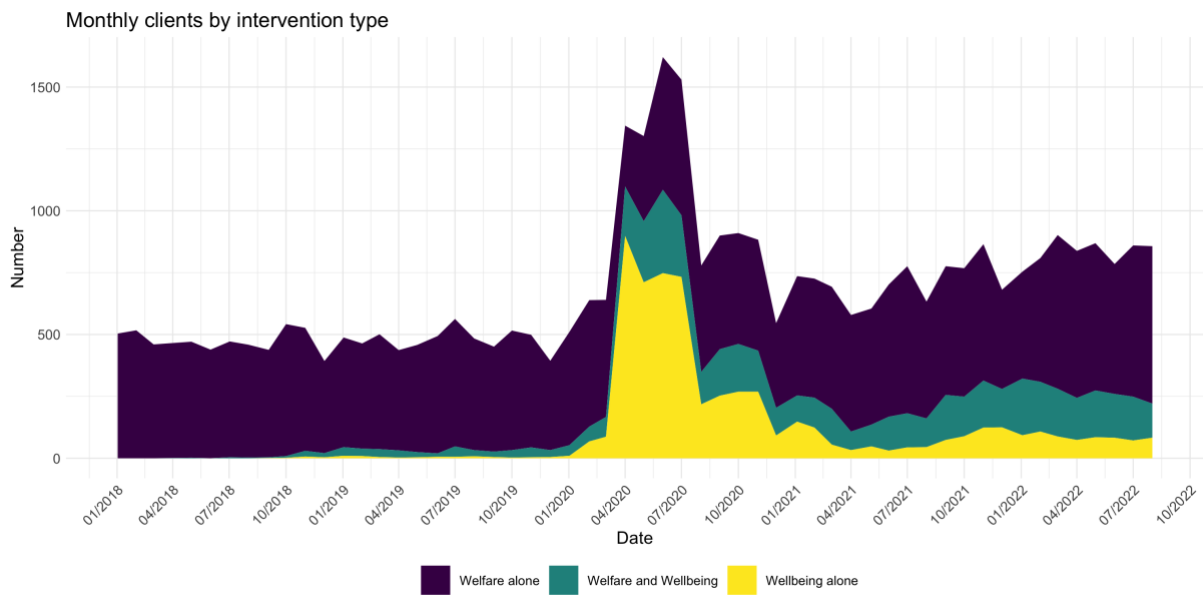




*Types of issues and support provided*

Figure 18 shows the number of clients receiving either welfare support alone or wellbeing support alone, and those receiving both. As receipt of welfare or wellbeing support may be defined as separate cases, this chart is based on clients. The largest group is those receiving just welfare support at around 500 clients a month, with the numbers receiving just wellbeing support rose considerably during the pandemic with the introduction of the link workers and fell back to around 80 clients per month, more recently. The number receiving both welfare and wellbeing have been increasing. In 2022 around 180 clients a month have received a combination of welfare and wellbeing support (22% of all clients).

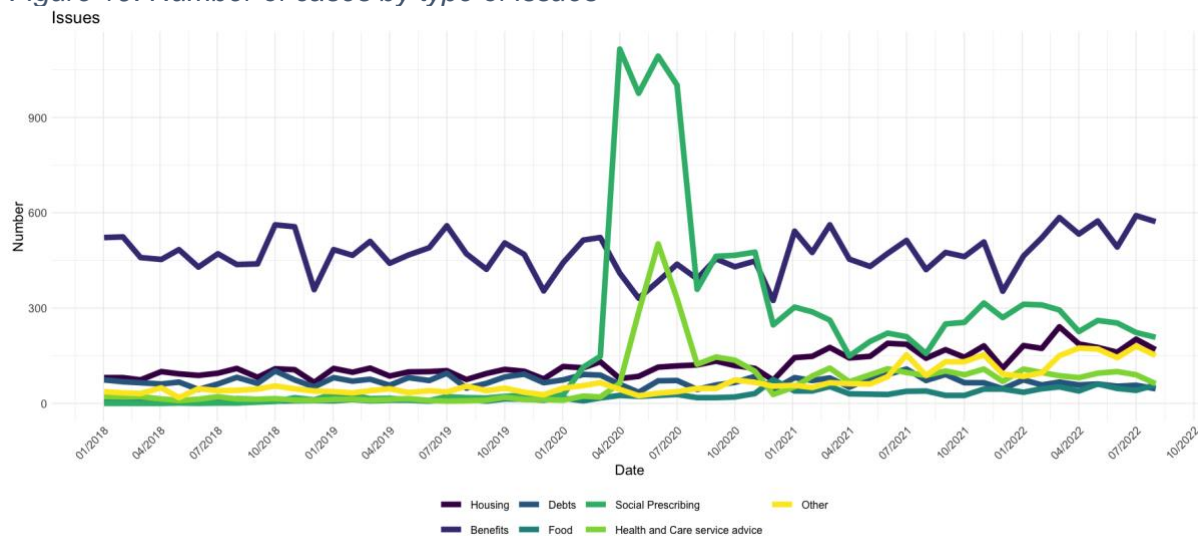
*Figure 18: Monthly numbers of clients by intervention type – showing the number of clients who received welfare support, wellbeing support and both.*



Source:CAL

Figure 19 shows the numbers of cases presenting for a selection of issues. The majority of cases are provided with support with benefits or tax credits. During the pandemic there was a marked increase in clients provided with social prescribing support to access other community activities, reflecting the wellbeing offer. There has been a steady increase in the number seeking housing related advice since the pandemic. There has only been a relatively small number of cases recorded as seeking support for food related issues, although this has been increasing. This however may reflect lack of coding of this issue on the casebook system rather than necessarily a low number of people being offered or needing food related support.

Figure 19: Number of cases by type of issues



### Outcomes.

Figure 20 shows the % of clients reporting that they experienced improvements in each of the outcome areas. These set of questions are only asked to clients that have accessed the service through the GP practice, secondary care and perinatal pathways. Generally, a high proportion of the clients report improvement on outcomes reflecting psychological wellbeing (self-respect, anxiety, choice and control) as well as managing mental health and to a lesser extent physical health. A smaller proportion of clients reported improved material and social conditions (e.g employment, accommodation, participation in daily activities, isolation). It is not surprising that these are lower as it is likely that these take longer to change than wellbeing measures. This still represents quite a large proportion of clients reporting material improvements, with 40% reporting that the intervention had improved either employment, accommodation or their ability to participate in activities). In general, these improvements in material conditions were greater in working age groups compared to older age groups, and amongst people accessing the service through GP practices, compared to other routes and in people from the more deprived areas, compared to the more affluent areas. There was no difference in these outcomes between ethnic groups, gender or health status.

Figure 20: self-reported outcome set 1 by route of service access

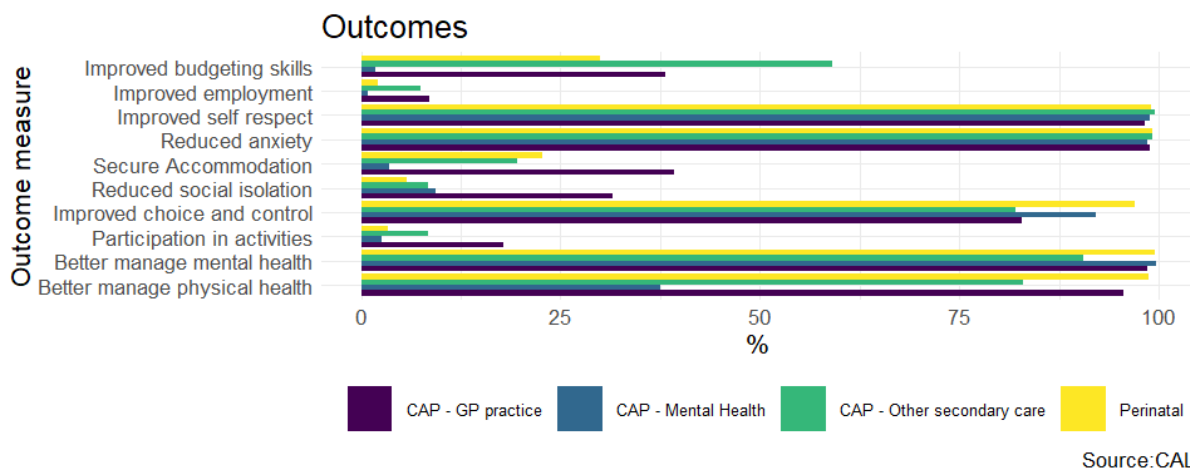
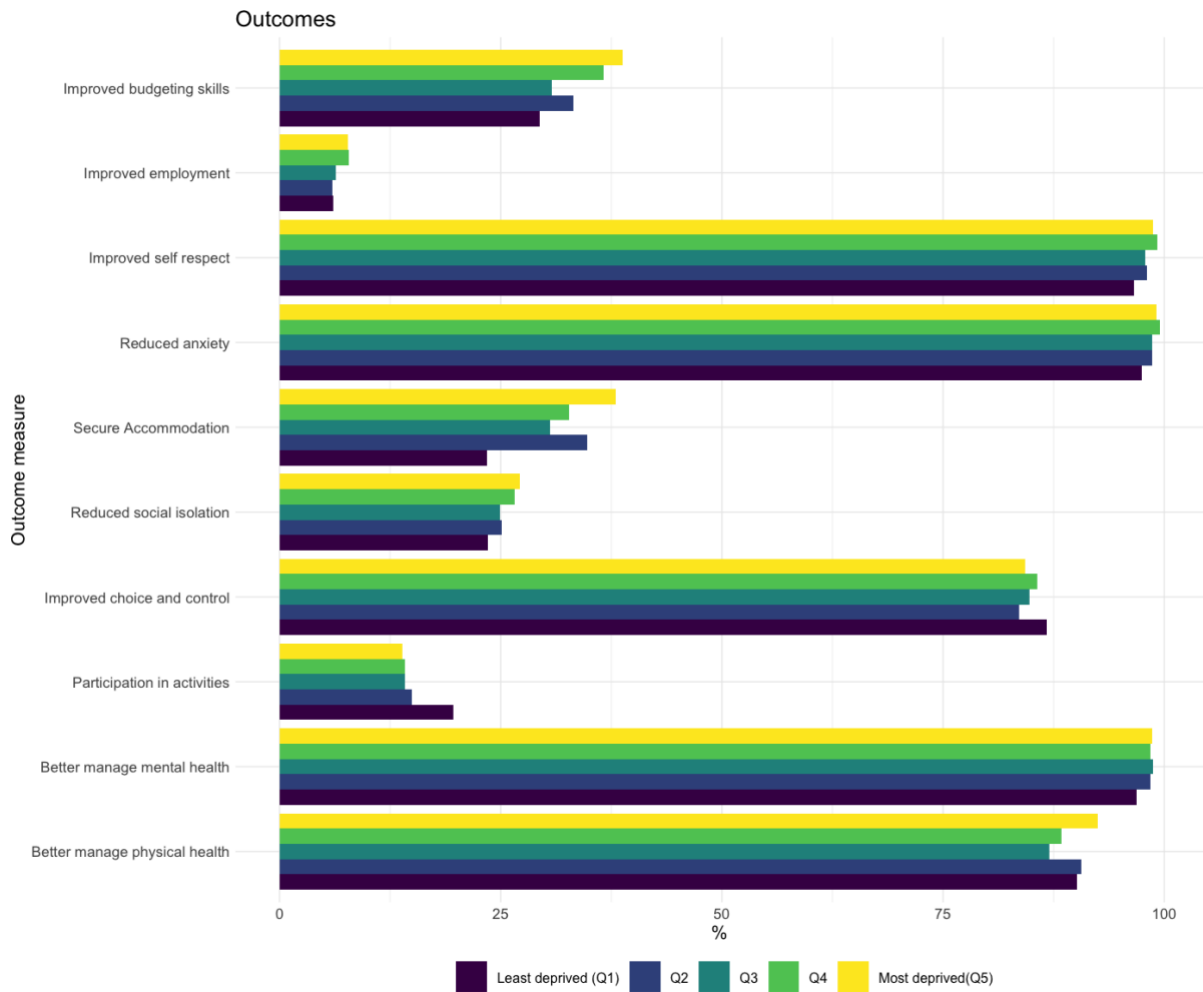


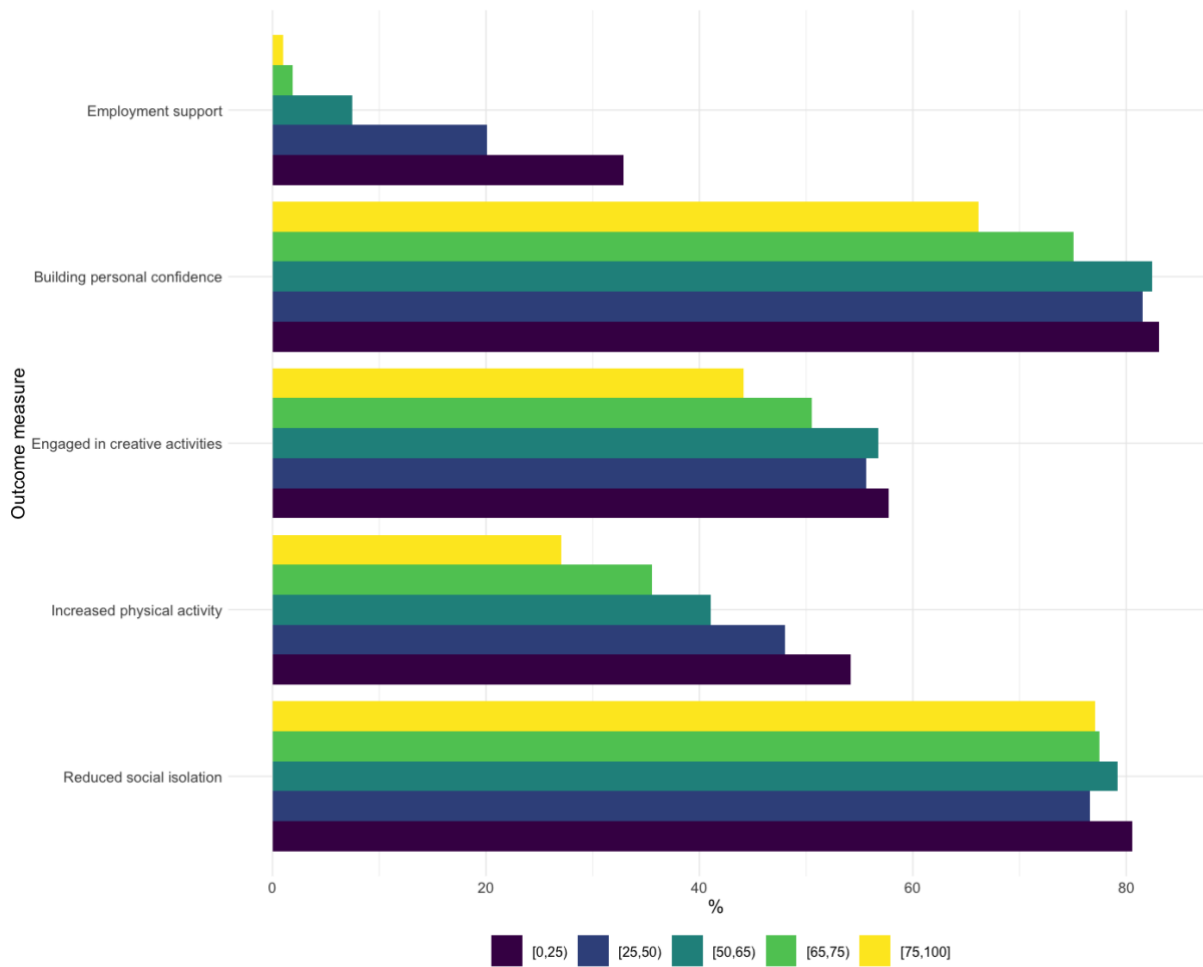
Figure 21: self-reported outcome set 1 by deprivation



Source:CAL

Figure 22 shows the outcomes reported for clients accessing CAP through link workers, i.e., they received their initial support from a link worker and they may or may not have then received additional support through other CAL case workers. A large majority report improvement as a result of the service in particular in building self-confidence and reducing social isolation. The major difference between clients in reporting of outcome was related to age. Younger clients accessing CAP through the link workers were more likely to report improvements than older people.

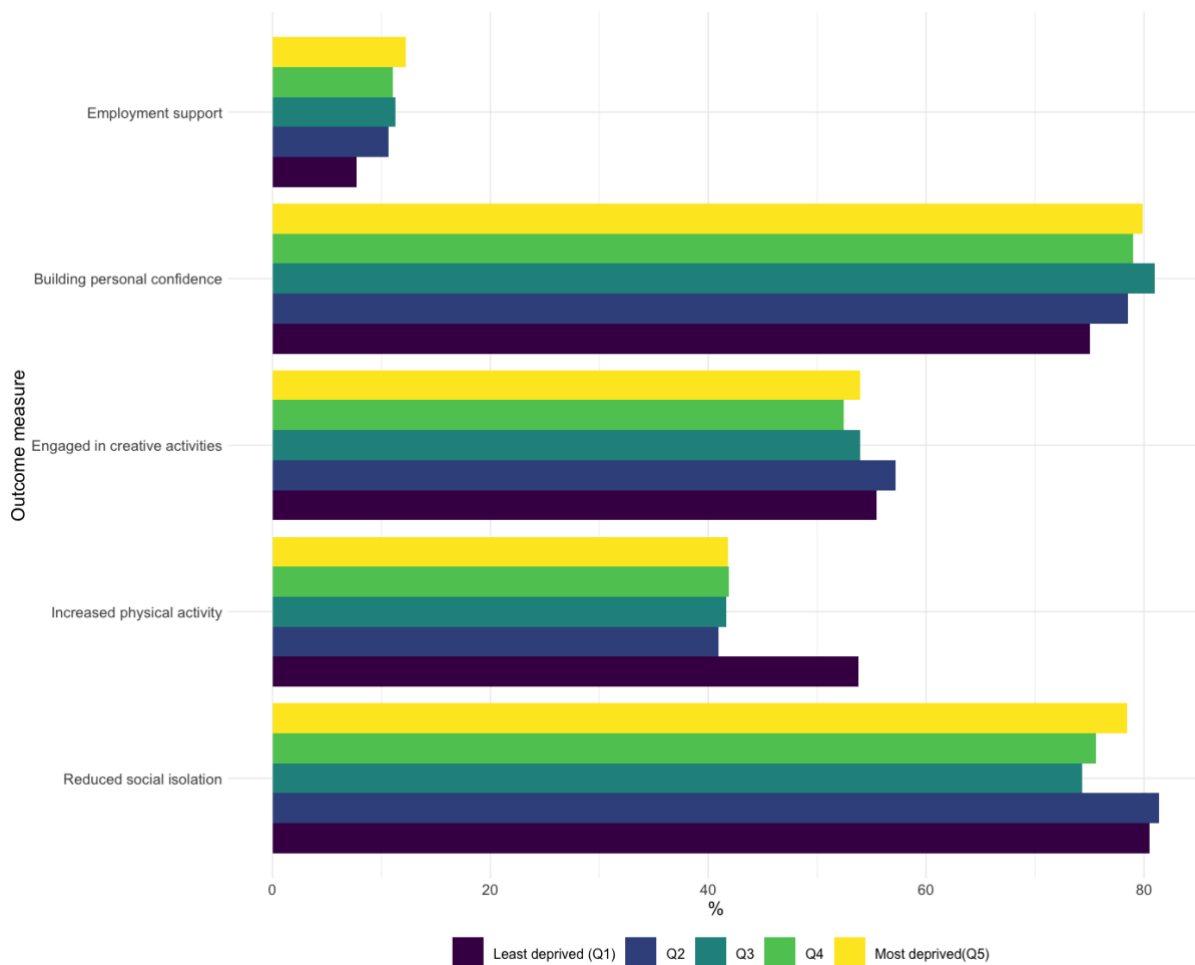
Figure 22: self-reported outcome set 2 by age group



Source:CAL

The level of improvement in some outcomes reported for clients accessing CAP through link workers, differed by deprivation level. People living in more deprived areas were more likely to report improvements in building confidence and engagement in employment support, than people, living in less deprived areas. People living in more affluent areas were more likely to report improvements in physical activity and engagement in creative activities. (See Figure 23).

Figure 23: self-reported outcome set 2 by deprivation



Source:CAL

### EQ-5D follow up measures

Our analysis focuses on the three measures derived from the EQ-5D<sup>2</sup> as outlined above.

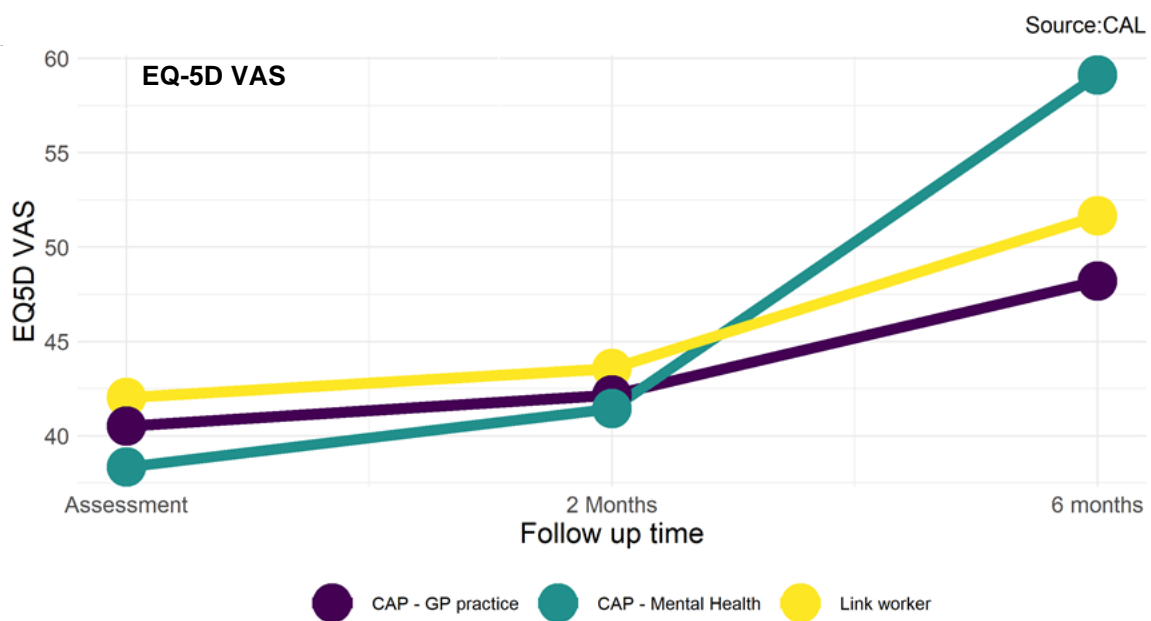
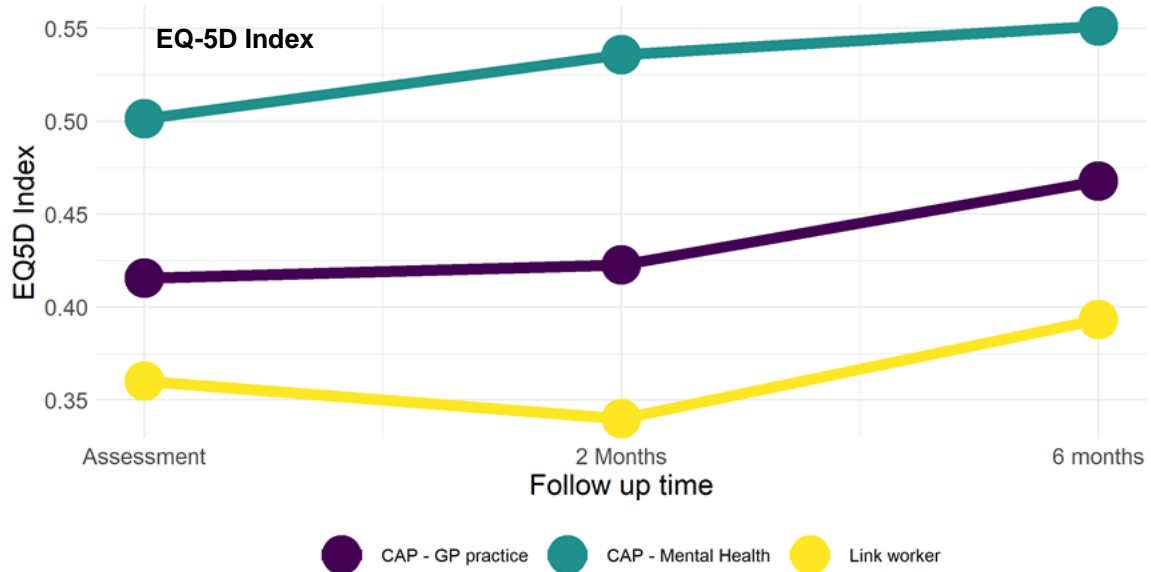
- The EQ-5D Index (0 to 1, where 0 is worst health and 1 best health)
- EQ-5D Visual Analogue Scale (VAS) (on a scale from 0 to 100, where 0 being the worst health status and 100 being the best health status), and
- Anxiety and Depression (ordered from 1 to 5, where 1 denoting 'not anxious or depressed' and 5 denoting 'extremely anxious or depressed').

As stated above, the EQ5D-VAS measures patients' own overall assessment of their health and is distinct from EQ5D index profile which is restricted to the five dimensions. Though the EQ5D-VAS is conceptually different than EQ5D index profile, it provides complementary information about the patients' view of their own health. Figure 24 shows the trend in these three outcomes over time for 98 people (53 referred from GP-practices, 9 from mental health services and 36 seen by link workers) who had completed the EQ-5D questionnaire at three time points: assessment, 2 months and 6 months. This shows improvements across all outcomes, most notably the VAS between 2 month and 6 months of follow up. For people accessing the service through mental health services, the proportion reporting severe or

<sup>2</sup> The results presented in this report are based on the number of observations completed in all stages, assessment and two follow-up points, and results could change as we have more people completing the questionnaire in all time points.

extreme anxiety and depression increased at 6 month follow up after reducing between assessment and 2 month follow up, but this is only based on 9 clients so is likely not representative of all people accessing the service through this route. For the other types of service access anxiety and depression reduced at each follow up point. As this is only based on a small, selected sample, improvements observed may be because people whose health improved could have been more likely to be assessed with the EQ-5D, rather than necessarily reflecting the causal effect of the intervention.

Figure 24: Trends in EQ-5D Index VAS and Anxiety/Depression at assessment, and follow-ups



Source:CAL

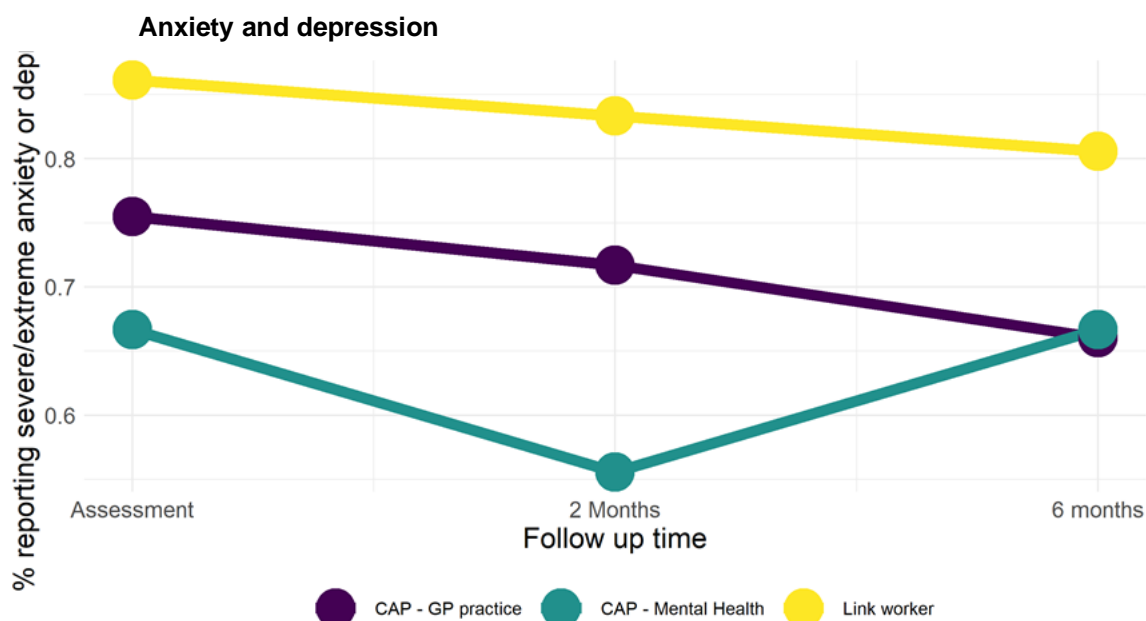


Table 2 presents the regression results for the changes in our three EQ-5D measures between assessment and the first follow-up, after 2 months, including all 399 people who had complete data at assessment and 2 month follow up. It shows some improvements for the EQ-5D VAS outcome ( $p=0.05$ ). With the clients score of overall health increasing by an average of 3 points, a 7 % improvement. And a 17% reduction in anxiety and depression (Odd Ratio = 0.83,  $p=0.04$ ). There was no significant change in the EQ-5D index.

Table 2: Change in outcomes between the assessment and first follow-up (2 months) ( $n=399$ )

outcome	Estimate	lcl	ucl	p
EQ-5D Index (change in index)	-0.0100	-0.0362	0.0163	0.458
EQ-5D VAS (Change in score)	2.8	-0.0	5.5	0.050
Anxiety and Depression (OR)	0.83	0.69	0.99	0.036

Table 3 further shows the changes in the EQ-5D VAS by the type of service through which people accessed CAP. The changes in the EQ-5D VAS between the assessment and 2-month follow-up were larger for clients accessing CAP through mental health services, but smaller and not significant for clients accessing through GP practices. There was no difference in effect on anxiety and depression at 2 months by service type, nor was there any difference on effect on either VAS or anxiety or depression by ethnicity, deprivation, age or gender.

Table 3: Changes between assessment and first follow-up – VAS by service (n=399)

service	Estimate	lcl	ucl	p
CAP - GP practice	1.31	-2.52	5.14	0.5
Link Worker	3.93	-0.32	8.18	0.07
CAP - Mental Health	6.72	0.2	13.24	0.04

Table 4 shows the changes in our three outcomes between assessment and 6-month follow-up for the 103 people who had complete data at assessment and 6 month follow up. Over this time period we see a larger increase in the overall health as measured by the VAS of 9 points (17% increase) and a larger reduction in anxiety and depression of 38% (OR=0.62, p=0.005).

Table 4: Change in outcomes between the assessment and 6 months follow-up (n=103)

outcome	Estimate	lcl	ucl	p
EQ-5D Index (0 (worst health) to 1 (best health))	0.0405	-0.0165	0.0976	0.163
EQ-5D VAS (Points on 0 to 100 scale)	9.4	3.5	15.4	0.002
Anxiety and Depression (OR)	0.62	0.44	0.87	0.005

We found no significant difference in these outcomes by type of service, age, gender, or ethnicity. Although the small numbers involved mean that such subgroup analysis is highly uncertain. There was some difference in effect on the VAS by deprivation level. Table 5 shows that the clients in the second most deprived group (Q4) has shown a larger change in their VAS outcome after 6 months compared to the assessment period indicating for an improvement in their self-reported health status. The smallest improvement was on the least deprived group.



Table 5: Changes between assessment and second follow-up – VAS by deprivation

service	Estimate	lcl	ucl	p
Q1 (Least deprived)	-11.00	-32.47	10.47	0.32
Q2	11.36	-2.53	25.24	0.11
Q3	1.21	-9.46	11.88	0.82
Q4	20.96	9.20	32.71	<0.001
Q5 (Most deprived)	8.37	-2.12	18.85	0.12

## Work Package Two: - Understanding service users' experience of the Citizens Advice on Prescription intervention

Work package 2 has two streams, focussing respectively on users of CAL services and stakeholders involved in delivering the intervention. Particularly, understanding how service users' experience of the Citizens Advice on Prescription intervention has influenced their health and wellbeing. And from a stakeholder perspective, identify enablers and barriers to effective implementation.

### Work Package 2. Methods

Semi-structured interviews are conducted with service users at three time points: shortly after their initial assessment with CAL (baseline) and approximately 2 months and 6 months later. Interviews are narrative in style to allow participants to tell their own stories, including what the situation was that led them to accept the referral, what impact that situation had on their wellbeing and health, how they experienced the referral and intervention, and any differences that the intervention has made so far. Follow-up interviews ask about any further appointments with CAL and changes to situation and wellbeing. The aim is to include a balance of male and female, younger and older participants who have been referred from the full range of CAP referrer types. We are also collecting a small amount of other demographic data from participants including ethnicity, country of origin, language needs, disability, long-term limiting illness and status as an informal carer. By including a range of participants with different characteristics we aim to capture a wide range of experience and to explore how that experience may differ for different groups.

As of October 10, 2022, we have interviewed 12 participants at baseline and have conducted follow-up interviews for five participants.

We are also conducting semi-structured interviews with selected stakeholders, to elucidate key roles and relationships between and within health and care (NHS, private and third sector) organisations that have enabled or constrained action to implement and embed a service which identifies and supports women in need in the perinatal period. We will recruit participants through health and care services that (are in a position to) refer patients to the intervention, seeking out 'key informants' - health professionals who are working with groups of people particularly targeted by the Citizens Advice on Prescription intervention and have experience relevant to the study. As of October 10, 2022, five stakeholder interviews have been completed. We have obtained University of Liverpool Sponsorship for recruitment and

interviews with healthcare professionals working in the NHS and are awaiting Health Research Authority (HRA) approval.

For both groups of interviewees (service users and stakeholders), data will be analysed using narrative and constant comparative approaches to develop thematic analysis<sup>40,41</sup>. We will involve our public advisors in the process of analysing anonymised participant transcripts to provide their perspectives on data interpretation. We will aim to triangulate findings across the interviews of stakeholders and service-users. For example, if service-users talk about the how service has helped their wider support network, we may interpret this alongside interview data from the stakeholders who talk about the process of developing wider support networks for service-users. We will utilise narrative interviews with stakeholders to explore the nature of the relationships between individuals and between organisations, feelings and processes, the exchange of knowledge and/or resources, how they have changed over time and the power or influence of the actors.

the analysis of stakeholder interviews will more specifically investigate different levels of learning related to the implementation, as well as broader dynamics such as collaborative learning and the role of knowledge and knowledge brokering<sup>42</sup> and change failure in complex systems<sup>43,44</sup>. The analysis will then explore how these individuals feel implementation can be improved and challenges overcome where difficulties arise in supporting service-users and patients across the intervention. In particular, we seek to develop an embedded learning approach, drawing on real-time lived experiences of actors' challenges and successes. Overall, we will translate these into understanding how the intervention enables or constrains the changes that have the potential to impact on health.

#### Work Package 2. Findings

The 12 participants interviewed so far were demographically varied, including six men and six women; one aged under 30, five aged between 30 and 45, and six aged between 55 and 65. Their countries of origin included the UK (n=7), Zimbabwe (n=1), Hong Kong (n=1), Syria (n=1), Jamaica (n=1) and India (n=1). The sample included one confirmed refugee and one asylum seeker.

All reported currently experiencing moderate (n=9), severe (n=2), or extreme (n=1) levels of depression or anxiety on the EQ-5D. All revealed other health conditions, including muscular or skeletal problems (n=6), severe mental health diagnosis (n=3), PTSD (n=2), long COVID (n=2), poor memory and concentration following a stroke (n=1), heart or circulation problems (n=3), asthma or COPD (n=3) and diabetes (n=2).

#### *Participants' stories – brief summaries.*

Four participants (all over the age of 55) had recently had to stop working for health reasons and needed advice and help to access benefits until they either reached retirement age or were able to return to work. Their health conditions had left them unable to complete the benefits application forms by themselves, and Citizens Advice staff completed the forms on their behalf. Following that help, three were in receipt of regular benefits payments.

Another participant, who had multiple long-term health conditions, was already receiving sickness benefits. Following a 'benefits review' arranged through her GP care coordinator, she found out that she was entitled to receive more money and received help from Citizens Advice to apply. This allowed her to increase her income.

One participant had recently given up his job to care for his wife who had become very ill. At his initial assessment, he was advised to go to the Job Centre and apply for Universal Credit.

He did this and was successful in his application, although he was worried that the amount would not be enough to live on and to meet his wife's health needs.

One participant was referred to CAP while he was in hospital suffering a mental health crisis. Prior to his admission he had stopped 'signing on' due to his illness, resulting in his benefits being stopped and him become homeless. On discharge from hospital he had new accommodation and access to benefits arranged for him.

Three participants required housing (one because she was new to the city, one because of unsuitable accommodation, one needing to leave an abusive relationship) and Citizens Advice had helped them to apply for social housing and re-housing, known locally as the Property Pool. At the time of the interview, two were still on the waiting list to be housed or re-housed.

One participant had fallen into arrears with his energy bills and was unable to negotiate manageable payment terms. Citizens Advice were able to help him access various hardship payments. Citizens Advice attempted to negotiate payment terms with his energy provider, although they were not able to secure more manageable terms. However, he credited the experience with giving him the language and confidence to negotiate this himself at a later date.

Most participants reported having more than one practical problem, and some had recently experienced other negative life events including redundancy, bereavement, trauma and displacement from their hometown or country.

A few participants had problems that Citizens Advice could not help with. For example, one participant asked for help with immigration issues. He was given a list of solicitors who would provide immigration advice free of charge through Legal Aid. However, he was unable to access help as all of the solicitors on the list were busy and none had the capacity to take on new cases.

### *Emerging themes*

- How the CAP intervention 'works' from the perspective of the user

The emerging themes presented below are ordered roughly chronologically, within the story of a person's journey through the CAP intervention. We have made no attempt at this stage to identify the relative importance of different themes:

- Referral to an organisation that is familiar and trusted

Most of the participants had heard of Citizens Advice and felt it had a good reputation. They were therefore pleased to be referred and had no worries about the referral. As we only interviewed people who had accessed the service and agreed to take part in the study, this may reflect the sample we interviewed rather than people who had not accessed the service.

- Easy Access

Participants reported that the easy access to the service, including the short waiting time and the fact that Citizens Advice contacted them, rather than them having to contact Citizens Advice, was important. Participants in poor mental or physical health often felt too overwhelmed to find and access help by themselves. Others had tried to access help themselves and had found it difficult because services were busy or seemed unavailable.

- Being 'listened to'

Some participants had been living in a stressful situation for a long time and reported feeling better simply because somebody was listening to them and taking their concerns seriously. This feeling extended from Citizens Advice to other agencies they might have been put in touch with at the same time.

- Relief from the burden of tasks

Most of the participants described how Citizens Advice staff had completed complicated application forms (e.g. for ESA, PIP or Property Pool) on their behalf, as they had been unable to do this by themselves (due to health problems, anxiety, lack of confidence or language needs). Participants experienced this help as the relief of a burden, even before they found out whether their application had been successful.

- Increased knowledge

Receiving advice was often perceived as a good thing in itself, as it clarified things for them, whether or not it directly improved their situation.

*“I think the most useful part was explaining, you know, what I actually can get on benefits for the condition I’ve got, you know... (afterwards) I felt slightly better”*

**Male aged 55 to 65, currently off sick from work**

Others reported that the experience gave them the language or confidence to help themselves – specifically to negotiate affordable repayments on utility bill arrears and to successfully appeal a benefits decision.

- Improvement in material circumstances.

The advice and help provided by Citizens Advice often (but not always) helped participants to change their material circumstances, most frequently by giving them access to welfare benefits, advocating for reduced debt repayments, facilitating access to hardship payments, or helping them to be re-housed. Most often this resulted in participants having more money to live on. This had several effects in relation to health and wellbeing, including:

- Reducing anxieties related to money and debt
- Improving physical living conditions, for example by enabling them to heat their home
  - *“....they reckon I’m going to get 120 pounds about a month more, so at least I can put the heating on a bit more when I need to, you know, instead of sitting round in jamas and dressing gown, that’s what... I’ve been doing, and then that was going to be my way of getting through, you know, when all of these hikes go up for fuel and all that, that’s what I was going to just do. Get a blanket, wrap myself up and then, you know, try and save what I can”*
  - **Female, aged 55-65, not working due mental and physical health problems**
- Allowing people the pleasure of buying occasional treats for family and friends,
  - *“... my little sister, I buy her sweets at lot more... she’s 20 and disabled, she has some sort of syndrome so she’ll be like a child for the rest of her life... I help my mum out a lot more, because she looks after my little sister...”*
  - **Male, aged 30 to 45, not working due to mental health problems**
- and (sometimes) allowing people to engage in physical and social activities that they previously couldn’t afford.

- Continued support/ follow-up

Participants talked about the importance of ongoing follow-up, which was perceived as a form of emotional support, as well as keeping open channels of communication that would enable them to easily access further help if needed. Follow-up was generally as simple as somebody telephoning or emailing after an agreed period of time to check how things were going, for example, whether they had heard anything back after submitting their benefits application form. This follow-up sometimes came from a Citizens Advice adviser or caseworker, sometimes from a Citizens Advice link worker, and sometimes from a GP practice link worker. It appeared to be equally valued wherever it came from.

- Security of being able to re-engage

Participants whose case had been closed spoke about the feeling of reassurance that came from being given a direct line phone number to Citizens Advice, enabling them to re-engage if they required help and advice in the future. This was important both to participants who had used the facility, and those who were simply reassured that they could use it in the future if needed

*“I know they’ve got my back”*

***Female, aged 55-65, unable to work due to long term health conditions***

- Availability of interpreters

One participant felt she did not have sufficient proficiency in English to understand complicated application forms such as those need to apply for housing and benefits. It was therefore very important to her that she had access to interpreters through Citizens Advice.

#### *The Wider Context – drivers of need*

- The impact of the COVID-19 pandemic – health needs

The participants’ stories suggest that COVID-19 may have increased the level of need in the population. Two of the 12 participants were currently unable to work due to long COVID and needed help to complete benefit application forms due to the effects of the illness on their concentration and memory. One had also suffered a traumatic bereavement during the first COVID lockdown.

- The impact of the COVID-19 pandemic – move towards remote access to services

Many mainstream advice and support services had switched to remote access during the pandemic and had not returned to previous ‘drop-in’ type service models. Some participants experienced the lack of visible, in-person services as a barrier to access, although the referral system meant that they did not experience remote access as a barrier to accessing CAP. Since COVID restrictions ended some participants have requested and been able to meet with Citizens Advice staff (especially link workers) face-to-face and have felt they have benefited additionally from that more personal contact.

- Sickness and Disability Benefits application processes

Participants talked about the overwhelming complexity of ESA and PIP forms, about their fear of making a mistake and getting into trouble, or of being called into to a face-to-face assessment and what that might entail. They were sometimes subject to mistakes or seemingly arbitrary decisions. The application and assessment process created a lot of stress and anxiety for people who were already in a stressful situation and took up a lot of time and energy which could be difficult for them to find while they were unwell. Citizens Advice were able to help people who needed to apply for these benefits, relieving some of the stress and increasing the probability that they would receive the benefits.

*“I don’t know how people cope (with having to apply for ESA and PIP). I couldn’t have coped without Citizens Advice”*

***Female aged 55-65, unable to work due to a long-term health condition***

- Housing shortage and complexity of processes for applying for social housing

Participants reported that the applications process for social housing and re-housing (known locally as ‘Property Pool’) was very complex and difficult to navigate, creating an additional stressor at a stressful time. Citizens Advice were able to help people with Property Pool applications, relieving some of that stress and giving people access to the waiting list. However, there is currently a shortage of housing, meaning that people often have long waits for housing and re-housing, regardless of any help and advice they receive from Citizens Advice.

- The 'cost of living crisis'

Recently-interviewed participants spoke about their worry over the future cost of their utility bills. This included one participant who was already in arrears with his energy bills and lived in a flat with single-glazed and poorly-fitting windows. Increased living costs seem likely to increase levels of hardship and debt while increasing pressure on both the CAP and mainstream advice and support services.

- The asylum and immigration systems

The experience of one participant, who was seeking asylum in the UK was that they were unable to get the advice they felt they needed. Immigration advice is specialist area of law, not provided by Citizens Advice on Prescription and this is a potential unmet need for a very vulnerable group.

- Non-financial barriers to participation in social activities

Some participants talked about wanting to take part in activities that would improve their wellbeing, but being unable to, due to their own health problems or caring responsibilities. However, that does not necessarily mean that the input of a link worker was not experienced as helpful - one participant spoke about her gratitude at being provided with a list of suitable activities, which she hoped to do one day if her work and caring responsibilities allowed.

## Conclusions.

Our analysis demonstrates that a relatively large number of people are utilising this service and the service was able to rapidly respond to increased demand during (and after) the pandemic. The service is being used by a population with very high needs experiencing a combination of mental and physical health problems alongside poverty. This clustering of social and health problems is likely to be an important driver of adverse outcomes and demand for health and social care services. Reducing the double burden therefore has the potential to markedly improve outcomes.

The diversification of the service to include a wider wellbeing offer, has changed the profile of clients slightly meaning they are overall slightly less likely to be living in poverty and be experiencing debt problems, than previously. This might suggest that the further widening of the offer, for example, self-referral, might lead to slightly less targeting of support to the groups with the highest needs.

The analysis shows that in some cases where the service has introduced changes in order to reach under-served population groups, there has been some improvement. For example, in targeting the service to populations living in more deprived areas, mothers and babies, and black and ethnic minority groups. The improved access for ethnic minority groups is the direct result of actions of the improvement collaboration to reshape the service support access from these groups. The most noticeable gaps in access relative to need appear to be under utilisation of the service in some deprived neighbourhoods of South Liverpool. This appears to be related to engagement with primary care networks in those areas and potentially provision by alternative providers of related but different services. This suggests that the service will need to continue to adapt in response to the changing delivery context in order to always reach under-served groups.

Welfare benefit and housing support and debt advice remains at the core of the service offered by CAL. The interaction between health problems, financial insecurity and negotiating the benefits system were a common theme driving need for the service amongst clients interviewed. Emerging needs included increased health problems due to the COVID-19 pandemic, the complexity and changes to the disability benefit system, housing shortages, the

increase in energy prices and the asylum and immigration system. Important components of the intervention according to service users were (1) the trusted nature of the provider, (2) easy and rapid access, (3) the sense that their concerns were being listened to, (4) practical support and increased knowledge, (5) continuity of support and follow up beyond an initial session, (5) the option to re-engage if needed.

Initial findings indicate that the service seems to be associated with improved patient assessment of their own overall health and a decrease in anxiety/depression. Importantly many of these improvements appear to be greatest in the more disadvantaged groups. Given the service is being used by a highly socioeconomically disadvantaged segment of the population, these initial findings indicate that the service could play an important role in reducing health inequalities and reducing demand on health services.

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