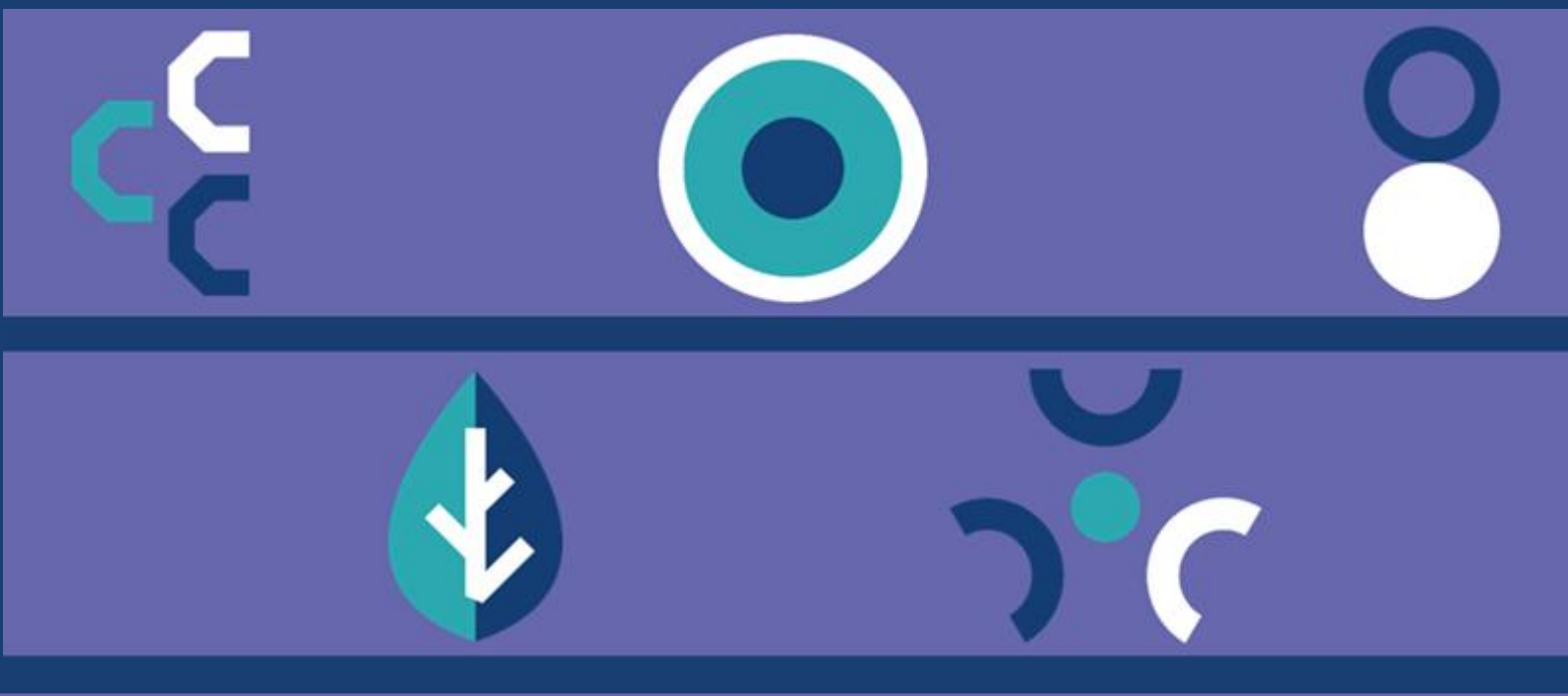
NIHR | Public Health Intervention Responsive Studies Teams

Evaluation of Liverpool funded local welfare schemes

August 2025



Research undertaken by PHIRST LiLaC

This report was prepared by Dr Emma Coombes[1], Dr Huihui Song[1], Harris Kaloudis[2], Dr Emma Halliday[2] and Professor Ben Barr[1].
The evaluation was produced with input from PHIRST LiLaC public partners Tim Wilson and Amy Wizard Ponter.

[1] Public Health, Policy & Systems, University of Liverpool, UK; [2] Department of Health Research, Lancaster University, UK

Contents

Summary of key findings 2

1) Introduction 4

2) Evaluation design 6

3) Findings 10

3.1 Equity of access and uptake, and implications for health inequalities 10

3.2 Impact of welfare provision on clients' health and wellbeing 23

3.3 Costs of delivering the welfare schemes 37

4) Conclusions and recommendations 38

5) Acknowledgements 41

6) References 41

Appendix I 43

Appendix II 44

Summary of key findings

This evaluation has focused on three core components of Liverpool City Council's (LCC's) local welfare provision including the Benefits Maximisation Service (BMS), Discretionary Housing Payments (DHPs), and the Liverpool Citizens Support Scheme (LCSS). The combined cost of delivering the services is £7.8 million each year.

Evaluation findings indicate that these schemes have been effective at engaging with residents living in high-need communities, with analysis suggesting uptake has been concentrated in areas of high deprivation and poor mental health, particularly for the LCSS. Uptake was greatest among women, the working age population, and people with a long-term health condition or disability. However, there may be some gaps in uptake, including a recent decline from more deprived areas for DHPs and to a lesser extent the BMS. Additionally, a policy was introduced in April 2023 for the LCSS that restricted eligibility for social housing tenants and this has led to a recent decline in applications from the most deprived areas of the city, where social housing is more prevalent.

In terms of service delivery costs, these were in line with those of similar schemes. For example, the BMS was £166 per client, which is comparable to other non-cash-based referral interventions such as Citizens Advice on Prescription (£145 per client). For the LCSS, the cost was £194 per client and again this is comparable to similar services such as Manchester City Council's Welfare Provision Scheme (£109 per client), although the LCSS is slightly more generous in its awards which accounts for the slightly higher cost per client. Lastly, DHPs were the most expensive at £1,647 per client, which reflects that their purpose is to cover a shortfall in rent and that clients often make repeated applications for support.

We undertook a more detailed evaluation of the LCSS, compared to the BMS and DHPs, as it is of particular interest because it is tailored to the needs of residents who are experiencing a crisis. As part of this, we interviewed 23 LCSS clients who indicated that the scheme's support has had a profound and multifaceted impact on them, including alleviating immediate financial crises and contributing to both emotional and physical wellbeing. Clients reported that the Urgent Needs Award enabled them to meet essential needs (e.g. food, heating, and transport), while the Home Needs Award supported them to establish a safe and functional household. In addition to supporting the clients themselves, the findings indicated that the LCSS plays a role in supporting wider family members, particularly for households with children. Notably, LCSS support may have implications for children's future trajectories by promoting conditions that support healthier development, emotional security, and educational continuity.

We also used client data routinely collected by LCC and linked this to health data to examine the impact of LCSS support on area level mental health-related outcomes, including reductions in antidepressant prescribing, GP appointments, A&E attendances, and emergency hospital appointments. We found that each additional £1 in LCSS award provision per person in the population per quarter was associated with an estimated quarterly per capita reduction of £0.63 in healthcare costs. Overall, a total of £16,432,789 was awarded through the LCSS between 2018 to 2023, which corresponds to an estimated NHS saving of £10,352,657 and a net intervention cost of £6,080,132. This is a conservative estimate, as it does not take into account other potential benefits such as improved physical health, reduced social care needs, increased economic participation, or reduced crime.

We held focus groups with stakeholder organisations to understand their views of LCC's local welfare provision. They praised the LCSS for its responsive and humane approach. Stakeholders acknowledged the scheme's effectiveness in preventing deeper crises such as debt, rent arrears, and homelessness. Overall, the LCSS was viewed as a crucial safety net that could fill gaps left by inadequate or inaccessible alternative support systems, including national welfare provision.

All three of the welfare schemes we evaluated offer vital short-term relief by providing financial or in-kind support to reduce hardship. In terms of whether the LCSS can move people out of crisis longer-term, the findings are somewhat mixed and likely depend on individuals' circumstances. For example, stakeholder organisations raised that some clients are caught in a cycle of repeat applications and may be unlikely to break from this. However, in contrast the client interviews indicated that where support facilitates people to escape a difficult situation (e.g. homelessness or domestic abuse) it could potentially move individuals onto a more positive longer-term trajectory. Additionally, it supports clients to maintain stable tenancies and avoid housing instability, thus mitigating future risk of crisis.

Lastly, our findings suggest there may be some barriers to effective implementation including those related to equitable access and inclusivity. Notably, clients and stakeholders felt that accessibility and inclusivity would likely be enhanced by offering a choice of application channels including face-to-face, telephone, and online.

1) Introduction

1.1 Background

Councils have increasingly developed local welfare schemes, in response to reductions in support from national welfare programmes, devolution of national schemes to local administration, and to address unmet needs in their populations resulting from financial hardship. This Local Welfare Provision (LWP), provides financial or in-kind support (e.g. furniture, domestic appliances, and shopping vouchers) to those most in need. This includes those who are unemployed or looking for work, those with low earnings, raising children, retired, caring for someone, or who have a long-term illness or disability. They also support those who are vulnerable due to circumstance, for example due to recently leaving prison, those experiencing domestic abuse, or those who have endured a crisis such as a fire or flood. The aim of these schemes is to reduce financial hardship and therefore potentially improve health and wellbeing[1]. Their wider objectives can be to reduce demand on other public services such as the NHS, homelessness services, or social care organisations[2].

1.2 Liverpool funded local welfare schemes

Liverpool is one of the most deprived cities in the UK. Welfare reforms introduced since 2010, combined with other austerity measures, have had a disproportionate impact on communities across the city. To address the risk of financial hardship to health and wellbeing, Liverpool City Council (LCC) have made a considerable investment into welfare provision, of more than £7 million per year. In particular, they have focused investment on schemes where they have flexibility to tailor implementation locally, with the aim of best meeting the needs of the local community. While every local authority across the UK offers LWP schemes, LCC invests more in these schemes compared to other councils.

This evaluation focuses on three local welfare schemes: the Benefits Maximisation Service, Discretionary Housing Payments, and the Liverpool Citizens Support Scheme, which are each described below. The reasons for focusing on these schemes include that they: i) target high needs groups, ii) the council has some discretion over eligibility for and implementation of these schemes and is responsible for their administration, and iii) the council has targeted funds at these initiatives in addition to funds provided from central government.

1.2.1 Benefits Maximisation Service (BMS)

The BMS consists of specialist advisers who provide advice and support to Liverpool residents. The team helps people to claim benefits, largely from national welfare schemes and wider support, and they also provide assistance with representation at benefit tribunals. They can also refer people into LWP. The team receives referrals from council departments, external organisations, and residents of Liverpool. They also work with Adult Social Care to maximise the benefits of those who are not eligible for free social care. This includes, for example, older adults or people with disabilities whose income or savings place them above the threshold for free care. BMS advisers help these individuals access entitlements such as Attendance Allowance or disability premiums in Pension Credit, which do not directly pay for care services, but they increase the person's overall income allowing them to privately fund the care they need. In the year 2021-2022, the team received 5,914

referrals and they helped residents to claim £8.3 million in additional benefits. The BMS is a discretionary service, and the cost of the team is approximately £1.1 million per year.

1.2.2 Discretionary Housing Payments (DHPs)

DHPs were introduced in 2001 and provide financial support to people who need extra help with rent or housing costs when their Housing Benefit or Universal Credit does not fully cover these. This is normally because of government welfare reforms, in particular the under-occupation penalty, the benefit cap, and reductions in local housing allowance rates. These reductions in entitlement can result in hardship and risks to residents' tenancy. DHPs can provide either short-term or long-term support depending on individual circumstances. Unlike the Liverpool Citizens Support Scheme described below, which operates locally across Liverpool, DHPs are a national scheme although they are administered by local authorities who have some discretion over local eligibility and implementation. The government provides an annual allocation for local authorities, and this can be added to using local funds. In the year 2021-2022, LCC received £1.65 million from the government and added £1 million themselves, giving a total budget of £2.65 million which was used to make 10,259 awards.

1.2.3 Liverpool Citizens Support Scheme (LCSS)

The LCSS was launched in 2013 and provides support to people with no immediate funds, for example when they are in the process of applying for a state benefit payment or after an unforeseen crisis event. The scheme consists of a Home Needs Award (HNA) which covers furniture, white goods, domestic appliances, and essentials such as bedding and crockery to help maintain or establish a home. This award is available for those leaving care or prison and those who have needed to move due to violence or other reasons. The scheme also consists of an Urgent Needs Award (UNA) which covers food, essential items for children, essential clothing, fuel costs or help where people have suffered a crisis such as a fire or flood. Lastly, the Mayoral Hardship Fund (MHF) was introduced in 2017 as a temporary initiative lasting approximately two years. It was established in response to growing financial pressures on low income households and was designed to complement the existing LCSS provision by offering additional support to those in need including help covering broadband costs. LCSS clients are limited to two awards in a 12-month period, although LCC have discretion to make additional awards where they feel it is appropriate to do so. In the year 2021-2022, the LCSS made 17,881 awards with the overall expenditure for the year being £4.04 million.

The LCSS is of particular interest because it is tailored to the needs of residents who are experiencing a crisis. A more in-depth evaluation of this scheme has therefore been undertaken. To provide context for this work, we have produced a logic model (Figure 1) that sets out the activities associated with the LCSS and the intended scheme outcomes.

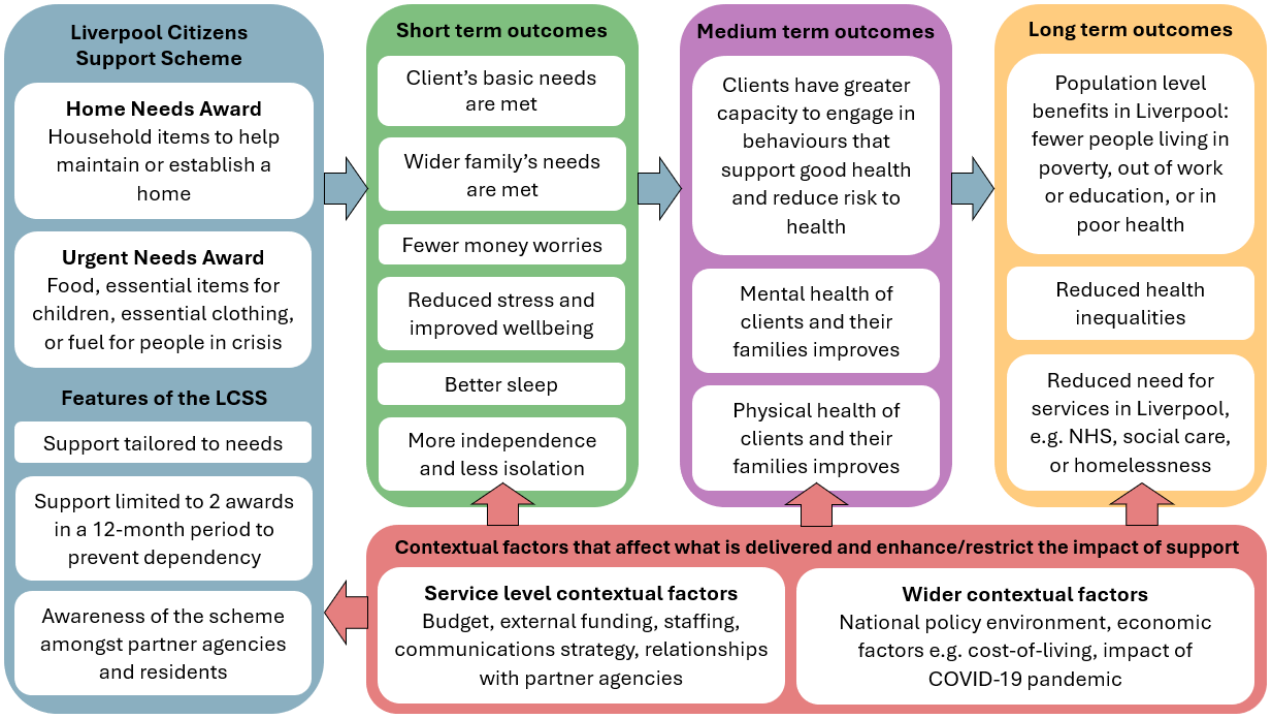


Figure 1: Logic model for the LCSS.

The logic model shows that in the short-term the LCSS aims to meet the basic needs of clients and their family, reduce money worries and stress, and improve wellbeing. In the medium-term it aims to bring mental health benefits to clients and their family, which in turn will increase their capacity to engage in behaviours that promote good health such as eating well, undertaking physical activity, and reducing alcohol intake and smoking. In the long-term it aims to reduce the number of people living in poverty, out of work or education, and living in poor health, thus leading to reduced demand for NHS, social care, and homelessness services.

2) Evaluation design

This evaluation has been undertaken by the PHIRST LiLaC team. PHIRST (Public Health Intervention Responsive Studies Teams) are funded by the National Institute for Health and Care Research (NIHR) to undertake independent evaluations of public health interventions that are delivered or commissioned by local government. PHIRST LiLaC is a collaboration between the University of Liverpool and Lancaster University. The evaluation objectives and methods are detailed below.

2.1 Objectives

The evaluation focuses on the following objectives:

1) To examine equity of access to and uptake of the welfare schemes, and implications for health inequalities.
2) To understand the impact of welfare provision on clients' health and wellbeing.
3) To assess the cost of delivering the welfare schemes.

2.2 Quantitative methods

2.2.1 Analysing access and uptake using routine data

As part of their service delivery, LCC routinely collect information on individuals who have accessed support from the BMS, DHPs and LCSS. We accessed this routine data for all clients who engaged with the three schemes between January 2017 and December 2024 (when the data were extracted). The reason for selecting this time period is that LCC retain clients' data for approximately 8 years.

The data for the welfare schemes contains information on clients' characteristics e.g. age, gender, ethnicity, and health status. It also includes their home postcode, which was replaced with Lower Super Output Area (LSOA) of residence prior to receiving the data. Additionally, the data contains information on clients' engagement with the welfare schemes including the number of cases or applications they have had support with, the type of issues faced (e.g. benefits, debt, help required to set up a home), and information on outcomes (e.g. whether or not their application for support was successful). The data for the LCSS additionally includes information on the specific items awarded to clients (e.g. furniture, white goods, domestic appliances, food, clothing, fuel costs).

We linked the client data (via LSOA of residence) to UK Census data that details the sociodemographic characteristics of the local population and to information on area level deprivation (IMD). These data were then used to analyse the trend in application rates for each welfare scheme by age group, sex and deprivation, and also assess levels of uptake across sociodemographic groups, compared to the profile of Liverpool as a whole. We also compared the geographical spread of applicants in relation to measures of need, referral routes and reasons for referral, and predictors of success among those that had applied.

2.2.2 Investigating impact on mental health and implications for health inequalities using routine data

To assess how welfare provision may be associated with area-level mental health-related outcomes we also linked the LCSS client data to a mental illness index at the LSOA level using aggregate LSOA data derived from NHS records[3].

Firstly, we used the LCSS client data from 2018-2023 to construct a quarterly panel dataset at the LSOA level, that was stratified by age group and gender. UK Census data were incorporated to capture key characteristics including the total population, the proportion of households living in social rented housing, and the number of unemployed individuals. Finally, the income score from the English Indices of Deprivation 2019 was merged into the dataset.

Mental health outcome variables

The mental illness index was derived within the Cheshire and Merseyside NHS secure data environment. Firstly, we estimated four LSOA mental health indicators: i) the rate of antidepressant prescribing, ii) the rate of GP consultations for mental health conditions, iii) the rate of A&E attendances for mental health issues, and iv) the rate of emergency hospital admissions for mental health reasons[2]. To summarise the overall burden of mental health-related service utilisation at the population level, we applied factor analysis (i.e. a statistical method used to identify patterns in a set of variables by identifying a small number of underlying factors that explain most of the variation) to these four variables and derived a composite index. The index provides a score for each age and gender group within each LSOA that indicates how good or bad the overall mental health is of people living in the LSOA relative to other LSOAs in Liverpool. These five mental health variables (i.e. the four

mental health indicators and the composite index) served as the primary outcome measures for analysis.

Policy exposure variables

In April 2023, the LCSS introduced a policy change that imposed expenditure limits on awards for tenants in social housing. We utilised this policy shift (hereafter referred to as the LCSS Policy Control) to investigate the impact on mental health-related outcomes at the LSOA level.

In addition to the LCSS Policy Control described above, 12 relevant policy changes were introduced at both national and local levels during the time period that our analysis covered (between 2018 to 2023). Full details of these are provided in Figure 2 (which depicts a timeline of policy changes, see Section 3.1.1), but examples include the Universal Credit £20 per week uplift, the Household Support Fund, and the Cost-of-Living Payments. These 12 policy changes were included as controls in our analysis as they may have indirectly influenced both the demand for the LCSS and broader trends in population mental health.

Instrumental variable indicator

The LCSS Policy Control variable, interacted with the proportion of social housing tenants at the LSOA level, was used as an instrumental variable to estimate the effect of LCSS award uptake on mental health. An instrumental variable is a variable that influences whether people received the intervention (in this case the LCSS) that could not influence the outcome (in this case mental health), except through its effect on the intervention. In this case we are assuming that the change in the policy, which had greater effect on areas with higher levels of social housing after 2023, could only effect the change in mental health in those areas by reducing the probability of the population receiving the LCSS. The interaction was selected as an "instrumental variable" therefore, on the basis that the policy disproportionately affects social housing tenants, generating variation in welfare access that is plausibly exogenous to change in local mental health-related outcomes after 2023.

Regression analysis

We fitted a two-stage least squares regression model with fixed effects at both the unit level (defined by LSOA, age group, and gender) and the time level (quarter). This approach was used to estimate the impact of local welfare provision on mental health-related outcomes while addressing other potential confounders and reverse causality (i.e. that poor mental health might lead to increased LCSS uptake). Full details of the regression model are provided in Appendix I.

2.2.3 Assessing trends in clients' wellbeing using self-reported questionnaires

To explore the impact of welfare provision on LCSS clients' wellbeing, LCC advisers administered a short questionnaire at baseline (when individuals first made contact with the LCC team to assess their eligibility for support) and at 3-month follow-up.

The questionnaire consisted of the Office for National Statistics (ONS) four questions that relate to wellbeing. The ONS questions were answered on a Likert scale ranging from 0 "not at all" to 10 "completely". The questions were worded as follows: 1) Overall, how satisfied are you with your life nowadays?, 2) Overall, to what extent do you feel the things you do in your life are worthwhile?, 3) Overall, how happy did you feel yesterday?, and 4) Overall, how anxious did you feel yesterday? These questions have been previously validated and have been used in a large number of studies (see the ONS website[4] for further details).

The questions above were supplemented with an additional question related to mental health. The wording of the question was “In general, would you say your mental health is: Excellent, Very Good, Good, Fair or Poor?” Again, this question has been previously validated and is widely used[5].

We have examined change in reported wellbeing over time for clients who provided data at both time points.

2.2.4 Examining service delivery costs

LCC supplied data on service delivery costs for the BMS, DHPs and LCSS for the financial years covering the period April 2017 to April 2024. This included information on funding contributions from both central government and those locally sourced by LCC. This information was further broken down into costs associated with administration (e.g. staff salaries, training expenses, IT equipment, and overheads) and those associated with funding clients’ awards.

We used this data to summarise the costs associated with delivering the three welfare schemes. We have also estimated potential savings to the NHS via improvements in clients’ health and wellbeing as a result of welfare provision.

2.3 Qualitative methods

2.3.1 Understanding service implementation via stakeholder focus groups

To identify key enablers and barriers to effective implementation of the BMS, DHPs and LCSS, we have undertaken four focus groups with 17 stakeholders in total. Stakeholders included LCC staff from the Benefits, Adult Social Care, and Public Health teams involved in commissioning or delivering the welfare schemes, or supporting clients to access them. They also included staff at organisations across Liverpool who signpost people to welfare support and/or who help them submit an application (e.g. Citizens Advice, End Furniture Poverty, Torus Foundation, Raise Advice, Liverpool Access to Advice Network, and Toxteth Town Hall Community Resource Centre).

Focus groups were conducted online using MS Teams and lasted approximately 90 minutes. The discussion schedule was semi-structured and listed the following topics: reach, access, uptake, and delivery of local welfare assistance schemes; outcomes achieved for individuals; key changes in scheme provision and scheme contexts over time; service enablers and barriers.

2.3.2 Assessing clients’ experiences and outcomes via interviews

To explore how clients experience the LCSS, and the ways in which it has or has not influenced their health and wellbeing, we have undertaken interviews with users of the service. Recruitment for interviews was via the wellbeing questionnaire, which included an option for participants to leave their contact details if they consented to be contacted by the PHIRST LiLaC team. We additionally attempted to recruit via a flyer distributed by Citizens Advice, but this was largely unsuccessful. In total, 23 interviews were completed.

Interviews took place by telephone and their duration ranged from 12 to 50 minutes, with an average duration of 25 minutes. The interview schedule was semi-structured and listed the following topics: the circumstances that led to the client engaging with the LCSS; their experience of applying for and receiving LCSS awards; the type of awards received and their impact on the clients’ life; the client’s suggestions for improvements to the LCSS; and the client’s socio-demographic information.

The audio recordings from the focus groups and interviews were transcribed and a thematic analysis was undertaken to identify key themes and sub-themes.

3) Findings

This section details the study findings, which are organised according to the evaluation objectives.

3.1 Equity of access to and uptake of the welfare schemes, and implications for health inequalities (Objective 1)

3.1.1 Timeline of policy changes that affect access and uptake

The delivery of welfare schemes is directly influenced by changes in government policies (e.g. national welfare reforms) and local policies (e.g. to control expenditure). These policies can alter funding levels, eligibility criteria, and the way support is accessed by clients, impacting not only how effectively these schemes meet the needs of recipients but also the number of welfare applications submitted. To provide wider context to the findings presented in this report we have collated information on policy changes with input from LCC. Figure 2 provides an overview of policy changes that have taken place since 2018. Note the figure focuses on DHPs and the LCSS, as the BMS is a discretionary advice-based service and therefore its funding and delivery model is less impacted by welfare reforms. For brevity, Figure 2 simply lists the policy names, but a full description of each policy can be found in Appendix II.

In summary, Figure 2 shows that a range of policies were implemented between 2020 to 2021 in response to the COVID-19 pandemic that aimed to have a positive impact on residents' finances (shown in green). Examples include the Universal Credit £20 per week uplift, the Test and Trace Support Payments Scheme, and the Covid Winter Support Grant, all of which impacted delivery of the LCSS. When the pandemic began to ease, there was a shift towards policies that potentially negatively impacted residents' finances (shown in red). This was partly because some of the temporary measures that had been implemented to reduce hardship at the height of the COVID-19 crisis were rescinded. This included a return to a limit of two awards in a 12-month period for the LCSS, compared to four during the pandemic. Additionally, new policies were also implemented around this time including that the government introduced a temporary cap limiting annual social housing rent rises to 7%, replacing the usual Consumer Price Index (CPI) + 1% formula. With CPI at 10.1% in 2022/23, this cap still led to significant rent increases for many tenants, resulting in more DHP applications to cover shortfalls.

It is noteworthy that social tenants in particular have been negatively impacted by policies (shown in yellow) from 2023 onwards. A further example of this is the policy change highlighted above (the LCSS Policy Control), which aimed to limit expenditure following funding cuts in April 2023, by advising those living in social housing they were no longer eligible to apply for LCSS Home Needs Awards and instead they were encouraged to seek support from their Registered Social Landlord. At the time, it was felt this policy would not result in those living in social housing having poorer access to furniture support because Registered Providers can offer furnished tenancies and recover costs through service charges, which tenants can then claim via Housing Benefit or Universal Credit. Registered Providers were consulted by LCC and both parties are currently working together to share best practice, however at present not all Registered Providers are consistently ensuring

provision is available. As such, LCC still allow furniture packages in exceptional cases e.g. for people fleeing domestic abuse, care leavers, or when no alternative options are available.

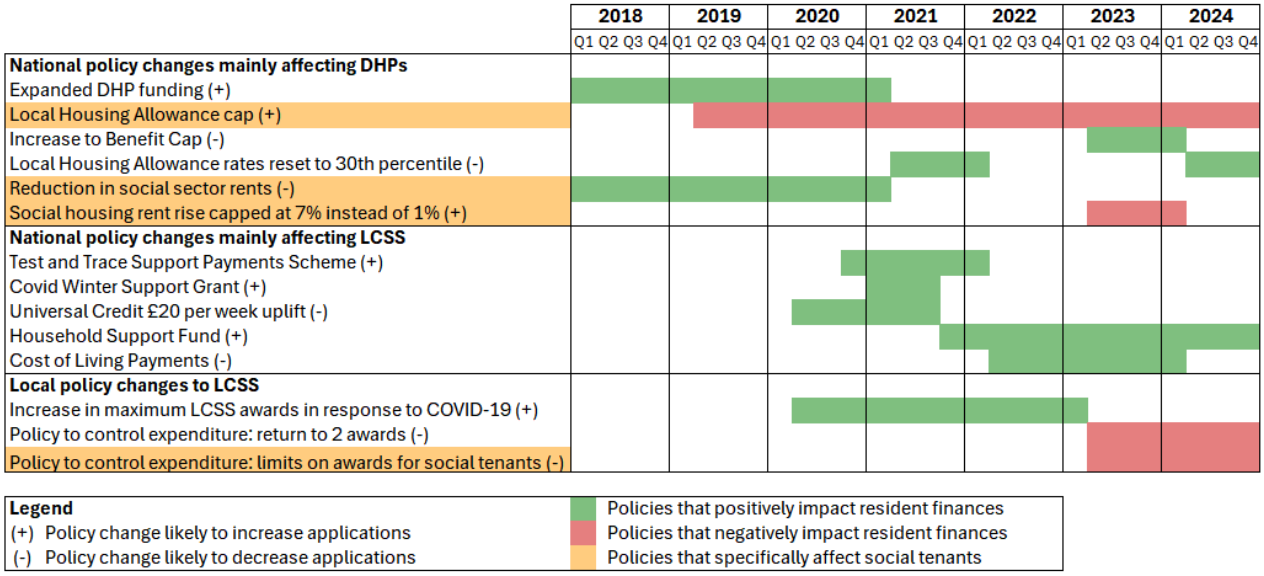


Figure 2: Timeline of policy changes affecting DHPs and LCSS between 2018-2024.

3.1.2 The trend in applications to the welfare schemes

To understand how the schemes have responded to these policy changes and how uptake has changed over time relative to need, we have plotted the application rate for each scheme by the level of deprivation. Overall there were 50,835 applications (from 37,350 unique applicants) for the BMS, 53,554 applications (48,493 applicants) for DHPs, and 154,254 applications (150,697 applicants) for the LCSS between 2017 to 2024.

Throughout this period, applications to the BMS have fallen slightly over time, with an average of 1,207 per quarter. This decline has been due to the BMS team scaling back proactive campaigns that encourage residents to apply for BMS support, in order to manage high demand for the service. In contrast, there has been a steep decline in DHP applications over the period, which averaged 2,070 per quarter at the start of 2017 and reduced to 347 per quarter at the end of 2024. This included a substantial drop in 2020, which reflects a combination of a reduction in funding for DHPs from central government around this time (resulting in fewer awards being made) and also the introduction of COVID-19 pandemic temporary support measures such as the Universal Credit £20 per week uplift and eviction bans (resulting in some individuals having reduced need for a DHP). Lastly, the LCSS consistently received a high number of applications over the period, typically exceeding 4,000 per quarter, with notable increases during the COVID-19 pandemic (2020-2021) and the peak of the cost-of-living crisis (2022-2023), while numbers then reduced as the new policy was introduced restricting access to groups living in social housing.

Figure 3 shows these trends by level of deprivation. For all three welfare schemes the application rates are highest in the most deprived groups. The results suggest that the BMS has good uptake from the most deprived areas, but compared to the other schemes it reaches more people from the least deprived areas (Q1). This reflects that it is an advice-based service, rather than one which provides financial or in-kind awards, and many clients

accessing the BMS are older adults including those from more affluent areas that want advice about accessing non-means tested awards such as Attendance Allowance. In contrast, DHPs and the LCSS are more effective at targeting the most deprived neighbourhoods (Q4 and Q5), at least initially in the case of DHPs.

It is notable that the reductions in DHPs, and to a lesser extent the BMS, have been greatest in the more deprived parts of Liverpool. Trends in LCSS applications remain fairly similar by level of deprivation until the change in policy in 2023, which reduced application rates in the most deprived areas – where there are higher proportions of social housing residents. Declines in DHP and BMS applications have also been greatest in the 35-64 age group and among women. There is no reason to think that need for these schemes has declined in these groups and this therefore likely suggests a reduction in availability for support relative to need. The LCSS scheme has compensated slightly for the reductions in DHP applications in that LCSS applications have tended to increase slightly more in population groups experiencing declines in DHP applications, but this association is small – on average for every 100 fewer DPH applications there were in a population group, there was an increase of around 4 LCSS applications. These trends mean that the LCSS has tended to become more aligned to populations with high levels of deprivation and associated high levels of mental health problems over time (until 2023), whilst the BMS and DHP schemes have become less targeted at populations with high levels of mental health problems. The LCSS has been responsive to changes in risk of unemployment within population groups; for each additional 100 unemployment claimants in a population group this was associated with an additional 2 LCSS applications.

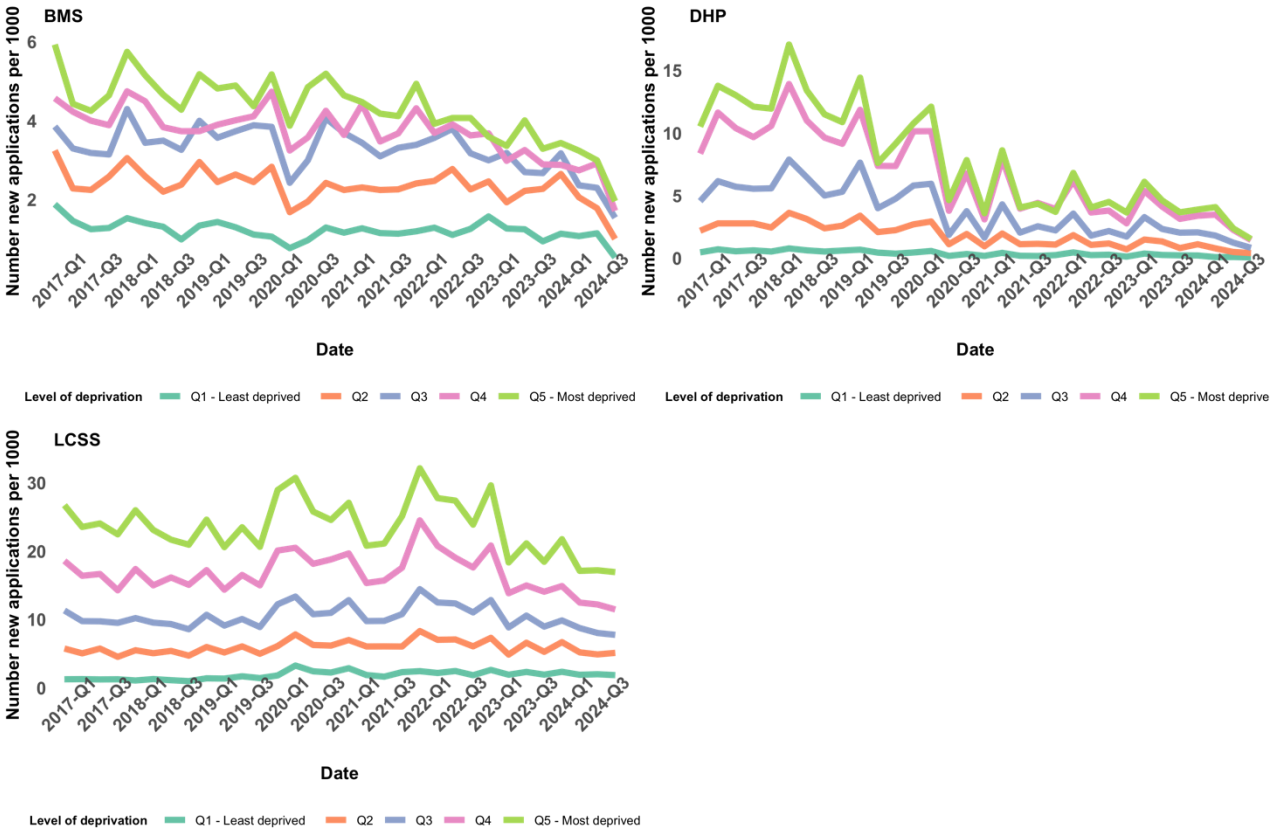


Figure 3: Quarterly number of new applications to the BMS, DHP and LCSS between 2017-2024.

3.1.3 Characteristics of welfare clients

We have also examined uptake of the welfare schemes compared to the local population in relation to key demographic characteristics (e.g. gender and age) and measures associated with need for support including the presence of a long-term health condition or disability, along with living in deprivation as shown in Table 1. For LSOAs across the city of Liverpool (which represent the area over which the local population is eligible to access the schemes), the table shows the percentage of the local population that have a particular characteristic, where this is available from the 2021 Census and the percentage of clients that also have that characteristic.

Across all three welfare schemes, female clients were overrepresented compared to the local population, with particularly high representation among DHP clients (66% vs 52%).

In terms of age, BMS clients included a greater representation from older age groups compared to the local population, with 44% aged 65 and over, versus just 15% locally. The clients using this service are older than those using another welfare advice service in Liverpool called Citizens Advice on Prescription (CAP), which is provided by Citizens Advice through health services. Only 18% of the clients using the CAP service were over 65 years old[6]. The older clientele of the BMS reflects that many people are referred to the service from Adult Social Care services.

DHP clients were concentrated in the 35-64 age range, with 34% aged 35–49 and 39% aged 50–64, both of which were significantly higher than the corresponding local figures of 18%. LCSS clients were predominantly younger, with 79% aged 16–49, and a particularly strong overrepresentation among those aged 35–49 (a difference of +21% compared to the local population). For comparison, the CAP service clients were concentrated in the 50-64 age group.

Among clients accessing the BMS and LCSS, there was a substantially higher proportion of individuals reporting a long-term health condition or disability compared to the local population. Specifically, 81% of BMS and 66% of LCSS clients reported having a long-term health condition or disability, in contrast to 28% of the local population. For comparison, 90% of CAP service clients reported having a long-term mental or physical health condition or disability.

More detailed information is recorded on client characteristics for the BMS compared to the other welfare schemes. The majority of BMS clients (91%) were of White ethnicity, compared to 77% for Liverpool as a whole, suggesting that ethnic minority groups are underrepresented in the service. Furthermore, the majority (72%) reported being single. Regarding housing situation, just over half of BMS clients (54%) lived in rented accommodation, while 33% were homeowners, and 13% were categorised as “Other” which included those who were homeless or staying in hospital. This is fairly similar to the figures from the 2021 Census (54% renting).

Information on housing structure is available for the LCSS and indicated that the majority (58%) of clients were single without children, followed by those who were single with children (29%). The remaining 12% of LCSS clients consisted of a mix of couples (both with and without children) and pensioners.

Clients from the most deprived areas (Q5) were markedly overrepresented across all three welfare schemes. This was particularly evident for the LCSS, where 41% of clients lived in the most deprived quintile, compared to 20% locally. These findings suggest that the

welfare schemes are effective at reaching more disadvantaged groups, although as noted above this has reduced over time for the BMS and DHPs. The association with deprivation is greater for the LCSS and DHPs than for other national welfare schemes (e.g. Universal Credit), suggesting that the schemes are being accessed by groups with greater needs than the average for welfare recipients. Uptake of these schemes was also more highly correlated with deprivation than the CAP service, which had 30% of its clients from the most deprived quintile.

Table 1: Comparison between characteristics of welfare clients and the local population.

	Local population (%)	BMS	DHP	LCSS
		Clients (%)	Clients (%)	Clients (%)
Gender				
Male	48	42	34	47
Female	52	58	66	53
Age group				
16-34 yrs	32	17	23	40
35-49 yrs	18	18	34	39
50-64 yrs	18	21	39	18
65+ yrs	15	44	4	3
Long-term health condition or disability				
With	28	81	-	66
Without	72	19	-	34
Ethnicity				
White	77	91	-	-
Minority	23	9	-	-
Marital status				
Single	34	72	-	-
Couple	66	28	-	-
Household type				
Single without children	37	-	-	58
Single with children	15	-	-	29
Couple without children	13	-	-	2
Couple with children	21	-	-	5
Pensioner	14	-	-	5
Housing situation				
Renting	53	54	-	-
Homeowner	47	33	-	-
Other (e.g. homeless, hospital)	0.1	13	-	-
Home location by local deprivation quintiles				
Q1 (least deprived)	19	11	3	3
Q2	20	15	10	10
Q3	20	21	20	18
Q4	21	24	31	28
Q5 (most deprived)	20	28	37	41

3.1.4 Geographical reach of the welfare schemes

The geographical reach of the schemes is shown in Figure 4, which illustrates the total number of clients per 1,000 of the population who have engaged with the BMS, DHPs and LCSS between 2017 to 2024. Darker shades of blue indicate a greater number of clients after adjusting for population size. Figure 4 also shows the Index of Multiple Deprivation (IMD) local deprivation quintiles for Liverpool, where darker shades of red denote more deprived areas. The mental illness index is shown in orange, where darker areas indicate

poorer mental health. Together, these maps enable a direct comparison between uptake of the schemes compared to the geographic distribution of deprivation and mental ill health.

The findings suggest that for all three welfare schemes uptake broadly reflects the patterns of deprivation and mental ill health, with LCSS application rates having the greatest corelation with deprivation and mental illness. The LCSS map, however, also suggests lower than expected uptake in the north-eastern part of the city, despite being characterised by high levels of deprivation and high levels of mental health problems. Notably, this area contains a high proportion of tenants living in social housing (Figure 4 shown in green), who since April 2023 have been advised that they are no longer eligible for LCSS Home Needs Awards. This discrepancy in uptake in north-eastern Liverpool suggests there may be a gap in the reach of the LCSS in terms of residents' needs.

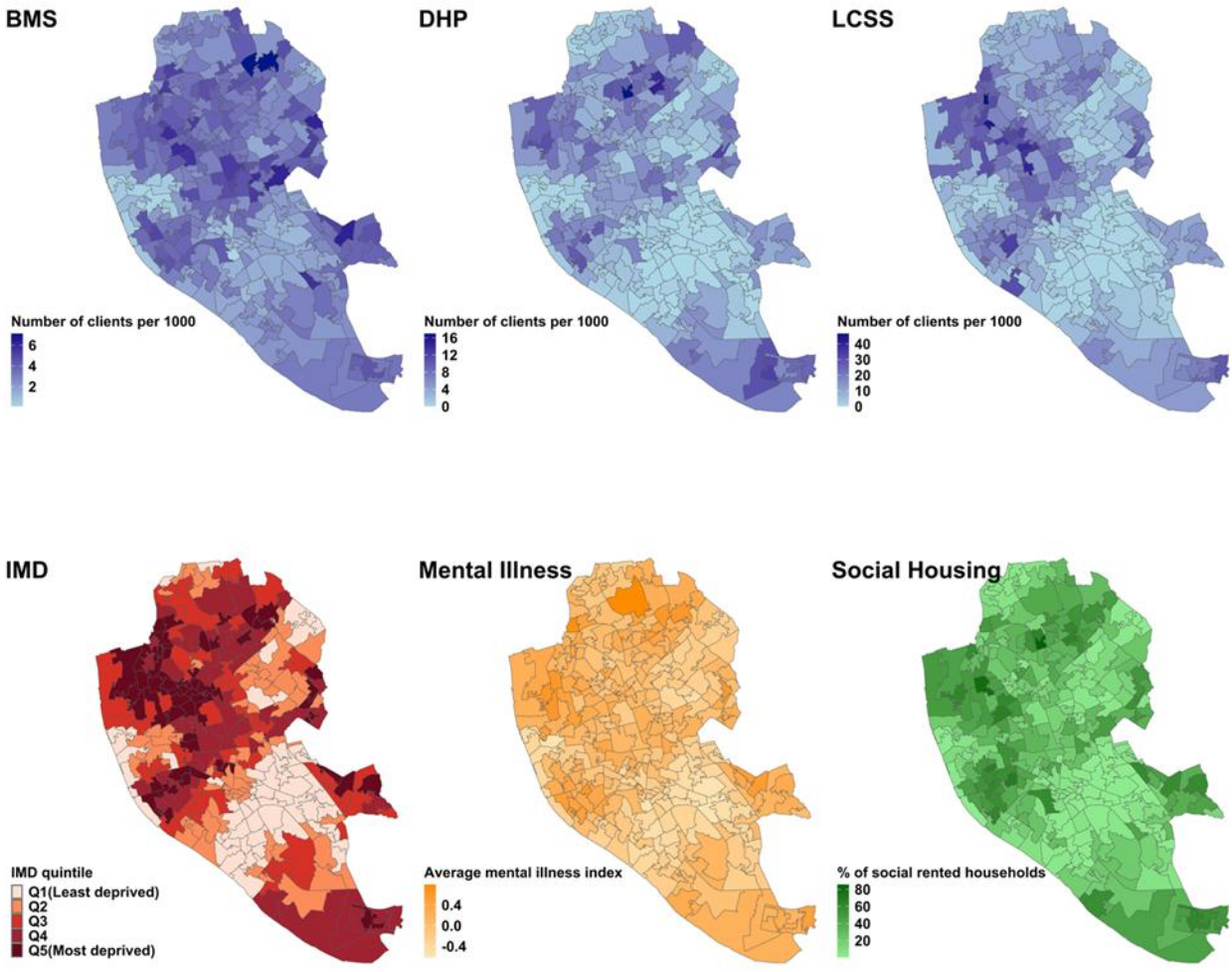


Figure 4: Geographical reach of the welfare schemes along with local deprivation quintiles, mental ill health, and percentage of social housing for LSOAs in Liverpool.

3.1.5 BMS cases and outcomes

When clients first get in touch with the BMS a new case is opened. In total, 50,835 cases were opened between 2017 to 2024. Although most clients only have one case, some

clients return to the service for further support and therefore may go on to have further cases. The average number of cases per client was 1.8 and the maximum number of cases a client had BMS support with was 17. In terms of the duration of cases, the median was 44 days with an interquartile range spanning from 21 to 123 days, which represents the 25th and 75th percentiles and provides a measure of the variation in case duration.

Clients may be referred to the BMS via a number of routes. Table 2 shows these included self-referral (36%), referral by a family member or friend (6%), referral via a local authority service such as the LCSS or Adult Social Care (35%), referral via a community service or charity such as Citizens Advice or Macmillan Cancer Support (7%), and referral via another agency such as the NHS or a Registered Social Landlord (15%).

During the initial meeting the adviser seeks to understand the issues the client is facing. There was a large amount of missing data with respect to the issues clients presented with, but Table 2 shows that the most common reasons included a full benefit check (82%), advice about claiming non-disability related benefits e.g. Universal Credit, Child Benefit, or Pension Credit (6%), advice about claiming disability related benefits e.g. Personal Independence Payment, Disability Living Allowance, or Attendance Allowance (3%), a change in circumstances with implications for benefits claimed (1%), and a benefit suspended, stopped, or sanctioned (1%). Other reasons, such as the client was homeless or had no funds, accounted for the remaining 7% of issues.

Table 2: BMS case characteristics.

	Number of cases	Percentage
Referral route to BMS (n=38,368)		
Self-referral	13,982	36
Family or friend referral	2,339	6
Referral via a local authority service	13,290	35
Referral via a community service or charity	2,821	7
Referral via another agency	5,936	15
Reason for contacting BMS (n=7,960)		
Full benefit check	6,491	82
Advice related to non-disability benefits	497	6
Advice related to disability benefits	226	3
Circumstance change with implications for benefits	102	1
Benefit suspended, stopped, or sanctioned	56	1
Other (e.g. homeless, no funds)	588	7

During each case, the adviser works with the client to address the issues they have raised and reach agreed outcomes. At the end of a case, when it closes, advisers generally aim to record the outcomes that were achieved. For some cases (n=41,309, 81%) this has been possible, while for other cases this has not been possible for a range of reasons including that the client stopped engaging with the service. Furthermore, some cases currently remain open with their final status yet to be determined, but it was not possible to differentiate these in the data from closed cases with no outcomes.

For cases where outcomes were recorded, Table 3 shows that 27,616 (67%) were classified as “successful”. The remaining cases were classified as “unsuccessful”, which includes those where a positive outcome was not achieved e.g. because a benefit claim or appeal that the adviser was providing support with was unsuccessful, or because the client stopped engaging with the service.

Some cases focus on benefit checks, advice, or appeals and these cases sometimes do not lead to a new benefit claim. However, often cases do lead to a claim. Of the 27,616 cases that were classified as successful, 14,946 cases resulted in one or more claims. The top five claims that were fulfilled included Personal Independence Payments (25%), Attendance Allowance (22%), Council Tax Support (13%), Pension Credit (11%), and DHPs (10%). The remaining claims (73%) included support from a mix of other sources e.g. LCSS and Child Tax Credit.

Lastly, of the 13,693 cases that were classified as unsuccessful, 4,783 involved one or more claims that were unfulfilled. The top three types of unsuccessful claims mirrored those most commonly seen in successful cases, followed by DHPs and Council Tax Discounts.

Table 3: BMS claim outcomes.

	Number of claims	Percentage
Outcome (**n=41,309**)		
Successful	27,616	67
Unsuccessful	13,693	33
Top five successful claims (n=14,946)		
Note cases can fall into >1 category so values sum to >100%		
Personal Independence Payment	3,686	25
Attendance Allowance	3,266	22
Council Tax Support	1,957	13
Pension Credit	1,629	11
Discretionary Housing Payment	1,511	10
Other (e.g. LCSS, Child Tax Credit)	10,938	73
Top five unsuccessful claims (n=4,783)		
Note cases can fall into >1 category so values sum to >100%		
Personal Independence Payment	1,424	30
Attendance Allowance	756	16
Council Tax Support	405	8
Discretionary Housing Payment	346	7
Council Tax Discount	236	5
Other (e.g. LCSS, Child Tax Credit)	2,043	43

3.1.6 DHP applications and outcomes

In total, 53,554 DHP applications were submitted between 2017 to 2024. On average, each client submitted 4.5 applications, with the highest number of applications submitted by a single client reaching 36.

Table 4 shows the reasons for submitting an application. The most common reason (86%) was a rent shortfall due to clients' Housing Benefit or Universal Credit not fully covering their rent, which in some cases may be due to the impact of welfare reforms. Other reported reasons included that the client had moved to alternative accommodation (11%), or that they needed help with rent until a move could take place (1%), or help while seeking employment (1%), or help with rent for disabled accommodation (1%). A small number of applications (<1%) related to rent support for foster carers.

In terms of the impact of welfare reforms, over two thirds (69%) of clients were affected by the Social Sector Size Criteria, which is often referred to as the "bedroom tax". Clients also reported being affected by the Local Housing Allowance (16%) and the Benefit Cap (8%). A small proportion of clients (<1%) were affected by two or more welfare reforms, while 6% of clients were not affected by any welfare reform.

Table 4: DHP application characteristics.

	Number of applications	Percentage
Reason for DHP application (n=48,910)		
Rent shortfall	42,192	86
Has moved to alternative accommodation	5,217	11
Help with rent until moves	578	1
Help with rent until employed	614	1
Help with rent for disabled accommodation	247	1
Help with rent for foster carer	62	0.1
Impact of welfare reforms on DHP client (n=52,139)		
Affected by Social Sector Size Criteria (bedroom tax)	35,873	69
Affected by Local Housing Allowance	8,455	16
Affected by Benefit Cap	4,422	8
Affected by two or more reforms	48	0.1
Not affected by welfare reforms	3,341	6

Overall, 89% of DHP applications were successful. Table 5 indicates that the most common reason for being awarded a DHP was that the client was unable to move to alternative accommodation (62%). This was followed by challenges related to family size (9%), which included the impact of bedroom tax, but also household overcrowding and shared child custody issues. Furthermore, short-term illness (9%), financial hardship due to debt (6%), and disability-related housing needs (5%) were recorded as reasons for a successful application. The remaining 9% of applications were successful for a mix of other reasons, including that the household contained children under five years of age or that the client had insufficient available income.

In terms of unsuccessful applications, the most common reasons for refusal were that the client's rent was already fully covered by their Housing Benefit or Universal Credit payments (27%) or that their available income exceeded the required amount of £30 per week (27%). Other reasons included that the client failed to respond during the DHP application process (12%), that they were not eligible for a DHP due to not receiving Housing Benefit or Universal Credit (9%), or that their rent charges were excessive (7%). An additional 18% were unsuccessful for other reasons, such as rent arrears owed to a Registered Social Landlord prior to April 2013 when welfare reforms were introduced or issues related to Council Tax costs that could not be covered by a DHP.

Table 5: DHP application outcomes.

	Number of applications	Percentage
Outcome (n=53,554)		
Successful	47,879	89
Unsuccessful	5,675	11
Reason a DHP was awarded (n=46,794)		
Unable to move to alternative accommodation	28,964	62
Family size constraints	4,224	9
Short-term illness	4,008	9
Financial hardship due to debt	2,709	6
Disability-related housing needs	2,346	5
Other (e.g. children under 5, insufficient income)	4,543	9

Reason a DHP was rejected (n=5,550)		
Housing Benefit/Universal Credit covers rent	1,481	27
Available income exceeds £30 per week	1,491	27
Failed to respond during application process	662	12
Not receiving Housing Benefit/Universal Credit	518	9
Excessive rent charges	375	7
Other (e.g. rent arrears, Council Tax issues)	1,023	18

3.1.7 LCSS applications and outcomes

In total, 154,254 LCSS applications were submitted between 2017 to 2024. The average number of applications per client was 1.0 and the maximum number of applications a client had LCSS support with was 10. In terms of application type, Urgent Needs Awards (UNAs) accounted for 73%, Home Needs Awards (HNAs) accounted for 17%, and the Mayoral Hardship Fund (MHF) which was only available for two years accounted for <1%. The remaining 10% of clients applied for more than one type of award.

Table 6 illustrates that relatively few people (3%) self-referred into the LCSS e.g. after finding out about the service in the press or from using an internet search engine. Instead, clients were more likely to be referred by a family member or friend (15%). Outside of personal referrals, the most common referral route (46%) was from a wide mix of sources including GPs, social workers, and landlords. This was followed by referrals from government agencies such as the Department for Work and Pensions (24%), local authority services such as the BMS or Adult Social Care (10%), and community services or charities such as Citizens Advice (2%).

The top reasons for an LCSS application included a lack of funds (16%), that the client was receiving Universal Credit but was unable to budget (13%), to replace broken or faulty items (9%), assistance with setting up a new home (8%), or a shortfall in funds due to delays or waiting periods for a benefit to be awarded (6%). The remaining 48% were attributed to a range of other reasons, such as lost money, homelessness, and essential living expenses.

When a client submits an application for LCSS support they can request multiple items under a single application. Table 6 shows that a total of 471,260 items were requested. The top five requested items included food (45%), heating costs (15%), bed furniture such as a bed frame and/or mattress (9%), white goods (8%), and kitchen appliances (6%). The remaining 17% of requests covered a mix of items including clothing, bedding, and repairs to heating systems.

Table 6: LCSS application characteristics.

	Number of applications	Percentage
Referral route to LCSS (n=154,247)		
Self-referral	4,544	3
Family or friend referral	22,941	15
Referral via a government agency	36,643	24
Referral via a local authority service	155,12	10
Referral via a community service or charity	3,521	2
Other (e.g. GP, social worker, landlord)	71,086	46

Reason for LCSS application (n=151,357)		
No funds	24,421	16
Receiving Universal Credit but unable to budget	19,368	13
To replace broken or faulty items	13,354	9
To help set up a new home	12,232	8
Shortfall due to a delay or wait in benefit award	8,911	6
Other (e.g. lost money, homeless)	73,071	48
Top five requested items (n=471,260)		
Food	214,383	45
Heating costs	70,055	15
Bed furniture	41,602	9
White goods	37,498	8
Kitchen appliances	30,429	6
Other (e.g. clothing, bedding, heating system repair)	77,293	17

Note: bedding is no longer supplied following a policy update in April 2023.

Overall, 74% of LCSS applications were successful for both UNAs and HNAs. Applications involving multiple award types show a slightly higher success rate of 78%. In contrast, the MHF had a notably lower success rate of just 37%, but this was because MHF applications were routinely cross-referenced against the list of items permitted under an UNA or HNA to see if they could instead be fulfilled under one or both of those awards.

In terms of the time taken to process applications, LCC aim to process UNAs within 2 days (excluding weekends and public holidays) and analysis indicated they met this target, as the average time taken was 1.2 days. In contrast, LCC aim to process HNAs within 10 days and again analysis indicated this was achieved, as the average time taken was 3.8 days. MHF awards were processed within 9.0 days on average.

Table 7 shows the costs of fulfilling applications that successfully received one or more awards. Overall, £20,840,104 was given out in awards between 2017 to 2024 for 100,662 awards with complete data, which equates to an average of £207 per award. The UNA and HNA each accounted for £7.7 million (37%) of funding. The MHF accounted for just over £27,000 (<1%) of funding, while applications that involved more than one type of award received a total of £5.4 million (26%) of funding.

HNAs received the highest amount of funding with an average of £640 per award. This was followed by applications that involved more than one type of award (£530) and then MHF awards (£247). Lastly, UNAs received the lowest amount of funding with an average of £98 per award, which likely reflects their role in addressing urgent, short-term needs.

Table 7: LCSS costs and costs per award.

Award type	Total cost (£)	Average cost per award (£)
UNA (n=78,265)	7,670,718	98
HNA (n=12,025)	7,701,793	640
MHF (n=112)	27,692	247
>1 type of award (n=10,260)	5,439,901	530
Total (n=100,662)	**20,840,104**	**207**

3.1.8 Association of clients' characteristics with application success

Not all applicants who apply to the welfare schemes have a successful outcome. This is because some applicants do not meet the scheme's specific eligibility criteria e.g. they may

already be receiving benefits that preclude them from further support. It is also noteworthy that all local authorities tighten and loosen their eligibility criteria for welfare schemes over time, depending on the amount of funding available from central government, and this has implications for the number and/or size of awards they can make.

Figure 5 shows the percentage of applicants to the three schemes that were successful between 2017 to 2024. Applicants to the BMS had the lowest success rate, which was 67% on average. This is not unexpected because a primary aim of the service is to evaluate whether people are accessing all of the support they are entitled to, and sometimes it is the case that they already are. DHP applicants had the highest success rate, which was 90% on average. This is because there are clear eligibility criteria for these payments, which are only available to people on Housing Benefit or Universal Credit. Lastly, the success rate for LCSS applicants has varied somewhat over time, but on average it was 74% across the period. Compared to the other schemes, LCC have more flexibility to change the eligibility criteria of the LCSS in response to changes in demand (e.g. during the COVID-19 pandemic and cost-of-living crisis), changes in available funding (e.g. during recent cuts in 2023), and also in response to need (e.g. discretion to make furniture awards to those living in social housing where no other support is available), all of which have implications for fluctuations in success rate.

Figure 5: Quarterly percentage of successful applicants to the BMS, DHP and LCSS between 2017-2024.

We examined the sociodemographic characteristics that were associated with the likelihood of a successful application using a logistic regression model. We applied this model separately to the BMS, DHP, and LCSS datasets to assess whether these sociodemographic predictors have consistent effects across the different welfare schemes.

Table 8 summarises the logistic regression results and it includes odds ratios (which are a way of comparing the odds of an event happening in one group, to the odds of it happening

in another group) and p-values (which provide a measure of statistical significance). In terms of gender, both the BMS and DHPs show no statistically significant difference in the likelihood of success between male and female applicants. In contrast, the LCSS model indicates that male applicants are significantly less likely to be approved than their female counterparts (OR=0.94, p<0.001).

Across all three welfare schemes, age consistently emerges as a significant predictor of success. Applicants aged 35–64 years have higher odds of success compared to the youngest age group (16–34 years), and this effect was most pronounced for DHPs. However, the DHP results diverge for the 65+ group, where applicants are less likely to be successful (OR=0.72, p<0.001), unlike the BMS and LCSS where likelihood of success increases with age. Furthermore, applications to the LCSS from single parents were more likely to be successful than those from single people without children.

The association with area deprivation (IMD quintiles) also varies across the schemes. For both the BMS and DHPs, level of deprivation is a positive and significant predictor of application success. Clients from more deprived areas (Q2 to Q5) are more likely to be successful than those from the least deprived quintile (Q1). In contrast the chances of LCSS applications being successful did not vary markedly by level of deprivation.

Table 8: Association of sociodemographic characteristics with application success.

Variable	BMS (n=10,621)		DHP (n=52,541)		LCSS (n=150,139)	
	Odds ratio	p-value	Odds ratio	p-value	Odds ratio	p-value
Gender (baseline: Female)						
Male	0.99	0.90	1.03	0.43	0.94	<0.001
Age group (baseline: 16-34 yrs)						
35-49 yrs	1.04	0.64	1.45	<0.001	1.10	<0.001
50-64 yrs	1.07	0.33	2.71	<0.001	1.35	<0.001
65+ yrs	1.40	<0.001	0.72	<0.001	1.37	<0.001
Ethnicity (baseline: White)						
Minority	1.10	0.27	-	-	-	-
Long-term health condition or disability (baseline: No)						
Yes	1.02	0.72	-	-	0.98	0.15
Household type (baseline: Single without children)						
Single with children	-	-	-	-	1.33	<0.001
Couple without children	-	-	-	-	0.90	0.01
Couple with children	-	-	-	-	1.00	0.97
Pensioner	-	-	-	-	1.08	0.07
IMD quintiles (baseline: Q1 (least deprived))						
Q2	1.03	0.71	1.43	<0.001	1.10	0.02
Q3	1.13	0.15	1.71	<0.001	1.04	0.32
Q4	1.04	0.60	1.89	<0.001	1.03	0.38
Q5 (most deprived)	1.09	0.27	1.72	<0.001	0.99	0.87

Note: standard errors are clustered at the client level.

3.2 Impact of welfare provision on clients' health and wellbeing (Objective 2)

3.2.1 Wellbeing questionnaire

LCSS advisers have administered the wellbeing questionnaire to clients at baseline (when they first made contact with the LCSS team to assess their eligibility for support) over a period of approximately five months from 25th October 2024 to 2nd April 2025. During that period, 7,285 new clients made contact with the service and while the plan was to invite all new clients to complete the wellbeing questionnaire, only 928 (13%) were invited to do so. This was because LCSS advisers were operating under tight schedules and therefore did not always remember to email clients a link to the questionnaire. Of those who were invited to complete it, 118 (13%) chose to do so. For those who did, follow-up data was collected 3 months later but only 13 clients (11% of the baseline sample) provided data at both time points.

In terms of analysis, the questions relating to life satisfaction, things feeling worthwhile, and happiness were coded on a scale where higher values represented more positive responses. Conversely, the questions relating to anxiety and mental health were coded on a scale where higher values represented more negative responses. Therefore, to make the findings more straightforward to interpret, we reverse coded the responses for anxiety and mental health.

Table 9 shows clients' responses to the ONS four wellbeing questions at baseline compared to the responses of the Liverpool local population as a whole (collected as part of the Annual Population Survey[7]). Note wider Liverpool data is not available for the mental health question and so this is not included in the table. On average, LCSS clients had poor wellbeing across all four domains, scoring between 1.6-2.5 points lower than the Liverpool average.

Table 9: Responses to the wellbeing questions for LCSS clients at baseline versus the Liverpool population.

ONS wellbeing questions	LCSS clients at baseline (n=118)	Liverpool population
Life satisfaction	5.6	7.2
Worthwhile	5.7	7.5
Happiness	4.9	7.1
Anxiety	4.7	7.2
Mental health	1.9	-

Figure 6 shows LCSS clients' responses to the wellbeing questionnaire at baseline and follow-up. At baseline most clients reported scores for the domains of life satisfaction, things feeling worthwhile, happiness, and anxiety that were in the middle of the scale (e.g. they had a score of between 4.7-5.7, corresponding to being midway between "not at all" and "completely"). However, the interquartile range which indicates the spread of the data, suggests there was some variation between clients' responses. In terms of overall mental health, most clients reported their mental health as having a score of 2 at baseline, which corresponded to being "Fair" (the second from worst response).

At 3-month follow-up, there was little change across any of the domains, although there was a drop in life satisfaction and happiness of 1 point on the scale (equivalent to 10% lower wellbeing). This suggests a slight decline in clients' wellbeing for those two domains,

but given the small sample size (only 13 responses at follow-up) it is not possible to draw strong conclusions from the data. Furthermore, we do not know what would have happened in the absence of LCSS support i.e. LCSS clients may have declined less than their counterparts who did not receive support.

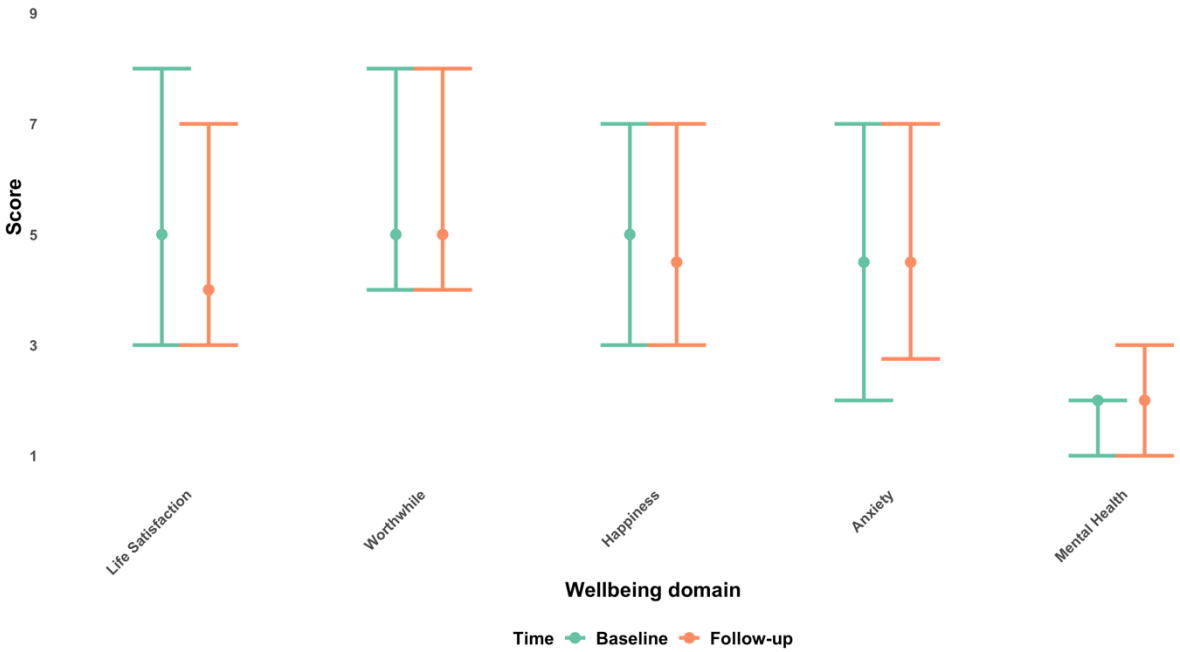


Figure 6: LCSS clients' scores across five wellbeing domains at baseline and follow-up. Note dots represent median values and error bars indicate the interquartile range.

3.2.2 Client experiences of the LCSS

This section provides an overview of the findings from the qualitative research undertaken with LCSS clients to understand their experiences of the LCSS and implications for health and wellbeing. While the findings focus primarily on client experiences, we also include short vignettes to illustrate stakeholder organisations' perspectives of the scheme.

3.2.2.1 Client interview sample

Of the 23 LCSS clients who took part in an interview, 18 had received an Urgent Needs Award (UNA) and 9 had received a Home Needs Award (HNA) in either their most recent award or previously. The socio-demographic characteristics of participants are reported in Table 10. Participants tended to be aged 35-64 years, single parents or living alone, identifying as 'White', and living with one or more long-term health issues or disabilities.

Table 10: Socio-demographic profile of the LCSS client interview sample.

Category	Sample profile
Age	65% (15 of 23) of participants were aged 35-64 years. None were over the age of 64.
Household composition	74% (17 of 23) of participants were the sole adult in the household. Of these participants, 11 were single parents and 6 lived alone.
Ethnic group	87% (20 of 23) of participants identified as being 'White' when asked their ethnic group.

Long-term health issue or disability	61% (14 of 23) of participants reported living with one or more health issues or disabilities. Of these participants, 86% (12 of 14) had received an UNA in their most recent engagement with the LCSS.
Escaped domestic abuse	17% (4 of 23) of participants were women who reported having escaped domestic abuse.
UNA recipients	78% (18 of 23) of participants reported having received an UNA in either their most recent award or prior to having received a HNA more recently. Of these participants, 72% (13 of 18) did not have income from employment and the same percentage were the sole adult in the household. Furthermore, 50% of UNA participants had dependent children.
HNA recipients	40% (9 of 23) of participants reporting having received a HNA in either their most recent award or prior to having received an UNA more recently. The interview sample included a participant who had applied for a HNA but who had been turned down reportedly on the grounds that they were a tenant of a Registered Social Landlord. Of these participants, 78% (7 of 9) were single mothers to young children and 44% (4 of 9) reported having escaped domestic abuse. Two participants reported living with a health condition.

3.2.2.2 Experiences of the Urgent Needs Award

Reasons for applying for an UNA

When asked about the circumstances that led to their application for an UNA, participants talked about: i) chronically low household income (e.g. whether from employment or social security payments or a combination) and they reported budgeting carefully for everyday expenses, habitually rationing essential expenditure (e.g. on food and home energy), and regularly coming close to or running out of money to pay for essentials; ii) increased expenditure during the winter months for home energy, weather-appropriate clothing, and Christmas presents for children; iii) income 'shocks', including large and sudden income reductions from loss of employment and reductions in Universal Credit or other social security payments; and iv) crises such as fleeing domestic abuse and needing to undertake medical tests or treatment.

Quotes from LCSS clients

"Cause I'm in that much debt and stuff and this, that and the other, and me benefits never cover me bills, never. So it's always last week. Like I got me benefits today, so like yesterday I had no food in whatsoever, nothing, so like I'd had nothing to eat all day" [P17]

"Well, I call it a ridiculous amount of drop of income. All of a sudden, out of the blue, from nowhere, because they [Universal Credit] don't tell you how much you're gonna lose until about four or five days before you get your money […] So I knew I was gonna lose something, but I had no idea it was gonna be anywhere near that ridiculous amount of drop. […] Yeah, so that's why I phoned up for some help." [P11]

At the time of applying for an UNA, participants reported experiencing intense anxiety about sourcing food for themselves or their children, about maintaining a warm home, and about being able to attend medical appointments at sites far from their place of residence. Participants reported rationing food, missing meals, experiencing hunger, and living in cold homes in winter relying on coats, blankets, and hot water bottles for warmth.

Quotes from LCSS clients

"But it was a struggle, I didn't eat for a couple of… for like a week or something. You know, it was very, very hard, it was difficult, you know, was going to churches and stuff, I was getting tea and biscuits there, very grateful for that, that helped as well, you know?" [P19]

"I didn't put the heating on, not necessarily, because the payment would have come out like that, but just the knowledge that that would add to the next month's bills. Even though it was very, very cold that week in November, I didn't turn the heating on at all […] I've got like a kind of window thermometer, and it was like six degrees, something like that at night, a bit more in the day, more like ten, but yeah. Lots of blankets and hot water bottles help." [P28]

What participants used the UNA for

Interviewees reported the UNA was used to cover essential, immediate, and pressing needs: purchasing food, heating the home and paying energy costs, and covering transport (including for medical appointments and getting children to school). One participant, who had moved to Liverpool from overseas, used the UNA to buy a UK SIM card for their phone.

Dual role of the UNA

It was evident that the UNA played a dual role: i) a 'safety net' by reducing hardship or protecting household living standards at a time of a crisis allowing a return to pre-crisis normality; and ii) a limited source of support for people whose financial situation is chronically insecure and fragile. For many, the UNA appeared to extend a bridge over a period of crisis allowing a return to customary normality while protecting a household's usual standard of living or reducing the hardship caused by the crisis. The UNA prevented or lessened high levels of hardship during periods of crisis. However, other participants appeared to be facing longer-term financial precarity and vulnerability linked to a range of issues such as having chronically low household income, often being in a negative budget, being subject to social security payment caps (e.g. the two-child benefit cap), having had experience of the children's care system, living with or recently diagnosed with a chronic health condition, and caring for dependants living with health conditions. For participants in long-term financial precarity, the LCSS limit of two awards in a 12-month period was a source of anxiety, both when applying for an award (due to worry of being told they were ineligible) and when thinking about their future (due to the uncertainty of whether they could access any kind of support).

Quotes from LCSS clients

"I can't ring back, so, because I'm now, I've now been referred to a [consultant] and I've gotta get [medical imaging procedures], and that's gonna take another two weeks, so I would like to be able to phone back for more help, but I know I can't because you can only get help so many times a year, so, which is fair I guess, you know, there's a lot of people, but in my circumstances it's just, it can be difficult." [P14]

The perspective of stakeholder organisations

Third-sector organisations offering financial advice and support argued that for significant numbers of their clients the LCSS offered only temporary relief. These clients often found themselves "on a hamster wheel" of repeated applications for an UNA and for additional sources

of support such as National Energy Action vouchers, Household Support Fund payments, and food vouchers. The causes of their clients' financial hardships were to be found partly in the failures of the local housing context and the national social security system.

UNA participants' views on award adequacy

Most UNA interviewees considered the size (financial value) of the UNA to have been adequate for meeting their needs at the time and expressed strong satisfaction with what they had been awarded. Three interviewees felt the UNA was insufficient for their needs (although it did help relieve some pressure). Their main concerns related to covering high home energy costs (via prepayment meters) and being in arrears with utility bills even after the UNA.

Service responsiveness and speed of delivery of the UNA

Overall, participants expressed strong satisfaction with the service responsiveness. Most reported that following their initial contact and assessment with the council, the LCSS team let them know the outcome of their application either the same or next day. For most participants, the award was then sent quickly, often immediately or at the very least in the same day.

Cashing the UNA

Just over half of UNA participants reported issues with cashing or redeeming the vouchers provided by the LCSS. Some experienced difficulties when they tried to cash their PayPoint vouchers, as they found that many of the shops listed as PayPoint sites, mainly independent, corner shops and post offices, would not redeem the vouchers or made it difficult to do so. Consequently, participants found they needed to visit multiple stores or the same store multiple times before they were able to redeem the vouchers. Typically, participants found that supermarket stores could redeem PayPoint vouchers more easily than independent shops. LCC are aware of this issue, and it is outside of their control, but they have raised it with PayPoint. In contrast, participants did not report encountering problems with the Love2Shop vouchers with the exception of one participant.

Physical health-related impacts of the UNA

The UNA prevented or reduced the duration of periods of hardship in terms of securing food and a warm home environment. In terms of more specific beneficial changes to health attributed to the UNA, different examples were provided. This included being able to cover or compensate for increased transport costs incurred to attend medical appointments and maintaining a diet in accordance with needs arising from health conditions. More generally, the award had also mitigated against the effects of cold homes which had led to a reliance on coats, blankets, and hot water bottles to keep warm. Half of the UNA interviewees were members of households with dependent children and concern about children's welfare was therefore prominent in participants' accounts.

Quotes from LCSS clients

"Helped us immensely, cause it helped us to survive until I got paid. I know it was like, it was like two, two to three weeks away from when I was getting paid, but that helped immensely, cause it made us… It helped us to get more gas, more leccy on the meter, cause the meter we have is a prepayment meter you see, […] and especially when you got two people in your house who have health issues, and you're constantly washing for them, then that does become a burden, because you're trying to find where can I get me money from, where can I get money

from to keep the leccy on and keep the gas on and keep the place warm and keep them two people fit and healthy and warm." [P23]

Mental health-related impacts of the UNA

Several interviewees receiving an UNA spoke of the award as reducing their anxiety around household financial circumstances. Participants spoke of having "felt low" with their anxiety compounded by feelings of depression, shame, and guilt. Participant anxieties related to: i) the impact of household finances on children and their wellbeing; ii) not being able to afford food (for themselves or their dependants), household bills and other expenses; and iii) the financial implications of attending either frequent or distant hospital appointments. These anxieties were typically experienced as a heavy burden and as mental pressure that the UNA relieved. The award was typically described by participants as a huge relief, a weight being lifted, and as a positive psychological boost involving feelings of joy, optimism, and gratitude.

Quotes from LCSS clients

"When you know you have to [inaudible] for the month and you know you could, you're able to make a meal when you feel hungry, you get, like I said, you get this burden off your chest. So yeah, it felt good not to think of where your next meal is going to come from, believe me, that's a struggle. You do not talk, it's more mental than it is physical actually, cause you struggle with it in your head, especially if you're someone like me that doesn't have anybody there to talk to, so you struggle with it. And it's quite difficult, so yeah. Felt good. It felt really good." [P5]

"…but with my anxiety and that, when it gets to a point where it's impacting on your children, that's when you're at your lowest. So, that like alleviated that pressure for me. Allowed me then not to be so preoccupied, preoccupied with them anxieties and focus on just looking after the children better if that makes sense. Because when you can't afford the basics, obviously that's quite stressful. So that alleviated all that pressure and upset." [P7]

Other social impacts of the UNA (e.g. family, employment)

Other social benefits were connected with receiving the award, and the associated mental health impacts this brought. For example, one mother explained that the relief of the financial pressure meant she was less intensely preoccupied around her children, could be more present with them, and focus on their care more. Two other participants said that after the award of the UNA they felt better able to cope with day-to-day life. One participant who applied for an UNA after having been made unexpectedly redundant talked about being better able to cope with being rejected in job applications and carrying on until they were eventually offered a new job. Another participant said that being awarded an UNA made them feel like "somebody cares and is listening".

However, this picture is complicated by participants' accounts of how contacting, engaging, and receiving support from the LCSS is accompanied by feelings of shame, guilt, embarrassment, and anxiety over seeking support and the possibility of being exposed to negative social judgements about their circumstances. Shame and stigma are discussed as barriers to accessing the LCSS further below in Section 3.2.2.4.

Alternatives to the UNA

Interviewees' accounts also compared the UNA to their experiences of attempting to access other sources of emergency financial support.

i) Alternative sources of support may not be available: Some participants reported not being able to draw support from family, friends or other informal social networks, food banks, employers, or mainstream lending services. Other participants reported receiving spare furniture from friends or neighbours, borrowing small amounts of money from neighbours, and receiving financial support from parents.

ii) Alternative sources of support may be inadequate, unreliable, or inappropriate: Support from family members, food banks, charity and discount shops could not always meet household needs adequately or reliably. Family support, where available, was described as minimal relative to their needs, discount shops as unaffordable, food banks as unsuitable for certain health conditions and lacking items such as washing powder and shower gel, and charity shops as unreliable in their availability of needed items.

iii) Alternative sources of support may carry significant risks: A small number of participants had resorted to or were considering using pawnbroking, doorstep lending, and shoplifting. One person reported using social media apps to request food donations from neighbours, which they suggested could have put them in situations of risk as a young person living alone and without family support.

iv) Exposure to social stigma or affecting social relationships: Participants expressed deep embarrassment about considering or actually visiting food banks. Similarly, borrowing from family or friends was described as undesirable and uncomfortable. However, it was also evident that stigma was additionally attached to using schemes such as the LCSS (see Section 3.2.2.4).

v) Not addressing a person's urgent financial needs: Participants engaged in several actions to manage their household finances such as reducing their expenditure by rationing home energy use and household shopping, contacting utility companies to negotiate more affordable payment plans, using food banks and charity shops, contacting Citizens Advice, seeking support from community centres and charities, and considering moving out of Liverpool to an area of more affordable housing. However, these options, although helpful in the medium and longer-term, did not meet their immediate pressing need for money to pay for essential household expenses.

3.2.2.3 Experiences of the Home Needs Award

Reasons for applying for a HNA

Of the 9 participants in the interview sample who had received a HNA, 4 were women who had fled with their children from abusive partners. They had received a HNA after moving into permanent accommodation that was completely unfurnished. The remaining participants included one who was care system experienced and had been awarded a HNA as part of the transition from homelessness to independent living; three were single mothers to young children; and one HNA participant was a man who lived alone.

Two examples of the difficult circumstances participants faced that led to a HNA application
One participant talked about sleeping on the kitchen floor with clothes for pillows for about a week until a friend gave them a bed and mattress. The same participant used social media apps and 'freecycling' websites to source furniture and appliances, including a kettle which they used to cook pasta and Pot Noodles during the two-week period they waited for their HNA delivery.

A further participant reported using their washing machine even though it was leaking because they could not afford the repair costs they were quoted. Eventually, the washing machine stopped working altogether but the water leaking on the kitchen floor had created damp on the kitchen wall. Without the HNA, the participant who has a child with additional health needs that entail frequent changes of bedding would have gone longer without a washing machine. The participant reported being in part-time employment but only working a small number of hours because of their caring role. The participant reported that if they had paid to repair the washing machine, they would then have been unable to pay for household bills.

HNA participants' views on award adequacy

Participants did not discuss the adequacy of the HNA in depth, other than a small number mentioned that the HNA does not include flooring, curtains, or blinds, which unfurnished tenancies typically lack. Overall, participants expressed deep gratitude for what they had received and offered no criticisms for what was lacking in their homes.

Service responsiveness and speed of delivery of the HNA

All HNA participants expressed strong satisfaction with the installation and quality of the HNA items they received. However, waiting times for receipt of a HNA ranged from 1-6 weeks. Participants described the difficulties involved in living life without essential appliances and furniture within that time. Participants reported: i) themselves and their children sleeping on the floor; ii) shopping for fresh, perishable food, such as fruit, every day because they lacked a fridge or freezer; iii) storing and cooking food in a relative's house; iv) using the washing machines of family and friends or using a launderette; v) living in homes with concrete or floorboard floors and without curtains or blinds; vi) not having their children visit or stay overnight because of the lack of a bed and of kitchen appliances; and vii) being unable to cook at home and relying on convenience meals such as sandwiches, pasta and Pot Noodles, takeaways and microwaveable meals.

One participant considered finding a different place for their children to stay until the new property was made liveable. Another participant could not have their child visit and stay overnight (the child did not live with them) until they received the HNA.

Quotes from LCSS clients

"It was bittersweet really. It was really, it was bittersweet, because we'd gone for so long living in temporary accommodation that we were so happy, I was so happy that we had a property. But we… I was also really anxious and really worried about how we were gonna actually fill it! [laughs]." [P25]

Financial impacts of the HNA

The financial impacts related to: i) the avoidance of accruing debt (e.g. by falling behind on bill payments); ii) the avoidance of having to reduce essential household expenditure to finance the purchase of the HNA items from second-hand and charity shops; iii) the avoidance of continued expenditure on expensive outlays such as using a launderette for washing clothes, and buying takeaway or microwave meals instead of cooking in the home; and iv) the availability of money for other beneficial purchases (e.g. one mother purchased pieces of flooring to protect her children's feet from floorboard splinters).

Physical health-related impacts of the HNA

The physical impacts related to: i) the shortening of the time period participants and their children experienced difficulties, deprivations, and hardships of living without basic,

essential appliances, furniture, and furnishings (examples of these were sleeping on the floor, living in accommodation that lacked flooring, curtains, or blinds, and being unable to cook in their home); ii) improved diet for the interviewees and their children; iii) better sleep and rest; and iv) being better able to care for the needs of children.

Mental health-related impacts of the HNA

The emotional and psychological impacts related to: i) intense positive emotions of joy and relief for the alleviation of everyday hardships; ii) a sense of a return to normality, of living again in accordance with prevailing social norms, leaving behind the sense of living in exceptional or transitional circumstances (e.g. families can feel they have re-joined mainstream society and are living lives similar to their peers); iii) a return to a valued sense of household self-sufficiency and independence, leaving behind a reliance on family and friends (where these are available) and on public and third-sector services; iv) the alleviation of anxiety about financing the equipping of the home; v) the alleviation of anxiety about impacts on children and the alleviation of guilt and self-blame for their living circumstances; and vi) being able to have children living elsewhere visit and stay over.

Quotes from LCSS clients

"I mean felt so relieved and kind of like OK, like we're just, we have a normal household again, you know for my [child], like we can have normal things, like [inaudible] wash our clothes or have chilled food in date. Like it was more the relief for my [child] more than me. I'm by myself, like you know, when you have a child it's different." [P10]

"because we had so much fun the day that everything [the LCSS HNA items] got delivered, because we went out and we did a food shop […] And we stored all our fruits and veggies, we put them in the fridge, and we cooked some fresh meals for all of us and it was amazing, it was the best, and that was the night that I had the best sleep as well, so that was the best day." [P25]

Other social impacts of the HNA

Regarding social impacts, one participant credited the HNA for functioning as a stepping stone in her path to returning to employment and financial self-sufficiency. Other participants mentioned being able to have friends visit them. Additionally, stakeholder organisations also spoke of wider social benefits, as described below.

The perspective of stakeholder organisations

Prevention of debt, housing instability and homelessness

A representative from a national third-sector organisation stated that they strongly believe that HNAs contribute to the prevention of homelessness by supporting people to maintain their tenancies whether in the private or social rented sector. In their view, HNAs prevent people from accruing debt early on in their tenancies to pay for furnishings and decrease the likelihood of people falling into rent arrears.

Third-sector representatives argued that HNAs prevent people from resorting to rent-to-own retailers which charge very high interest rates, from getting into debt, and from resorting to illegal money lending.

Alternatives to the HNA

Participants were not aware of alternatives to obtaining the items they were awarded through the LCSS via a HNA. Participants reported that the state of their finances would not have allowed them to buy, repair, or replace essential household appliances and furniture.

3.2.2.4 Participants' experiences of service access and service delivery, and their suggestions for improvement (UNA and HNA)

Becoming aware of the existence of the LCSS

Participants learned of the service's existence mainly from: family and friends who had been in similar circumstances to them; online routes; and their housing provider. The following were reported by one participant each as their source of information about the LCSS: Crisis UK, Universal Credit, the local authority leaving care team, the job centre, the food bank, their children's school, a homelessness charity, and a flyer in public transport.

The perspective of stakeholder organisations

The extent of the service's reach to the general population and the awareness of the service's existence among population groups likely to benefit from the LCSS was a matter of divergence among stakeholder organisations. LCC staff and Registered Social Landlord representatives were more likely to suggest the service was well known. Third-sector representatives questioned the extent of service awareness among those who are likely to need it the most. Their argument was that intersecting issues relating to mental health, literacy, and living in complex circumstances and with complex needs create barriers to both awareness and access.

Telephone queue waiting times

Most participants had contacted the LCSS via the telephone. One participant said that their local Member of Parliament contacted the service on their behalf. A minority said they had experienced long waiting times on the phone to the LCSS.

Liverpool City Council staff attitudes towards LCSS clients

Almost all the participants who offered their view spoke very positively of the LCC staff they interacted with. Staff were typically described as 'helpful', 'understanding', 'really nice', 'non-judgemental', and 'sympathetic'.

Eligibility assessment process

Most participants described the eligibility assessment process as straightforward. A small number of participants: i) talked of a sense of discomfort at being asked a lot of questions including questions they thought of as irrelevant or as difficult to answer (e.g. "how much money do you spend on food every week?"); and ii) found the questions and requirements of the process (e.g. providing the LCSS with a copy of their bank statements) 'embarrassing', and 'a little bit invasive'. One participant found the process upsetting as she was asked to talk about her experiences of fleeing domestic abuse and relive the trauma of those events. In contrast, another participant who had also recently fled domestic abuse did not have the same experience. She surmised that this was because the LCSS and the other agencies supporting her at the time had exchanged key information about what had happened. Overall, participants acknowledged that the council needed to ensure fairness and prevent fraudulent claims.

Signposting

Approximately half of the participants reported being signposted by the LCSS to other services. Services mentioned were: debt management and advice, food banks, housing, mental health, Universal Credit, and Council Tax advice. The other half said that they were not signposted to other services or could not remember whether they were signposted or not.

Participants' overall sense of satisfaction with the LCSS

Most participants spoke highly of the service. Participants expressed very strong positive views of the service overall or of specific elements of the service, or expressed a strong sense of gratitude to the LCSS, or had no suggestions for improvements when asked. Participants who did not express satisfaction with the service referenced either the size or the frequency of the awards they had received as inadequate, or that they had been denied an award.

The perspective of stakeholder organisations

Stakeholder organisations praised Liverpool City Council for its Local Welfare Provision and for its commitment to the BMS, DHP and LCSS schemes through very difficult budgetary conditions. They contrasted LCC with neighbouring local authorities in Merseyside whose provision they described as minimal.

Shame and stigma as barriers to accessing and using the LCSS

Several participants mentioned that contacting the LCSS and going through the award application process was fraught with feelings of embarrassment, shame, and anticipatory anxiety about the prospect of being subjected to negative social judgements and a negative critical attitude by LCC staff. These feelings were associated with participants describing their financial and living circumstances, and with asking for and receiving support. Participants reported being able to overcome these feelings and engage with the LCSS because they saw no other option for securing household essentials and for lessening the impact of their situation on their children.

Quotes from LCSS clients

Yeah, if it was just me on me own, I don't think that I'd even… I'd just go without basically. But I do… It's sort of degrading a bit, isn't it, even having to ask people for help, so it's for [the children's] wellbeing that I do it...." [P16]

"So, it does make me feel emotional that I'm asking for help, because I'm struggling to provide for my children, and I think it, it hurts me and it makes me feel sad and it makes me feel guilty that I'm, I am struggling." [P18]

Suggestions and recommendations for improvement offered by participants

i) Expand provision: Six participants, although appreciative of the needs for economy and efficiency on the part of the council, asked for a relaxation of the limit of two awards in a 12-month period, larger award sizes, more support for vulnerable social categories such as families with children and older people, and a reversal of the exclusion of social housing tenants from the HNA.

ii) Develop accessibility and inclusivity: Although they did not themselves directly experience barriers to accessing and engaging with the service, five participants expressed concern for people who did not have the confidence or skills to use digital technologies effectively, and for people who were living with mental health difficulties. Participants observed that engaging with the service requires that: i) an applicant is in good mental health and capable of dealing with the psychological and administrative burden of seeking support and going through the eligibility and application processes; and ii) an applicant overcomes internal barriers (e.g. embarrassment and shame about seeking support, or fear of being judged) and social barriers (e.g. perceived stigma, or lack of social support).

The perspective of stakeholder organisations

Stakeholder organisations expressed concerns about the accessibility and inclusivity of the LCSS. Remote service access (by telephone or online) was deemed in general to raise barriers for different groups including people: with mental health needs and disabilities; experiencing multiple forms of disadvantage; from social groups that are 'seldom heard' such as minoritised and racialised communities; for whom English is not their first language; with low levels of literacy; with no recourse to public funds; and newly settled people and communities.

Third-sector organisations that offered face-to-face appointments to citizens needing financial advice and support reported that they witness very high demand for their services, which is contributed to by people who are underserved by remote service access. These organisations reported that their clients highly value the opportunity to speak to a person, they feel listened to and reassured, and they find it easier to express their needs (e.g. by bringing with them paperwork they have questions on). They also reported that their caseworkers can pick up on important client needs based on the person's presentation and their body language.

Finally, the LCC's role as a debt collector for Council Tax arrears may complicate their relationship with residents.

iii) Make changes to the eligibility assessment process: Three participants would like to see changes to the eligibility assessment process on the grounds that: i) they found it hard to give an accurate and full account of their household expenditure in a telephone call; and ii) the eligibility process can be experienced as judgemental and undignified.

iv) Reduce waiting times: Three participants asked for reductions in the waiting times for contacting the service on the telephone, and for the UNA decisions to be made.

v) Resolve issues with PayPoint: Two participants requested that the availability of shops that will cash an UNA is improved. A suggestion offered was to exclude small independent shops from the PayPoint scheme and only use banks or post offices that are more likely to have cash readily available.

vi) Other suggestions: Two participants suggested that the service: is more proactive in advertising itself; follows-up on people to check their situation post-award; connects people to other services and includes them in broader networks of support; and does not call applicants from an unknown number as people receive a very high number of spam calls.

3.2.3 LSOA level mental health-related outcomes

This section presents findings from the instrumental variable analysis that assessed the effect of LCSS welfare provision on mental health-related outcomes, by comparing indicators before and after the LCSS Policy Control was implemented in April 2023, and how this varied across places with different levels of social housing.

To provide context for the findings, Figure 7 shows the quarterly average LCSS financial value of awards per person between 2018 to 2023 by quintiles of social housing concentration. A pronounced decline in award levels is evident in areas with higher concentrations of social housing following the implementation of the April 2023 policy restriction.

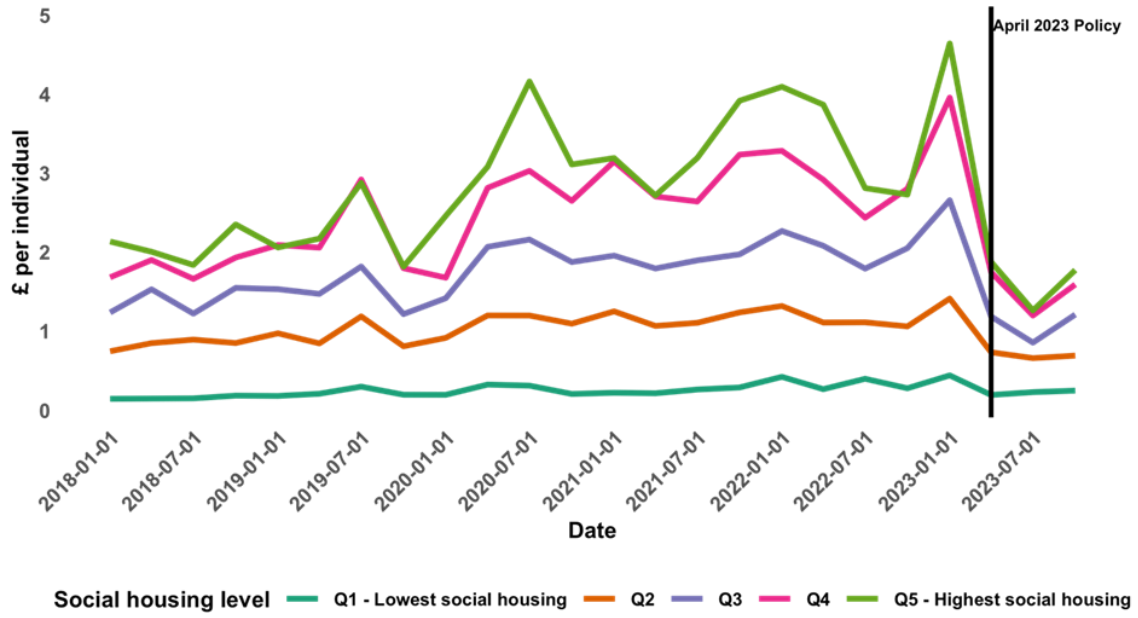


Figure 7: Trends in the LCSS financial value of awards per person by social housing quintile between 2018 to 2023.

Table 11 shows the estimated effects of the LCSS award rate on a range of mental health-related outcomes using instrumental variable analysis. For each outcome, the table reports the point estimate along with the corresponding 95% confidence interval (which is the range within which we can be 95% confident the true value of the estimated effect lies) and p-value (which provides a measure of statistical significance).

The results indicate that greater levels of LCSS award provision were consistently associated with improvements across multiple mental health-related outcomes. Specifically, a £1 increase in LCSS awards per person in the population per quarter was associated with a 0.1 point reduction in the quarterly mental illness index (95% CI: -0.1 to -0.1; $p<0.01$). Specific outcomes also showed beneficial associations: the additional £1 LCSS award per person per quarter was significantly associated with a reduction of 309 Average Daily Quantities (ADQs) of antidepressants prescribed per 1000 people per quarter (95% CI: -536 to -83; $p=0.01$), and a reduction of 3 mental health-related GP consultations per 1000 people per quarter (95% CI: -5 to -0.2; $p=0.04$). In addition, a £1 increase in award provision per person per quarter was associated with a reduction of 1 A&E visit per 1000 people per quarter and 1 emergency hospital admission per 1000 people per quarter, although the latter association did not reach statistical significance.

Table 11: Instrumental variable estimates of the impact of an additional £1 in LCSS award provision per person in the population on mental health-related outcomes.

Outcome variable	LCSS award per person			
	Estimate	Lower CI	Upper CI	p-value
Quarterly points on the mental illness index	-0.1	-0.1	-0.1	<0.01
Quarterly ADQs of antidepressant prescribing per 1000 people	-309	-536	-83	0.01
Quarterly number of mental health-related GP consultations per 1000 people	-3	-5	-0.2	0.04
Quarterly number of mental health-related A&E attendances per 1000 people	-1	-1	-0.1	0.02
Quarterly number of mental health-related emergency hospital admissions per 1000 people	-1	-2	0.3	0.15

To quantify the cost savings attributable to the LCSS, we multiplied the estimated effect of the LCSS award rate on each mental health outcome by the corresponding unit cost of the relevant healthcare service: antidepressant prescribing (£0.20), GP consultations (£52), A&E attendances (£414), and emergency hospital admissions (£2,431). As the estimated effects were expressed per 1,000 people, we divided them by 1,000 to calculate per person savings. Finally, the per person savings were scaled by the total value of LCSS awards to estimate the overall cost savings to the healthcare system.

Based on this approach, each additional £1 in LCSS award provision per person per quarter was associated with an estimated quarterly reduction in mental health-related healthcare costs per person of approximately £0.63 (95% CI: £0.07 to £0.78), including £0.06 for antidepressant prescribing, £0.16 for GP consultations, and £0.41 for A&E attendances. The estimated saving for emergency hospital admissions was excluded from the total due to a lack of statistical significance. Between 2018 to 2023, a total of £16,432,789 was awarded through the LCSS, corresponding to an estimated total NHS saving of £10,352,657 (95% CI: £1,150,295 to £12,817,575) and a net intervention cost of £6,080,132 (95% CI: £3,615,214 to £15,282,494). However, there is a high degree of uncertainty around these figures, as reflected in the wide confidence intervals, and they should therefore be interpreted with caution. Moreover, this estimate is conservative, as it does not account for other potential benefits such as improved wellbeing, reduced social care needs, or increased economic participation.

These results have implications for addressing health inequalities. The instrumental variable analysis demonstrates that increased provision of LCSS awards (which is a relatively modest financial intervention) is associated with improvements in population mental health-related outcomes, including reductions in antidepressant prescribing and healthcare utilisation. Since LCSS awards are disproportionately accessed by individuals experiencing financial hardship, the mental health benefits observed are likely to be concentrated among lower income groups who face the greatest barriers to wellbeing. This may therefore suggest that the LCSS may offer more than short-term financial relief, as it may additionally act as a means to reduce the mental health burden that is unequally distributed across socioeconomic groups. Investing in targeted welfare schemes such as the LCSS may therefore represent a cost-effective policy strategy for reducing socioeconomic disparities in mental health and easing pressure on healthcare services.

3.3 Costs of delivering the welfare schemes (Objective 3)

The costs associated with delivering the three welfare schemes between April 2017 to April 2024 are shown in Table 12. The total administration costs for the BMS were £6.21 million over the 7-year period, serving 37,350 clients and resulting in an average cost of £166 per client. For comparison, the administration costs for DHPs were £2.08 million in total (£173 per client) and for the LCSS they were £5.36 million in total (£36 per client). Although the BMS did not involve the direct issuance of financial support, the cost per client is comparable to other non-cash-based referral interventions, such as Citizens Advice on Prescription, which reported an average cost of £145 per client[6]. Note the difference between the cost per client for the two services reflects that they have different delivery models. These include that Citizens Advice on Prescription provides a wide range of social welfare advice and operates from health service settings, while the BMS provides benefits advice largely via telephone consultations (although it does offer home visits for those who need them and undertakes outreach engagement) and it additionally supports clients with complex tribunal cases that require significant BMS adviser input.

Most of the costs that were involved in delivering the DHP and LCSS schemes related to the financial support they issued, which amounted to £17.69 million for DHPs and £23.81 million for the LCSS over the 7-year period. During that time, DHPs served 12,001 clients at an average cost of £1,647 per client overall. The high cost per client for DHPs reflects that the purpose of the scheme is to cover a shortfall in rent and that clients often make repeated applications for support.

Additionally, the LCSS supported 150,796 clients at an average cost of £194 per client overall. Note the value reported for the LCSS cost per client in Table 12 (£194) differs slightly from that reported in Table 7 (£207). This discrepancy is due to each value relating to a slightly different time period, with the Table 12 value being for the financial years April 2017 to April 2024 and the Table 7 value being for the calendar years January 2017 to December 2024. The cost per client for the LCSS is comparable to other similar schemes. For example, Manchester City Council deliver a Welfare Provision Scheme that supports residents in crisis via a range of measures. This includes vouchers of up to £49 for urgent fuel needs and emergency cash grants of up to £60 for people in financial crisis, which together total £109[8]. While the LCSS is slightly more generous in its awards, both schemes offer comparable levels of financial support.

Table 12: Total costs of delivering the welfare schemes between April 2017 to April 2024.

	BMS	DHP	LCSS
Total costs (£ million)	6.21	19.77	29.17
Total value of financial support issued (£ million)	-	17.69	23.81
Total administration costs (£ million)	6.21	2.08	5.36
Total number of cases/applications	50,835	53,554	154,254
Total number of clients	37,350	12,001	150,796
Total cost per case/application (£)	**122**	**369**	**189**
Total cost per client (£)	**166**	**1,647**	**194**
Administration cost per client (£)	**166**	**173**	**36**

4) Conclusions and recommendations

This evaluation has focused on three core components of LCC's local welfare provision including the BMS (around 6,000 clients per year), DHPs (around 10,000 clients per year) and the LCSS (around 18,000 clients per year). The combined cost of delivering the services is £7.8 million each year.

The schemes have been effective at engaging with residents living in high-need communities, with analysis suggesting uptake has been concentrated in areas of high deprivation and poor mental health, particularly for the LCSS. Uptake was greatest among women, the working age population, and people with a long-term health condition or disability. Uptake was low from ethnic minorities, at least for the BMS, while data were not available for DHPs or the LCSS. Whilst LCC undertake outreach activities with the aim of engaging with minority groups, for example the BMS runs an outreach surgery targeted at the Chinese community, the findings suggest that further work is needed. Additionally, we recognise that the BMS has historically had greater capacity to focus on proactive outreach engagement, and that current high demand for the service has meant that these activities have needed to be scaled back to focus on meeting demand. A challenge therefore remains to balance the immediate pressures of meeting high service demand with the longer-term need to invest in sustained, targeted outreach to underrepresented groups. Without dedicated capacity for proactive engagement, there is a risk that existing inequalities in awareness and uptake will persist or widen.

There may be some gaps in uptake as follows. Firstly, there has been a recent decline in uptake from more deprived areas for DHPs and to a lesser extent the BMS. While LCSS applications have historically been stable across deprivation quintiles, the April 2023 policy that restricted eligibility for social housing tenants has led to a decline in applications from the most deprived areas of the city (where social housing is more prevalent). Secondly, declines observed in DHP and BMS applications have been greatest in the 35-64 age group and among women. These declines are unlikely to reflect reduced need, but rather a reduction in availability of support relative to need. The LCSS has slightly compensated for the reduction in DHP applications, but the effect size was small (on average for every 100 fewer DPH applications, there was an increase of around 4 LCSS applications).

Some of these gaps in welfare provision may be being met by alternative services. For example, other organisations across Liverpool including, but not limited to, Citizens Advice, Raise Advice, and some food banks offer benefits advice similar to that provided by the BMS. However, to address remaining emerging gaps in welfare provision, LCC may wish to consider targeted outreach and engagement strategies aimed at groups showing declining uptake, particularly residents in deprived areas, along with women and those aged 35-64 for DHPs and the BMS. This could include clearer communication about eligibility and simplified application processes to reduce barriers. Additionally, a key area may be to develop and/or strengthen closer partnerships with allied organisations. For example, improve integration of referral pathways for welfare provision when people seek support from: i) the voluntary sector (e.g. local food banks), ii) health and wellbeing services (e.g. Primary Care Networks including GPs and social prescribing link workers), iii) housing associations (e.g. Torus Foundation, Onward Homes), and iv) community hubs and faith-based centres (e.g. Toxteth Town Hall Community Resource Centre and churches). These partnerships can increase trust, improve access, and ensure support reaches those who may not engage through formal council channels. Furthermore, the council may wish to review recent policy changes, such as the restriction on LCSS eligibility for social housing tenants, to address unintended impacts on access from those living in deprived areas.

In terms of service delivery costs, the BMS was £166 per client. This value is comparable to other non-cash-based referral interventions, such as Citizens Advice on Prescription, which reported a cost of £145 per client[6]. For the LCSS, the cost was £194 per client and again this is comparable to similar services. For example, Manchester City Council's Welfare Provision Scheme offers support to residents in financial crisis including vouchers of up to £49 for urgent fuel needs and emergency cash grants of up to £60, which together total £109[8]. The LCSS is slightly more generous in its awards, but both schemes offer similar levels of financial support. Lastly, DHPs were the most expensive at £1,647 per client, which reflects that their purpose is to cover a shortfall in rent and that clients often make repeated applications for support (on average 4.5 applications per client across 8 years, compared to an average of 1 application per client for the LCSS over the same time period). Each of the welfare schemes in this evaluation were well-established, having been operating for 12 years or more, and it is therefore likely they are benefiting from the cost efficiencies that typically come with sustained delivery and refinement over time.

Client interviews indicated that LCSS support has had a profound and multifaceted impact, including alleviating immediate financial crises and contributing to both emotional and physical wellbeing. The UNA enabled clients to meet essential needs like food, heating, and transport during times of acute hardship, often preventing hunger and cold while reducing anxiety, bringing relief, and restoring a sense of dignity. Similarly, the HNA supported clients to establish a safe and functional household, particularly for those fleeing domestic abuse. It improved living conditions, diet, sleep, and the ability to care for children, while also fostering emotional stability, independence, and a return to clients' usual living standards. These wellbeing benefits are in line with those identified from similar evaluations of local welfare provision schemes at other locations in England[9,10]. However, accessing support could evoke feelings of embarrassment and stigma, especially for those with complex needs or past trauma. Overall, the LCSS was viewed as a crucial safety net that could fill gaps left by inadequate or inaccessible alternative support systems, including national welfare provision.

We also examined the impact of LCSS support on mental health-related outcomes at the LSOA level (including reductions in antidepressant prescribing, GP appointments, A&E attendances, and emergency hospital appointments) and found that each additional £1 in LCSS awards per person in the population per quarter was associated with an estimated quarterly per capita reduction of £0.63 in healthcare costs. Overall, a total of £16,432,789 was awarded through the LCSS between 2018 to 2023 which, based on the values above, corresponds to an estimated NHS saving of £10,352,657 and a net intervention cost of £6,080,132. This is a conservative estimate, as it does not take into account other potential benefits such as improved physical health, reduced social care needs, increased economic participation, or reduced crime (noting that the client interviews revealed that some people had felt so desperate they had considered shoplifting). End Furniture Poverty have recently undertaken a cost benefit analysis that did look at potential wider savings. They examined LCC's suite of local welfare provision (i.e. the BMS, DHPs and LCSS) and estimated that for every £1 spent on these services this gives a benefit equivalent to £9.70 in terms of reduced demand for wider local authority services (such as social care) and £14.20 in terms of reduced demand on public services such as health (NHS), criminal justice, and benefits (DWP)[11].

In addition to supporting the clients themselves, the LCSS plays a role in supporting wider family members, particularly for households with children. For example, for women fleeing domestic abuse LCSS support has wider implications for the wellbeing and future

trajectories of their children. By enabling mothers to leave unsafe environments and establish secure households through the provision of essential items and financial relief, the LCSS plays a critical role in safeguarding children from further trauma and instability. The scheme therefore may help prevent the need for children to enter the care system and also promote conditions that support healthier development, emotional security, and educational continuity. As such, the LCSS may help to disrupt cycles of harm and disadvantage. It is recommended that local authorities and policymakers explicitly consider the child safeguarding and long-term developmental benefits of welfare schemes like the LCSS when shaping funding priorities.

In terms of stakeholder organisations' views, they praised the LCSS for its responsive and humane approach, especially in comparison to more limited welfare provision in neighbouring areas. They acknowledged the scheme's effectiveness in preventing deeper crises such as debt, rent arrears, and homelessness. However, third-sector representatives expressed concern that the scheme only offers temporary relief for clients facing long-term financial insecurity, likening it to being stuck "on a hamster wheel" of repeated applications. They also questioned whether the scheme was sufficiently known to the most vulnerable groups, noting barriers such as poor mental health, low literacy, and social isolation, and they emphasised the need for improved outreach.

All three of the welfare schemes we evaluated clearly offer vital short-term relief by providing financial or in-kind support to reduce hardship. In terms of whether the LCSS can move people out of crisis longer-term, the findings are somewhat mixed and likely depend on individuals' circumstances. For example, stakeholder organisations raised that some clients are caught in a cycle of repeat applications and may be unlikely to break from this. However, in contrast the client interviews indicated that where support facilitates people to escape a difficult situation (e.g. homelessness or domestic abuse) it could potentially move individuals onto a more positive longer-term trajectory. Additionally, it supports clients to maintain stable tenancies and avoid housing instability, thus mitigating future risk of crisis. Furthermore, the findings from the instrumental variable analysis demonstrated that increased provision of LCSS awards was associated with improvements in population mental health-related outcomes, including reductions in antidepressant prescribing and healthcare utilisation, all of which potentially suggest a move to longer-term client stability. However, it is noteworthy that many of the drivers of crisis (such as national welfare reform, employment insecurity, rising housing costs, and poor mental health support) are outside the control of the scheme and without broader systemic change the LCSS may, in some cases at least, only be able to help people stay afloat but not move out of crisis longer-term.

Lastly, our findings suggest there may be some barriers to effective implementation including those related to equitable access and inclusivity. Firstly, clients and stakeholder organisations suggested that relying primarily on access through the telephone raises barriers for a number of social categories including people living with mental health difficulties, people living with disabilities, people for whom English is not their first language, and people identifying as neurodivergent. Therefore, accessibility and inclusivity are likely to be enhanced by offering a choice of application channels including face-to-face, telephone, and online. This recommendation may be particularly important, since LCC highlight that their local welfare provision services are designed to integrate with each other, therefore it should not matter which service a client gets in touch with as all of them provide a 'gateway' into the welfare system, with LCC then providing wider 'wraparound' support through onward referrals to internal council services or external organisations. Secondly, clients highlighted that feelings of embarrassment, shame, and anticipatory

anxiety over exposure to severe social stigma can act as barriers to accessing welfare provision. A suggestion to help mitigate these would be for LCC to emphasise in its public-facing communications that services are delivered in an empathic and non-judgemental way.

In terms of recommendations that specifically relate to the LCSS, in our small sample of HNA clients at least 2 waited for more than 4 weeks to receive their HNA items. LCC may therefore wish to work with their suppliers to improve delivery times, as this would increase the service's effectiveness in alleviating hardship and its associated adverse outcomes. Furthermore, we suggest that LCC may wish to consider removing the UNA 2-award limit for people applying for travel funds in order to access medical services. The amounts of money involved are likely to be small, yet they appear to have a disproportionate positive impact on a person's mental health. Additionally, LCC currently make LCSS clients aware that the NHS will reimburse travel costs for medical appointments, yet none of the participants we interviewed raised this and it may therefore be beneficial to ensure that information about NHS reimbursement is communicated more clearly and consistently to clients. This could include reinforcing this message during consultations and displaying poster or leaflet reminders in the waiting areas of local health services.

Finally, we recommend that LCC consider all of the suggestions for improvement offered by research participants (both clients and stakeholder organisations) detailed in this report.

5) Acknowledgements

This project was funded by the National Institute for Health and Care Research (NIHR) [Public Health Research Programme (NIHR135517/PHIRST)]. The views expressed are those of the authors and not necessarily those of the NIHR or the Department of Health and Social Care.

PHIRST LiLaC worked closely with several members of LCC's Revenue and Benefits team during this evaluation including Bernie Davies, Peter O'Brien, and Sue King who supported the research by providing access to the council's routinely collected data and assisting with the wellbeing questionnaire. We are very grateful for their support. Vicky Powers from Derbyshire County Council supported the development of the LCSS logic model and timeline of policy changes as part of her NIHR funded Pre-doctoral Local Authority Fellowship (PLAF). Lastly, we wish to thank the clients and stakeholder organisations who gave their time to support this evaluation.

6) References

1. Akanni L, Lenhart O, Morton A. Conflicting economic policies and mental health: Evidence from the UK national living wage and benefits freeze. *J Policy Anal Manage*. 2024;43(4):1185-1208. doi:10.1002/pam.22592

2. Aregawi G, Roberta P, Konstantinos D, et al. The impacts of Liverpool Citizen's Advice on Prescription (CAP) on mental health outcomes– an Instrumental Variable (IV) approach. *SSM - Popul Health*. 2025;30:101785. doi:10.1016/j.ssmph.2025.101785

3. NHS Digital's Data Services for Commissioners Regional Office (DSCRO). Accessed June 30, 2025. https://digital.nhs.uk/services/data-services-for-commissioners/data-services-for-commissioners-regional-offices

4. Surveys using our four personal well-being questions - Office for National Statistics. Accessed April 22, 2025. https://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/methodologies/surveysusingthe4officefornationalstatisticspersonalwellbeingquestions

5. Ahmad F, Jhajj AK, Stewart DE, Burghardt M, Bierman AS. Single item measures of self-rated mental health: a scoping review. *BMC Health Serv Res*. 2014;14(1):398. doi:10.1186/1472-6963-14-398

6. Barr B, Anderson De Cuevas R, Abba K, et al. Evaluating the health impact and cost-effectiveness of Citizens Advice on Prescription, a whole system approach to mitigate poverty over the life course. Published online 2024.

7. Annual Population Survey Results - Office for National Statistics. Accessed June 23, 2025. https://www.ons.gov.uk/visualisations/dvc1262/wellbeingmap/index.html

8. Directorate - Revenues and Benefits Unit. Manchester City Council Welfare Provision Scheme - Policy document effective from April 2024. Published online June 2024.

9. Charlesworth Z, Clegg A, Everett A. Evaluation of Local Welfare Assistance: Final framework and research findings. Published online January 2023. https://policyinpractice.co.uk/wp-content/uploads/2025/03/Evaluation-of-Local-Welfare-Assistance-Policy-in-Practice-January-2023-2.pdf

10. McAteer M, Evans G, Earnshaw M. Developing an Evaluation Proposition for Local Welfare Assistance Schemes in London. Published online July 2021. https://inclusioncentre.co.uk/wp-content/uploads/2021/07/Developing-an-Evaluation-Proposition-for-LWAS-in-London-Final-Report-July-2021-1.pdf

11. Cost Benefit Analysis of Local Welfare Assistance and Furnished Tenancies. Published online November 2024. https://endfurniturepoverty.org/wp-content/uploads/2024/11/EFP-Cost-Benefit-Report-1.pdf

Appendix I

The two-stage least squares regression model was specified as follows:

First stage:

$$LCSS\ award\ pop\ rate_{it} = \alpha_0 + \alpha_1(Social_i * LCSS\ Policy\ Control_t) + \alpha_2 Unemployment\ Rate_i + \alpha_3\ Income\ Score_i *\ time_t + \alpha_4 Remaining\ Policy * Social_i + \tau_t + u_i + \varepsilon_{jt}$$

Second stage:

$$Medical_Var_{it} = \sigma_0 + \sigma_1 LCSS\ \widehat{award\ pop\ rate}_{\ it} + \sigma_2 Unemployment\ Rate_i + \sigma_3\ Income\ Score_i *\ time_t + \sigma_4 Remaining\ Policy * Social_i + \tau_t + u_i + \varepsilon_{jt}$$

In the first stage, we modelled one potentially endogenous policy intensity variable (LCSS award rate per individual) measured as the total value of awards relative to the local population. The instrumental variable was constructed by interacting the LCSS Policy Control indicator with the local proportion of social housing tenants.

The model also included a comprehensive set of controls to account for observable LSOA level differences that may confound the relationship between welfare generosity and mental health-related outcomes. These included the local unemployment rate, serving as a proxy for economic hardship, and interactions between remaining national and local welfare policy indicators, and the local proportion of social tenants. τ_t represents time fixed effects, and u_i represents unit fixed effects. The error term ε_{jt} captures the remaining unexplained variation.

In the second stage, we regressed the mental health-related outcomes (comprising four mental health indicators and the composite index) on the predicted values of the LCSS award rate derived from the first stage. The same set of control variables and fixed effects were included to ensure consistency across both stages of the model.

Appendix II

Table 13: Details of policy changes shown in Figure 2 that have taken place since 2018.

	Description
National policy changes mainly affecting DHPs	
Expanded DHP funding	Since 2016, LCC has added funding to the government allocation for DHPs to help support residents affected by welfare reforms that impact the Housing Benefit they receive. This included DHP funding of £800m for 2016-2021 with a peak of £185m in 2017/18.
Local Housing Allowance cap	This cap limited help for social sector tenants to the level of a private tenant in an equivalent position.
Increase to Benefit Cap	Benefit cap amounts were increased by 10.1%, the same percentage increase as for social security benefits linked to inflation.
Local Housing Allowance rates reset to 30th percentile	In response to the COVID-19 pandemic, Local Housing Allowance was returned to the 30th percentile of local rents. This helped to increase Housing Benefit award levels.
Reduction in social sector rents	A cash reduction of 1% per annum was introduced for 4 years, which applied to Registered Social Landlords. This affected business plans of social landlords and reduced their ability to invest in new schemes.
Social housing rent rise capped at 7% instead of 1%	Social housing rent rises are usually capped by the government at a maximum of Consumer Price Index plus 1%, set in September every year. As a result of rising inflation and the cost-of-living crisis, rents were instead capped at 7%. This affected business plans of social landlords and reduced their ability to invest in new schemes.
National policy changes mainly affecting the LCSS	
Test and Trace Support Payments Scheme	Introduced as there was a legal duty on all those who tested positive for COVID-19, or who were a close contact, to self-isolate. Additional LCSS support was identified to support these citizens.
Covid Winter Support Grant	Introduced to support those most in need with the cost of food, energy (e.g. heating, cooking, lighting), water bills and other essentials. The support provided was Local Welfare Provision and LCSS was one of the mechanisms to use this funding to support citizens in hardship.
Universal Credit £20 per week uplift	In response to the COVID-19 pandemic, the government introduced a temporary £20 per week increase to Universal Credit to provide additional support to low income households.
Household Support Fund	The government introduced the Household Support Fund to assist vulnerable households with essential costs such as food, energy, and water bills. These funds were used to deliver the LCSS.
Cost of Living Payments	These payments were available to citizens on certain benefits. This was a government initiative and during payment cycles of this support being provided demand on LCSS reduced.
Local policy changes to the LCSS	
Increase in maximum LCSS awards in response to COVID-19	The standard LCSS limit of two awards in a 12-month period was increased to four. Additionally, citizens furloughed without pay were given awards over a longer duration to allow them time to claim Universal Credit. Furthermore, award levels for food and fuel were increased.
Policy to control expenditure: return to 2 awards	After the COVID-19 pandemic had eased, the standard LCSS limit of two awards in a 12-month period was reinstated.
Policy to control expenditure: limits on awards for social tenants	To control expenditure following funding cuts, those living in social housing were advised they were no longer eligible for LCSS support and instead were encouraged to seek support from their Registered Social Landlord.