Health Justice Partnership

UCL

Health Justice Partnerships

Funding welfare rights advice services to work in partnership with healthcare

Report of survey findings

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UCL Health of the Public

Authors

Dr Sarah Beardon
Ms Sarah Ahmad
Professor Dame Hazel Genn

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Executive Summary

Introduction

Social welfare advice services help people to understand and act on their legal rights, tackling hardship and poor living and working conditions. Health justice partnerships integrate this support with healthcare to address health inequalities. Funding is a significant challenge for developing and sustaining these partnerships. This survey aimed to understand current funding circumstances in more detail in order to inform future policy actions.

Methods

An online survey was conducted with advice services who are funded to provide advice in partnership with healthcare (delivered within NHS settings or on the basis of NHS referrals). 75 responses were received and analysed.

Findings

The respondents represented diverse partnerships in a range of health settings. Funding for the advice work came largely from the NHS and charities, with some from local authorities and other sources. It covered the salaries of advisors but less often other project costs. The purpose of the funding was linked to a range of initiatives, including care for specific health conditions / patient groups, and poverty or cost of living issues.

Partnerships were most commonly funded for periods of 1-3 years. Some were unfunded and relying on fundraising or reserves to take NHS referrals. A small number had permanent arrangements where funding had been incorporated into core costs of NHS or local authorities. Only 20% said the funding fully covered the needs of the service. Reasons for the shortfall included: funding being insufficient to meet the level of demand for the service, which was often rising; rising costs due to salary inflation; funding not being full cost recovery; and short-term funding impacting on staff recruitment and retention.

Difficulties in gaining and maintaining funding were attributed to various issues, including: an overall limited availability of funds for social welfare advice due to public sector cuts and wider economic issues; funding being allocated in fragmented or unsuitable ways; lack of willingness or commitment to resourcing the partnerships; difficulties communicating the evidence and making the case for funding; and onerous funding processes that were difficult to understand and apply for.

Factors that helped services to leverage funding included: communicating the need and effectiveness of the partnership through good evaluation and reporting; ensuring a high quality of service delivery to build a positive reputation and inspire trust; building positive relationships with funders to gain their continued support; and developing strong working relationships on the ground with professionals who would act as advocates for the continuation of the partnership.

Conclusions

This survey provides the first detailed report on the funding circumstances of health justice partnerships in the UK. The picture is largely one of short-term, unstable and unpredictable arrangements, where funding levels are often insufficient to enable an optimum quality of service provision. Gaining and maintaining funds is a constant and challenging task, and relies on the dedication and commitment of local actors. Funding for the advice sector nationally is fragmented and fragile, but there is a strong case for investment to support health and address health inequalities. The information presented in this report is intended to inform both local and national action to improve the sustainability of health justice partnerships.

Introduction

Health inequalities and the law

Over recent years, there has been a growing interest and focus on health inequalities within the NHS, driven by the rising levels of poverty and deprivation that have impacted on health and widened gaps in life expectancy and other health indicators.[1] These inequalities were brought into stark relief during the Covid-19 pandemic, and remain a significant concern as the current economic and cost-of-living issues impact on local communities[2,3]. Acting to reduce health inequalities is a duty of the new Integrated Care Systems (ICS), providing a mandate for the NHS to take action in local areas[4,5]. However, the health inequalities action plans of ICSs are often vague, and focused on medical views of health rather than the underlying social and structural determinants[6,7].

In public health discourse, there is little awareness of the role that the law plays in shaping the circumstances of people's lives, including living and working conditions that are fundamental to good health and reducing health inequalities. Civil law specifies the rights, entitlements and obligations of individuals, companies and the state, covering diverse issues relating to personal and family life, working life, business, health and welfare. Rights that are particularly pertinent to poverty and inequality are those relating to social welfare; these rights exist to protect people from hardship and set out minimum standards and conditions for a decent quality of life. Welfare rights relate to: welfare benefits, debt, housing, employment, education, community care and immigration.

Taking action to secure these legal rights on behalf of individuals can address social and economic determinants of poor health, which are underlying causes of health inequalities[8]. For example, the law can be used to ensure people have a minimum level of income, that debts are managed and collected fairly and sustainably, that homelessness or poor housing conditions are rectified, that employment can be maintained, and that education, social care and other critical public services can be accessed. These are some of the most fundamental considerations for supporting life-long health and preventing avoidable illness[9].

Living with a health condition can create legal needs. For example, people may need help with benefits eligibility or debt issues due to loss of income and increased daily living costs, or need support with employment rights due to reduced work capability. When rights are not understood or acted upon, this contributes to creating and maintaining the poor conditions associated with poverty and destitution[10]. There are a number of reasons why people may miss out on the support or services they are legally entitled to.

This can include lack of knowledge or awareness about rights, feeling reluctant to seek help due to anxiety or shame, not knowing how or where to seek help, or not being able to access existing advice services (for example, due to lack of capacity in the services or lack of individual resources such as time, money or internet access)[11].

Free legal advice services are delivered in a range of healthcare settings to improve access for patients at a time of need. These services typically provide assistance with social welfare law issues, helping people who may be struggling with low income and debt, obtaining appropriate housing or avoiding eviction, and supporting people facing problems in their employment, among others. A range of suppliers provide free social welfare legal advice for patients. These include local authority welfare rights units, law centres and other specialist legal advice agencies, and a wide range of local charities such as Citizens Advice.

The assistance can include:

- advice on legal rights
- help with practical steps, such as form filling and writing letters
- advocacy and negotiation
- representation at courts or tribunal hearings

About health justice partnerships

Health justice partnerships are partnerships between health services and legal services that provide free social welfare legal advice for patients. They exist in many healthcare settings, including primary care, hospitals, mental health services, hospices, and a variety of community-based care. Commonly, they involve advice services being provided physically within healthcare settings. Referral mechanisms allow direct referrals to the advice team, or advice appointments are booked by healthcare receptionists. In some places the advisors are integrated into multi-disciplinary care teams, allowing close working relationships and collaboration between the professionals involved[12].

There is a strong rationale behind integrating legal advice with healthcare services, which is backed up by international research in this area:

- Legal assistance is provided at a time when it is likely to be needed (e.g. due to new and ongoing health issues), and in a location that is accessible and trusted. Healthcare professionals are in a position to identify welfare issues and to respond by connecting people with the advice services. This improves access to advice for people that would not otherwise seek help, and facilitates early identification and resolution of legal problems.
- The advice services work to resolve social welfare legal issues, which significantly impact on mental and physical health especially among more deprived and disadvantaged groups. Resolving these problems has a positive effect on mental health, reducing stress and anxiety and improving ability to self-care. It also improves living and working conditions, with potential to support recovery from illness and improve physical health in the longer term.
- The advice services are a valuable resource for healthcare services. In-house advisors can help healthcare professionals to understand and respond to social issues that are beyond their professional remit, which can reduce the time spent trying to support patients with welfare issues and allow them to focus on providing care. Advice interventions can resolve issues that are preventing patients engaging with their care, and have potential to support efficient hospital discharge by ensuring the necessary housing and income is in place.[13]

While examples of health justice partnerships in England can be traced back to the mid-1980's1[4], there has never been national policy or funding dedicated to this field. Current health policies encourage integrated working between the NHS and the voluntary and community sector in order to address social determinants of health and health inequalities[15],[16].However, to date there has been little recognition of the legal advice sector's importance as an intervention against hardship and a critical service for people most impacted by health inequality. For example, it is rarely featured within the discourse around social prescribing or highlighted within healthcare guidance on issues relating to poverty and inequality.

Sustainability of health justice partnerships

Funding for health justice partnerships can come from a variety of sources, including charities, local authorities and the NHS[17]. However, the funding streams are often short-term and unreliable, affecting the stability and longevity of the partnerships. Failure to secure ongoing funding is a common reason for these partnerships to close[18].

An important backdrop to the sustainability issues is the funding situation for the not-for-profit legal advice sector as a whole. Public sector cuts since 2009/10 have affected council budgets and resulted in the loss of in-house welfare rights advice services[19]. These cuts are anticipated to be greater than ever before in 2023/24. At the same time, cuts to legal aid have removed most areas of social welfare law from the scope of government funding[20]. These changes have resulted in widespread closure and downscaling of services able to provide specialist advice on welfare rights, impacting on specialist advice charities as well as law centres and law firms. Without a national mechanism to fund and deliver advice services locally, large areas are now without coverage[21] and the capacity to develop health justice partnerships is severely reduced.

In the absence of national policy or funding, developing health justice partnerships is entirely dependent on motivated and concerned individuals working at a local level. It is critical to ensure health justice partnerships can be resourced on a wider scale and in the longer-term, to support individuals and communities most affected by health inequalities.

Aims of the survey

This survey aimed to gather information about the current funding situation for health justice partnerships. This is a key issue to consider for future development in the field, given it is one of the most significant challenges affecting the development and sustainability of the partnerships.

Our aims in undertaking the survey were:

- To identify in more detail how the partnerships are funded, including the source(s), duration, goals, sufficiency and stability of funds.
- To explore advice services' experiences of being funded to work in partnership with healthcare, including any issues that significantly help or hinder their ability to work in partnership with health services.
- To identify issues where it may be possible to advocate or intervene in order to drive more sustainable resourcing for the partnerships.

The information is intended to support the work of organisations who are involved in the policy and practice of health justice partnerships across the UK.

Overview of methods

A short online survey was developed to cover key topics related to funding. Questions were developed with input from the research team and feedback from stakeholders. The questions included both multiple-choice and free-text answer formats.

The survey was distributed to existing contacts, including current health justice partnerships and advice service practitioners. It was also circulated more widely through advice sector newsletters and mailing lists to identify services that were not currently known to the research team.

The data were cleaned and analysed using descriptive statistics for the quantitative data and thematic analysis for the qualitative data.

A full description of the methods is provided in the appendix.

Findings

About the participating services

There were 75 responses in the cleaned dataset, which were analysed to produce the findings of this report.

Legal advice services provided

The most common legal issue that services provided advice on was welfare benefits, with nearly all the partnerships addressing this issue (n=72, 96%) (Figure 1). This was followed by housing and debt (n=38, 51%), employment (n=30, 40%), community care (n=22, 29%), immigration (n=21, 28%) and education (n=13, 17%). Under 'Other' legal issues, respondents reported providing advice on family law and relationships, disability law, consumer rights, maternity rights, wills and probate.

The majority of services (n=47, 63%) provided advice on more than one legal issue, with a small number reporting many or all of the areas specified in Figure 1. The remaining services (n=28, 37%) specialised in a single legal issue, predominantly welfare benefits.

Where the partnerships were situated

The most common healthcare settings for the partnerships in this survey was hospitals (n=42, 56%), followed by GP practices (n=27, 36%) and mental health services (n=23, 31%) (Figure 2). Some connected with social prescribing systems (n=18, 24%), which involve healthcare-based link workers navigating people to a range of different kinds of support services in the community[22]. Smaller numbers were based in hospices (n=10, 13) and maternity services (n=3, 4%). Advice services working in 'Other' healthcare settings (n=19, 25%) reported links with cancer centres, TB outreach services, home treatment teams, substance use services and adult social care. Some of the partnerships focused on specific health conditions or patient groups, commonly cancer, but also mental health and other long-term health conditions.

Just under half of the partnerships were connected with a single healthcare setting (n=34, 45%). For those working across different settings, there were some apparent clusters: it was common for the service to reach across primary care settings (e.g. GP surgeries and social prescribing systems) or between more specialist care settings (e.g. hospitals, mental health services and hospices).

> "We have an ad hoc arrangement with a local GP service to provide advice to their patients on request. We also have an informal partnership with the local Social Prescribers and undertake joint work and soft referrals."

Some of the advice work was undertaken in other settings, in addition to the healthcare outreach or where the partnership was based on referral pathways rather than physical co-location. Respondents described providing advice through home visiting, remotely via telephone, and in local advice offices or community settings such as libraries and community centres.

Figure 1: Which area(s) of law does the service provide advice on? (tick all that apply) (Respondents=75)

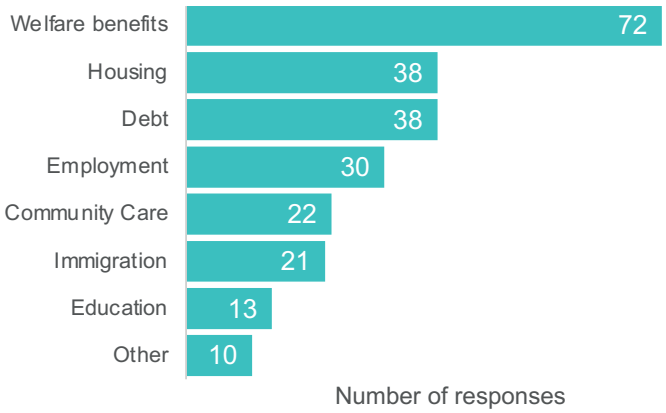
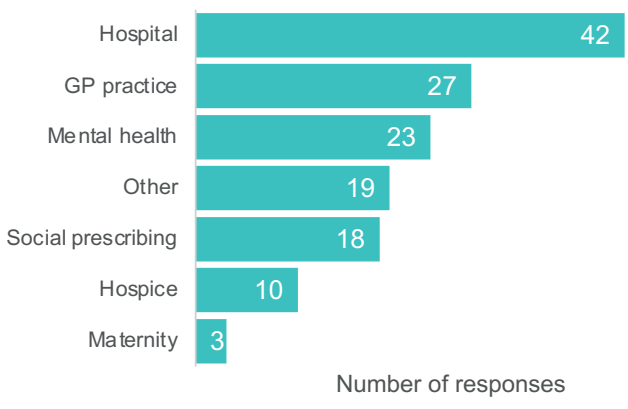


Figure 2: Which health or care setting(s) is the project based within/connected with? (tick all that apply) (Respondents=75)



Duration of the partnerships

This survey had a strong representation from partnerships that had existed over relatively long periods of time: just over four in ten respondents (n=32, 43%) said their service had been running continuously for more than 10 years, and nearly a quarter (n=18, 24%) said it had been running for 5-10 years (Figure 3).

Despite the relatively long duration of projects in this survey, it was clear that funding instability was nevertheless an issue, and more than half of respondents reported that the funding stream for the project had changed during the project's lifespan (n=41, 55%) (Figure 4). These changes included switching between different funding providers, as opportunities came and went or as priorities changed. Projects had come and gone over the years in response to the short-term and fragmented nature of funding. The need to continually prepare funding bids placed a significant time burden on advice service staff. Some services had experienced funding cuts, resulting in projects coming to an end or having to make up for costs through additional fundraising and use of core funds. A smaller number had received additional funding to account for inflation or recruitment of advisors due to high demand in recent years.

"Funding is always an issue and whilst we have had periods of continuous funding from the Big Lottery, we have always had to seek top up funding and are about to face a period where all of our funding runs out."

"The services that have ended were all effective and impactful but depended on small pots of NHS or charitable funding which ended."

Figure 3: How many years has the project been running continuously? (Respondents=74)

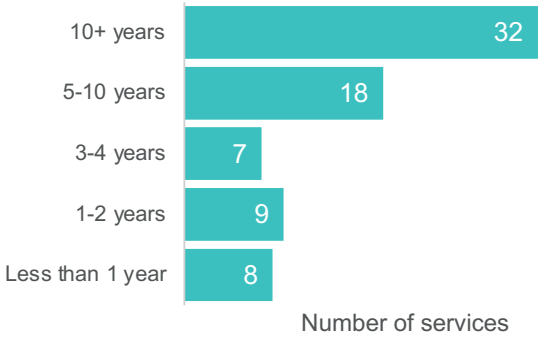
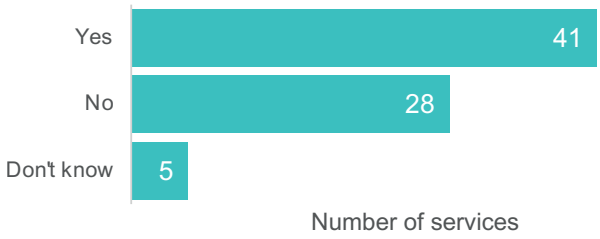


Figure 4: Has the funding stream for the project changed during that time? (Respondents=74)



Funding arrangements

Where funding came from

The most common source of funding for the partnerships in this survey was NHS (n=42, 58%), followed by charity (n=35, 48%) and local authority (n=18, 25%) (Figure 5). NHS sources included hospitals, local NHS, Additional Roles Reimbursement Scheme, or integrated care funding. Charity sources were diverse, including large national charities, NHS charities, private donations and fundraising activities. Local authority funding included public health grants. A small number of services reported 'Other' sources of funding, which included grant-giving organisations like trusts, foundations or societies, government departments, or no funding at all: several of the advice organisations were not funded for their health projects but were drawing on their own core funds or reserves to enable this work. Two services reported having private funds, from a law firm and the Lloyds bank charitable foundation.

"All funding has been through charitable foundations… [the service] is using a small amount of its own funds to maintain the service."

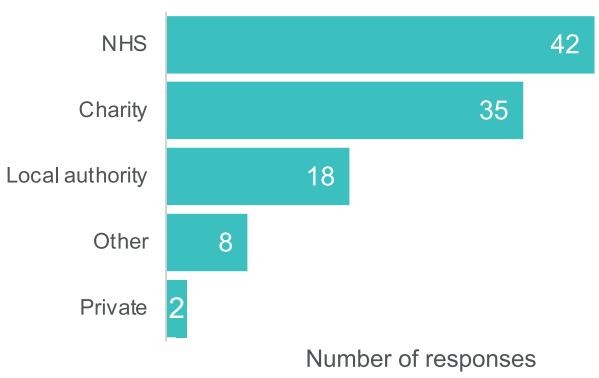
"[We do] not currently receive any ongoing grant, government or NHS funding, we provide advice services to those referred from NHS for free, currently from core funding"

The majority of services currently had a single source of funding for their partnership (n=47, 64%). Some had two funding sources (n=21, 29%), and a small number had three or four different sources. Services were using funding from different sources to cover different costs / activities, work in different health settings, or to expand their operations into different geographical regions.

"Although the NHS funds 1 full time post, the local authority supports this by providing a 2nd worker and management / supervision of the service"

"Funding is split for our debt and benefits work, by borough: one source is [the council], the other grant fund is intended to cover everywhere else where our clients reside"

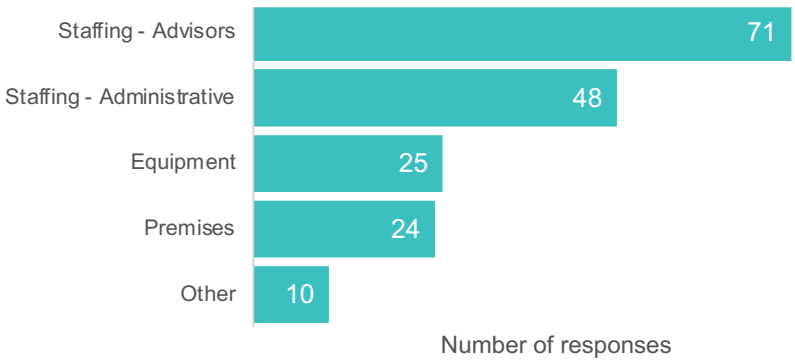
Figure 5: What is the source of funding for your project? (tick all that apply) (Respondents=73)



What was being funded

The funding most commonly paid for the salaries of advisors (n=71, 99%) and administrative staff to support the partnership operations (n=48, 67%) (Figure 6). Fewer projects had funding to cover equipment (n=25, 35%) and premises, for example rent and utilities (n=24, 33%). A small number of services had funding for 'Other' expenses, which included travel costs, phone bills, translation services, volunteer supervision, staff training, service evaluation, and other overheads. Non-financial support, such as rent-free office premises in NHS settings, was also mentioned here as an additional form of resource that services were provided with.

Figure 6: What does the funding pay for in the project? (tick all that apply) (Respondents=72)



Purpose of funding

Funding for the partnerships was most commonly linked with care for particular health conditions or patient groups (n=36, 49%) (Figure 7). This commonly included cancer or mental health, but also conditions such as heart disease, lung conditions, HIV, end-of-life care, long covid, motor neurone disease, renal disease, cystic fibrosis, sickle cell, major trauma and substance misuse. Some services focussed on particular cohorts including children, people with disabilities, carers, ethnic minorities, people experiencing domestic abuse, and those living in deep poverty or homelessness. Poverty or cost of living (n=32, 44%) and health inequalities (n=26, 36%) followed this as common initiatives that funding was linked with, demonstrating the pertinence of these partnerships in reducing financial hardship and poor living conditions.

Some partnerships were funded as part of the broader aim of integrating care and support locally (n=13, 18%). The partnerships existed to address significant socio-economic challenges, as part of integrated approaches to supporting health and tackling health inequalities.

> "The Women's Health and Maternity Programme had evidence of the detrimental impact that financial concerns and social factors had on mental health during the perinatal period for women and families in the local community."

> "The funding is for Social Prescribing but in the context of better integrated care and to assist with addressing health inequalities."

Reducing pressure on healthcare services was another purpose for funding these partnerships. Through addressing welfare issues, the services aimed to speed up the hospital discharge process and reduce readmissions to hospital. Additionally, they aimed to minimise the time clinical staff spent on social problems that they were not equipped to deal with, allowing them to use their time better to address the health problems.

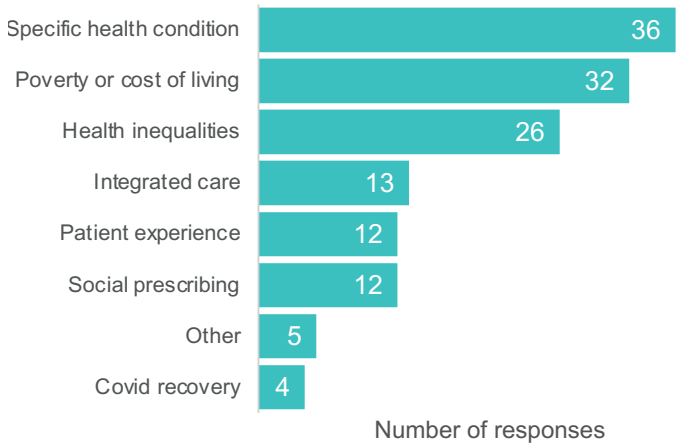
> "They invited us to apply to try and tackle earlier help on rights in health setting to try and reduce clinical time spent on problems."

One of the difficulties of funding being linked with particular initiatives was the often short-term nature of those initiatives; for example, funds linked with Covid recovery, emergency cost of living responses, or short-term health inequalities projects. The funding allowed partnerships to be initiated, but there was uncertainty about the future of the arrangement at the end of the funding term, and sometimes partnerships were discontinued at this point due to lack of ongoing funds.

> "The initial funding, until the end of 2023 came from Covid recovery funds. We are hoping to continue and expand this funding beyond 2023 through other sources."

> "In the longer term, we need to make it sustainable as a service by increasing the amount the charity is getting in to 'unrestricted income' (rather than given to a specific 'special purpose funds')."

Figure 7: Is the funding linked with any specific initiatives? (tick all that apply) (Respondents=73)

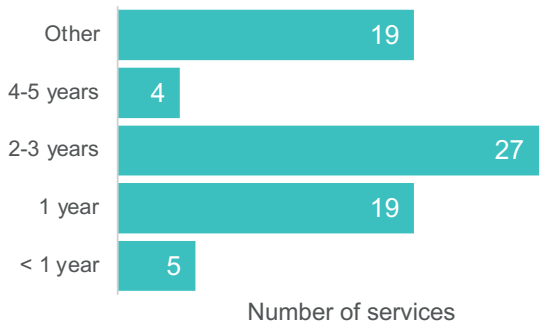


Funding stability

Length of funding

The most common time period for the partnerships' current funding was 2-3 years (n=27, 38%), followed by one year (n=19, 26%) (Figure 8). A small number of projects were funded for a term of less than one year (n=5, 7%), or for the longer period of 4-5 years (n=4, 6%). Under 'Other', some respondents reported variable short-term funding arrangements, continuous fundraising to seek ad-hoc donations, or no funding at all for the project. Others reported having rolling or continuous funding; in these cases, the money mostly came from core NHS funds and were for services within acute care or mental health settings. Some also received ongoing / permanent funding from the local authority, and one from a hospice where the service was based. Permanent funding was always from local public services rather than charitable and other non-profit sources.

Figure 8: What time period is the project currently funded over? (Respondents=72)



Funding shortfalls

One in five of the respondents reported that the funding was fully meeting the needs of their service (n=15, 20%), with the remainder reporting that funding met their needs mostly (n=35, 47%), partially (n=16, 22%) or not at all (n=8, 11%) (Figure 9).

The most strongly recurring theme for funding shortfalls was insufficient service capacity to meet patient demand. Funding had not kept pace with demand and there were not enough advisors to take on the referrals coming through. A contributing factor was rising costs for the services due to inflation and cost-of-living pressures in the last year, which had driven an increase in staff salaries and overheads. Consequently, many of the services had had to reduce the number of advisors on the payroll, and were not able to undertake the volume or quality of work they would have liked to meet the expectations of both funders and clients.

> "As the cases become more complex and the breakdowns in finances become more severe, we do not have enough funding to recruit the amount of experienced welfare staff to ensure we are getting to all patients in time"

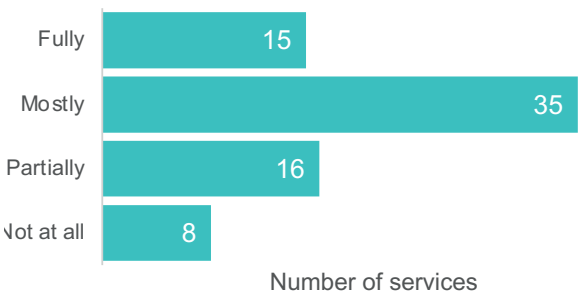
> "Staff have had pay rises, due to cost of living, that have exceeded what was anticipated. At the same time demand from patients has risen by over 50% in the last year."

Respondents commented that project funding was often not full cost recovery, with no resources for core costs like administration and management, or other overheads such as rent, utility bills, working spaces, equipment, evaluation or promotion and engagement work. The short-term nature of funding also meant the future of projects was often uncertain and decided last-minute, making it very difficult to plan, recruit and retain members of staff. It was recognised that this was not necessarily in the control of funders, who themselves may not know their budgets over the longer-term from central government.

> "It pays salary for the advisor and some supervision. It does not cover broader costs (HR, relationship management), nor core costs such as rent or utilities."

> "We do not have the clarity of funding for more than a year which makes it very difficult to plan and recruit for new members of staff."

Figure 9: To what extent is the funding meeting the needs of your service? (Respondents =74)



Predictability of future funding

Around half of the services expected that the funding for their projects would probably be renewed (n=36, 51%) and a quarter were not sure if it would be renewed (n=18, 25%) (Figure 10). Smaller numbers were confident it would definitely be renewed (n=10, 14%); these were largely projects with ongoing / permanent funding arrangements. About one in ten thought the funding would probably not or definitely not be renewed (n=7, 10%).

There were various factors that respondents thought might have a positive influence on the renewal of funding. Maintaining the goodwill of funders towards the project was felt to be very important in order for the funding to be continued. In light of this, services were making efforts to cultivate positive relationships and to maintain a good reputation. Receiving accreditations such as the Advice Quality Standard helped to demonstrate the high quality of their work. Respondents also emphasised the need to communicate the successful outcomes of the service to demonstrate its value to the funders. Services were undertaking regular reporting and evaluations to show they were meeting their targets and achieving positive impacts. Being able to demonstrate financial return on investment was felt to be both particularly important and particularly challenging.

> "As is usual with projects such as this, the future will depend on the deliverables being achieved."

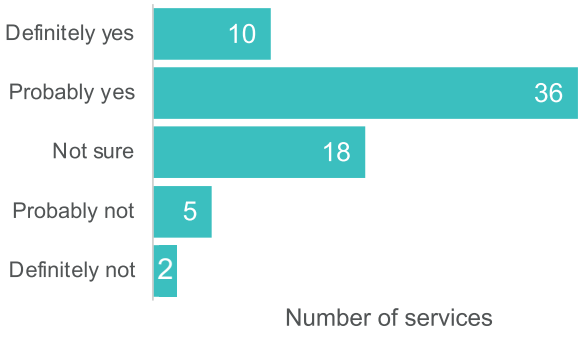
> "We will go through an application process, and the continuation will rely on that and the success of the service in the meantime, but we have a long-standing relationship with [the charity] and it's a service they're keen to continue."

Various factors contributed to respondents feeling unsure or unconfident about the renewal of their funding. Prominently this included the unstable nature of most funding, which was short-term and linked with specific initiatives that may end in the near future, or for pilots and one-off projects. Being able to continue with the service in these circumstances depended on what grants might be available at the time of renewal. The intense pressure on public budgets was also of significant concern. Funding shortages in local authorities had led to advice teams being shrunk over time, and the need to save money in the NHS was leading to additional scrutiny and cuts especially to non-clinical services. Therefore, much depended on the priorities of the funders and whether they remained positive about the importance of the service. Some respondents were unsure about the future due to poor communication from funders and being unclear about their plans and wishes going forward.

> "As the money was largely related to one-off Covid recovery, it is unclear if Public Heath budgets will be able to make similar grants again."

> "Due to financial strains on NHS our funding will be looked at in detail as required. As with all funding and especially in the NHS, the finance team are always looking to reduce the budget and non-clinical services are always the ones that are most at risk. We constantly need to prove our value."

Figure 10: Do you expect the funding to be renewed at the end of its term by the current funder(s)? (Respondents =71)



Evaluation activities

The majority of services were undertaking evaluation to provide information for project funders (n=62, 86%) (Figure 11).

The evaluations commonly combined a range of information, including service activities and outcomes, captured in both quantitative and qualitative formats (Figure 12). Where respondents commented on their methods, this included using routine data such as demographic information and activity records, gathering feedback from clients and healthcare professionals, running surveys of health or client experience, and using client case studies.

Evaluation requirements were sometimes set by the funders themselves. The most common targets / performance indicators related to the funding were the numbers of clients helped, and the resolution of welfare issues (most commonly, the amount of income generated for clients). Financial gains for individuals were often reported to total into the millions of pounds annually for the service, through benefits gained and debts reduced. This was significantly more than the cost of delivering the advice. Some services also had targets for the level of advice intervention provided (e.g. from information and first-line advice through to intensive casework).

> "Standardised reports for [our funder] are provided every quarter, mostly quantitative data on patient numbers and financial outcomes."

A range of other topics were being explored in the evaluations. This included client experience and satisfaction, such as ease of accessing the service, and whether the support had helped them to better manage their situations. Impacts for the clients' health and wellbeing were of significant interest, and some services were using health questionnaires to track these improvements over time. A small number of services were also making efforts to evidence the benefits for healthcare providers and other partner organisations, for example through exploring return on investment and potential financial savings. Some were evaluating the implementation of the service, exploring issues such as unmet needs in the community and whether outreach was working to connect with those most in need.

> "We have already established that the service increases the income of residents by more than the cost of delivery, and are now focused on determining the outcomes for health and creditor partners."

Respondents commented on some of the challenges around conducting these evaluations. Some services highlighted difficulties with collecting data due to a lack of administrative resources to routinely follow up with clients and determine the outcomes of the intervention. Issues around data sharing between partner organisations made it difficult to access the necessary information to look at wider impacts.

> "I would like to have improved evaluation around health outcomes/impact on the hospital – although it is very hard to get, as we do not run on the same hospital systems."

Figure 11: Are you evaluating the service to provide information for project funders? (Respondents =72)

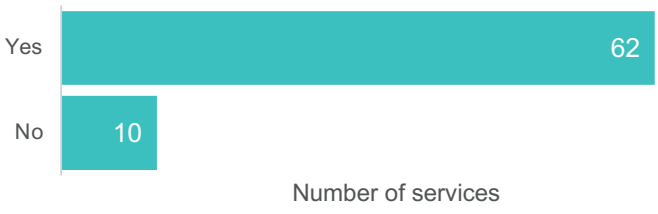
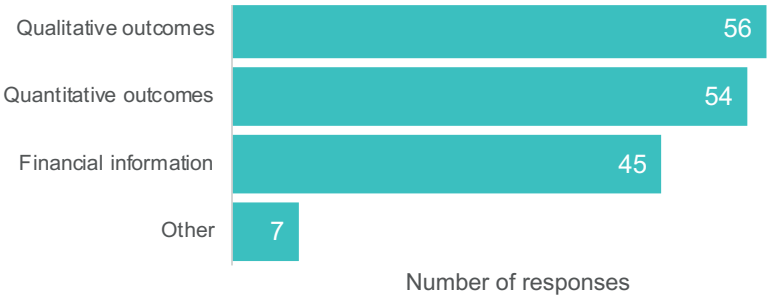


Figure 12: What kind of information are you using for this evaluation? (tick all that apply) (Respondents =62)



Challenges gaining and maintaining funding

The most common difficulties experienced in relation to funding for the partnerships were that it was insufficient to deliver an optimum service (n=43, 64%) and that the funding streams were unstable and short-term (n=36, 54%) (Figure 13). This reflects the findings presented above, relating to the stability and adequacy of funding. Other issues that were relatively common included having to compete for funding with other advice organisations (n=27, 40%), being able to communicate the relevance of the work to different funders' priorities (n=26, 39%) and knowing which funders to approach for project funding (n=25, 37%). Nearly a third of respondents reported difficulties in providing the evidence of impact that funders requested or expected (n=21, 31%). Under 'Other', respondents reported difficulties with confusing or onerous funding / commissioning processes. These topics are explored further in the discussion below.

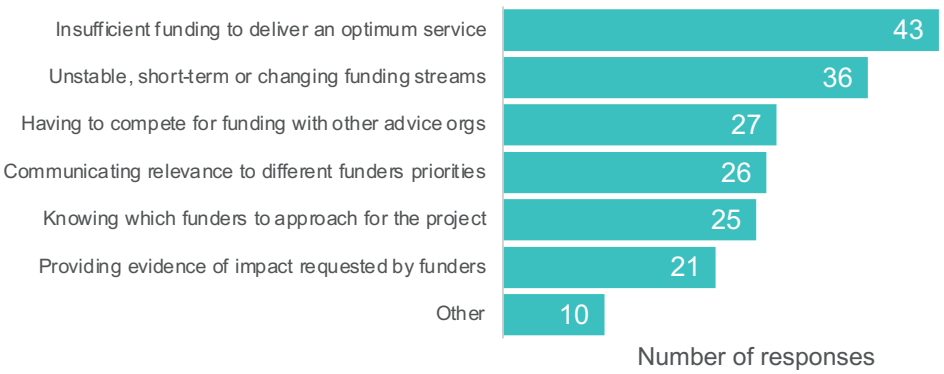
Limited availability of funds

As highlighted in Figure 13, many respondents experienced difficulties with funding being short-term and unstable, and being insufficient to cover costs or meet the level of demand for the advice service. This made it very difficult to recruit and retain staff, and to provide a continuous, sustainable and high-quality service. The funding shortages were related to wider economic issues, with funders themselves losing revenue to invest in services: the NHS and local councils have faced increasing pressure on their budgets, and charities have suffered large reductions in income during the pandemic. This has led to an increasingly competitive funding environment, with providers having to compete for a diminishing total pool of funds. Respondents reported that previous funding streams had become unavailable to them, and that efforts to bid for alternative sources had often been unsuccessful. The pressure was compounded by recent inflation leading to rising costs and the need for more money to sustain the services. Overall, this limited availability of funds led many respondents to feel uncertain about the short- and medium-term futures of their services.

> "Working with credible partners in the legal advice field has been beneficial. But all partners are struggling to access funding - and are in effect, fishing in the same pond for ever diminishing funds."

> "The initial funding was annual and very unstable, especially during the pandemic when many charities suffered large reductions in income. This has now been partially rectified by a 3 year deal but that brought its own problems when costs rose more than anticipated."

Figure 13: Have you experienced difficulties with any of the following? (tick all that apply) (N=67)



Limited scope of funds

Respondents reported some difficulties with funding being fragmented and unavailable to be spent where it was needed. One prominent concern was with the way that social prescribing was resourced, with the funding going towards creating referral and navigation systems rather than towards the voluntary and community sector organisations that were delivering the necessary interventions. **Advice organisations had experienced large increases in workload due to NHS social prescribing referrals, without receiving any funding to do the work for clients. Financial concerns were among the most common needs identified through social prescribing, but the advice organisations were having to find their own funds to manage this rising demand. Some respondents were therefore questioning their ability to continue engaging with the NHS.** Other issues included that funding was geographically limited, meaning the advice services could not operate over the necessary regions (such as whole hospital Trusts), and that it was not available for the more specialist advice work that was often needed to effectively resolve welfare issues.

"So much ££ has gone to social prescribing when a lot of clients are referred to us for advice. Advice was specifically excluded from receiving extra ££ as part of the set up in Leeds."

"The funding is mostly providing a basic Tier 2 advice service with some staff training to help build knowledge and capacity of hospital teams. While this is welcome, the real value of the work is taking on cases to help support and resolve the most complex immigration or housing issues."

Limited willingness to fund

Respondents described difficulties in getting commitment from funders to support the project, particularly over longer timescales. **There was a strong theme that health funders did not want to fund advice because it was not a medical service. In some cases, this was due to limited recognition of the role of welfare advice in supporting patient's health, wellbeing and recovery**. Other respondents had found the NHS was very keen to make referrals as part of their work on poverty and health inequalities, but did not want to be responsible for funding the work involved. Advice services were often seen as a free resource to draw on, and as a sector that could support itself through local council funding or the free work of volunteers; the pressure on the sector, and the need for financial support to provide the necessary capacity for healthcare referrals, was sometimes not appreciated.

"Whilst the NHS acknowledges the link between poverty and ill health, it does not acknowledge the need for the voluntary sector to be funded by health services to take on the additional work… They seem to think that, as we provide advice anyway, they do not need to fund additional work."

Difficulties making the case for funding

Services needed to make the case for investment to potential funders, by communicating the need for welfare rights advice and the benefits of developing a partnership. Some commissioners wanted to see the evidence before investing, but it could take some time to build this up: welfare issues can be complex and lengthy to resolve, and getting client outcomes confirmed consistently is also challenging. Respondents noted difficulties in providing the type of evidence that was wanted by funders, especially on topics such as health gains or financial savings for the NHS where the evidence was technically challenging to produce. Shortage of resources such as administrative staff time, access to data, and expertise for data collection and analysis, also made it difficult to obtain adequate information.

> "Difficulty of evidencing reduction in health service spending on patient as a result of advice intervention."

> "The focus on hard data, providing social value and more over enthusiastic monitoring with the provision of target figures and use of particular tools means that much of the funding is spent on providing management time for those objectives rather than providing the service itself."

Onerous funding processes

Respondents had found the processes of applying for funding confusing and difficult. One particular challenge was understanding and navigating local NHS organisations, which were large and complex. It was not clear what funding was available, particularly with frequent changes in strategy and structure, and respondents highlighted the difficulties in knowing who to contact and how to get through to local decision makers.

Some funding applications were extremely demanding in their length and complexity, placing a significant burden on the applicants to fill out. Smaller advice organisations were particularly disadvantaged by this, having less time and managerial capacity. Funding calls were sometimes unclear in their goals, or the priorities shifted over time. Respondents had also experienced frustrations such as having bids cancelled due to NHS restructures, and never hearing back about applications they had been told they would be awarded.

Some advice organisations who were in receipt of NHS funding experienced difficulties with the internal processes, for example lack of formal contracts, bureaucratic payment systems, late payments and last-minute decisions about renewal. Respondents commented that they did not know who to contact internally about their funding and had difficulties getting through to anyone, with no clear administrator or point of contact for the project.

> "Early on, we approached different commissioners about our HJP work, but it can be challenging identifying the right people to speak to within the health system."

> "Getting paid has been very difficult due to our lack of understanding of the processes, lack of communication and slowness of [the Foundation Trust]"

> "We have had a very negative experience locally with a chaotic bid around mental health service funding - the goal posts got moved and the NHS didn't seem to know what it wanted but asked for a huge amount of work from us. We are now very wary of applying for any health funding."

Factors that helped to leverage funding for the projects

Communicating need and effectiveness

Good communication and reporting were crucial for the successful renewal of funding, by providing evidence to support the funder's decision making. Respondents were presenting the case for their work by showing the high level of need for advice among the patient group, and the large and growing level of demand for the service. They described how their advice services could help support clients in difficulty and reduce the pressure on healthcare staff and services. It was particularly important to communicate the positive outcomes and impacts of the service to demonstrate its success in addressing funders' priorities. This included reporting on any key targets to show the service was performing well. Services were also drawing on wider evaluation activities to demonstrate positive impacts for clients and for the health service (see 'Evaluation activities' above for further details). Drawing on the data and telling a powerful story about the impacts of the service was important for generating commitment from funders.

"Our ability to show how many of our clients have mental health conditions, the correlation between that and advice, and the positive effect of our advice on the mental health of clients captured as part of our client feedback."

"Regular audits and record keeping (including STATS) to help provide the overall benefit of this service for our patients in a hospital setting. The difference it makes to our service users takes the strain from clinical staff and prevents bed blocking."

Building service quality and reputation

Developing a positive reputation locally was important to inspire trust in the service, and therefore support for its continuation. Advice services had benefitted from developing a high profile locally, becoming well recognised as experienced providers who understood local issues and were known for achieving good results. They took care to develop the quality of the service as much as possible, ensuring the advice was responsive to local needs, and that service delivery was continuously improved and adapted over time. Engaging well and working closely with partner organisations was also important so that it remained a well-used and valued service.

"A strong well-made case focusing on local priorities and needs. The team provides a service that is holistic and well-integrated into local NHS provision, the community and local authority requirements."

We have exceeded our targets for client numbers and as a well-established trusted provider of the service we work collaboratively with [the county council] to constantly look at improvements and issues that may need addressing."

Support and buy-in from funders

Having supportive and committed funders was clearly crucial when it came to funding allocation and renewal: where funders had positive attitudes towards the service, this contributed to favourable funding decisions. Funders were more likely to be positive when they recognised the need and value of the service, including how advice services were important in the context of health. Alignment of priorities seemed to be especially good where the funders were focused on health inequalities and the role of poverty in driving poor health outcomes. Developing and maintaining positive relationships with funders was also very helpful in gaining their continued support for the project.

"We have had great support from the Deputy Locality Director who has worked really hard to sustain funding as he recognises the value of what we deliver to improve the lives of patients."

"An understanding locally about the impact of advice on poverty/hardship and wider determinants of health."

Practitioner champions

Developing good working relationships between services on the ground was found to be helpful in building support and leveraging funding for the project. Healthcare professionals are well placed to recognise welfare needs among patients, and often see the value of the partnerships in supporting treatment and recovery. These professionals can become strong advocates for the partnerships, and will communicate this within management circles because of their enthusiasm to continue making referrals and working together. Cultivating positive relationships between health and advice professionals in day-to-day work is therefore important for an ongoing successful partnership.

"Establishing relationships with key health and social care staff who then advocate for project."

"Our link to the Social Prescribers who refer in, as soon as mention of the service ceasing they do tend to influence their managers and some money is found from somewhere as they see the service as invaluable to refer in their patients."

Discussion

Principal findings

Findings of the report are based on an analysis of 75 responses to the survey. The partnerships represented were diverse, covering a range of healthcare settings and legal advice activities. The majority of services represented in the survey had been running continuously for at least five years, however many still faced significant instability in their funding circumstances.

Funding for the partnerships in this survey came mostly from the NHS and charities, as well as some from local authorities and other sources. Over a third of partnerships (36%) were drawing together funds from more than one source in order to operate. The income mostly paid for the salaries of advisors, with fewer having funding to cover administration and other running costs. Funding for the partnerships was linked to a range of purposes and initiatives: most commonly care for particular patient groups or health conditions, followed by poverty or cost of living and health inequalities issues. The initiatives that funding was tied to were often short-term, contributing to the instability of funding for these partnerships.

Partnerships were most commonly funded over periods of between one and three years. Some relied on continuous fundraising or were doing the work unfunded, drawing on core funds and reserves to enable the partnership work. A small number had rolling or continuous funding, where the work had become incorporated within the core business of the NHS or local authorities. Only 20% of respondents said that funding was fully covering the needs of their services. Reasons for the shortfall included: funding being insufficient to meet the level of demand for the service, which was often rising; rising costs due to salary inflation; funding not being full cost recovery; and short-term funding impacting on staff recruitment and retention.

Difficulties in gaining and maintaining funding were attributed to various issues, including: an overall limited availability of funds for social welfare advice due to public sector cuts and wider economic issues; funding being allocated in fragmented or unsuitable ways; lack of willingness or commitment to resourcing the partnerships; difficulties communicating the evidence and making the case for funding; and onerous funding processes that were difficult to understand and apply for. Factors that helped services to leverage funding included: communicating the need and effectiveness of the partnership through good evaluation and reporting; ensuring a high quality of service delivery to build a positive reputation and inspire trust; building positive relationships with funders to gain their continued support; and developing strong working relationships on the ground with professionals who would act as advocates for the continuation of the partnership.

Strengths and limitations of the study

The survey achieved a good number of responses, with 75 services participating from across the country. However, it is not possible to determine how representative the survey is of health justice partnerships at large given there is no directory of services to compare against. The characteristics of participating services were slightly different from a previous survey we conducted in 2018, which sought to map health justice partnerships across England and Wales[17]. The current survey had a greater number of responses from hospital-based services and fewer from primary care, as well as a greater proportion of NHS-funded partnerships and fewer that were local authority funded. It is unclear if these differences represent changes over time or simply a different pool of respondents who participated. The quantitative findings should therefore be understood as specific to the context of this survey, rather than representative of health justice partnerships in the UK as a whole.

This survey does not capture the experiences of partnerships that have recently come to an end, where funding issues may have been important in their closure. Additionally, it may be skewed towards longer-standing and successful partnerships, given the connections the research team has built and maintained with services over time (42 respondents in the current survey were existing connections going back at least five years). This means the findings may not capture the full extent of the funding difficulties experienced in the field, at least in the quantitative results. However, including free-text questions allowed us to explore both challenges and facilitating factors in a reasonable amount of depth.

The survey was circulated as widely as possible, utilising existing contacts and advice sector newsletters. However, it is unlikely to have reached all the relevant services. Our attempts to re-contact services from the 2018 survey were largely unsuccessful, potentially due to changes of personnel / contact details or closure of the projects in the intervening years. There may also be some unofficial partnerships between advice and health services, who may not have come across the survey or understood its relevance to them.

Finally, respondents were primarily advice service professionals. While this group are predominantly the ones involved in applying for and managing funds for the partnerships, the survey is lacking the perspective of funders themselves (NHS, local authority and charity partners). This may influence the completeness of the results and bias the perspective towards that of funding recipients rather than funding providers.

Implications for policy and practice

Some of the issues identified through this survey relate to wider funding challenges for the not-for-profit legal advice sector; for example, the diminishing pool of funds that can be applied for, both locally and nationally. This is reducing the capacity of services and affecting their ability to meet the level of client need, which continues to grow due to increasing economic hardship. There is a strong case to be made for investment in social welfare legal advice, to prevent avoidable harm to health and reduce downstream spending on crisis services including healthcare[23,24].

The NHS is now required to take action against health inequalities, in partnership with other organisations locally. Social welfare legal advice is one of the few interventions that can directly tackle adverse social and economic circumstances, through improving income, reducing debt, securing better housing and protecting employment, among others. Health justice partnerships should therefore be part of the portfolio of actions against health inequality in every local place.

However, this survey demonstrates significant instability for the partnerships, which struggle to attract and maintain staff due to short-term, low-level and unpredictable funding. The partnerships very often depend on motivated individuals making the case for their existence, rather than on any stable policy or arrangement. Health justice partnerships need to be embedded as part of the healthcare offer and included within longer-term committed funding in order to exist in a more stable way. While some of the partnerships in this survey did have stable arrangements based on core funds of NHS and local authorities, these were rare and largely small-scale. Joint funding arrangements could also be considered, coordinated through the Integrated Care Systems which can enable shared local planning and pooling of resources[25].

Where possible, funding organisations should take steps to reduce the pressure on services and minimise the time and resources needed to make applications. This could include committing to longer funding periods where planning allows, and covering the full costs of running a project rather than just staff salaries. To improve the experience of applicants, the complexity of application processes should be kept to a minimum and communication with applicants should be clear and regular.

A challenging aspect of gaining and maintaining funding for the partnerships was the important task of communicating the need and benefits to potential funders. Helpful tools might include guidance to help with planning and carrying out evaluation work, and communicating the relevance of legal advice in the context of health priorities.

Conclusion

This survey provides the most detailed information to date about the funding of health justice partnerships in the UK. It provides insight into funding arrangements and the current stability of services in the field. It also explores the challenges experienced in gaining and maintaining funds and identifies factors that can facilitate positive funding outcomes. There is action that could be taken both nationally and locally to improve the sustainability of health justice partnerships, and we hope the findings of this report will contribute to discussions around policy and funding solutions.

Appendices

Methods

Questionnaire development

We aimed to develop a short survey that could be completed within 5-10 minutes, in order to maximise participation. As well as collecting some basic descriptors through multiple-choice questions, we included free-text questions in order to gain a more detailed understanding of the issues.

An initial set of questions was drafted to cover the key features of funding arrangements, such as source of funding, time period, what the funding covered, any initiatives it was linked with, and key challenges / enablers of ongoing funding. With input from the wider research team, this was developed further to include other important issues such as changes over time, sufficiency of funding, evaluation activity and future expectations. The draft was circulated to key stakeholders for their feedback, and revised based on their suggestions. The final version was built for online distribution using the Qualtrics platform.

Dissemination of the survey

An invitation email was drafted, containing background information on the survey and a link to the online form. This was sent to:

- Partnerships we had recently been in touch with and knew were in current operation (N=30).
- Other partnerships who had responded to a previous survey in 201817, where contact emails were correct and still active (N=61).
- Practitioners on our newsletter contact list, for distribution to any relevant colleagues (N=22).

We also contacted advice sector network organisations, with a request to include some information in their newsletters or next contact with their members. The organisations who assisted us were:

- Advice Services Alliance
- Age UK
- Citizens Advice
- Law Centres Network
- National Association of Welfare Rights Advisors

The online survey platform stayed open for 36 days during June – July 2023.

Follow-up conversations

A small number of respondents (n=7) were approached to provide more detailed information, as part of a wider consultation on the early experiences of establishing Health Justice Partnerships. Relevant notes from these conversations were included to contribute further insight into current experiences relating to funding.

Data analysis

Data cleaning
The dataset was cleaned before undertaking the analysis. Data cleaning involved:

- Deleting empty responses.
- Deleting incomplete responses, where a participant had answered less than 50% of the questions in the survey.
- Identifying duplicate responses from the same project, and merging the responses where they matched. All the comments were retained when merging answers.
- Checking for errors in the answers, where the comments indicated different information from the multiple choice responses. The data were corrected where errors could be clearly identified.

Quantitative analysis
New variables were created to count and categorise the multiple choice response options. Simple descriptive statistics were used to analyse the quantitative data in the survey: for each question, the frequency of responses to each multiple choice answer were quantified using numbers and percentages. The data were displayed using bar charts.

Qualitative analysis
The free-text answers and meeting notes were analysed to provide further detail on the topics within the survey.

- For brief comments (such where respondents provided short elaborations to their multiple-choice answers), the information was categorised and a written description was provided alongside each chart.

For the longer answers (such as questions relating to respondents' experiences) the information was explored in more detail: the data were coded and organised into themes using qualitative analysis software, and a full description of these themes was reported.

Questionnaire

Funding welfare rights advice in healthcare settings

We are running this short survey to gather information about the funding of advice services that are delivered within NHS settings, or in partnership with NHS services. This includes advice on people's rights relating to: welfare benefits, debt, housing, employment, education, community care and immigration.

We are doing this to better understand funding arrangements and circumstances, as well as explore current challenges and opportunities. The results will be written up as a short report that will be made publicly available and distributed widely. Our aim is that the results will inform our national advocacy and engagement work, as well as informing local funding applications or discussions.

Please note:

- The questionnaire should be completed by someone familiar with the funding arrangements for the advice service
- The questionnaire will take 5-10 minutes to complete
- Responses will be anonymised in the reporting of this survey

*I confirm I have read the information about the survey and I consent to participate

- ◯ Yes, I wish to take part in this survey
- ◯ No, I don't want to take part in the survey

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Funding welfare rights advice in healthcare settings

*Contact information

Contact name

Contact email

Name of service / project

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*Which area(s) of law does the service provide advice on? (tick all that apply)

- [ ] Welfare benefits
- [ ] Debt
- [ ] Housing
- [ ] Employment
- [ ] Immigration
- [ ] Education
- [ ] Community care
- [ ] Other (please specify any other areas of advice)

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*Which health or care setting(s) is the project based within / connected with? (tick all that apply)

- [ ] GP practice
- [ ] Hospital
- [ ] Mental health
- [ ] Maternity
- [ ] Hospice
- [ ] Social prescribing
- [ ] Other

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(Optional) Please briefly describe the partnership between advice and health services:

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How many years has the project been running continuously?

- ◯ Less than 1 year
- ◯ 1-2 years
- ◯ 3-4 years
- ◯ 5-10 years
- ◯ 10+ years

Has the funding stream for the project changed during that time?

- ◯ Yes
- ◯ No
- ◯ Don't know

What is the source of funding for your project? (tick all that apply)

- ☐ NHS
- ☐ Local authority
- ☐ Charity
- ☐ Private
- ☐ Other

(Optional) Please provide further details on the funding source(s) - e.g. the main income stream / any joint funding arrangements:

Is the funding linked with any specific initiatives, for example…? (tick all that apply)

- ☐ Health inequalities
- ☐ Poverty or cost of living
- ☐ Covid recovery
- ☐ Social prescribing
- ☐ Integrated care
- ☐ Patient experience
- ☐ Specific health condition(s) / patient group(s)
- ☐ Other

What does the funding pay for in the project? (tick all that apply)

- [ ] Staffing - welfare rights advisors
- [ ] Staffing - administrative / management support
- [ ] Premises - rent, upkeep, etc.
- [ ] Equipment
- [ ] Other (please specify)

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What time period is the project currently funded over?

- ○ Less than 1 year
- ○ 1 year
- ○ 2-3 years
- ○ 4-5 years
- ○ Other

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Do you expect the funding to be renewed at the end of its term by the current funder(s)?

- ○ Definitely yes
- ○ Probably yes
- ○ Not sure
- ○ Probably not
- ○ Definitely not

(Optional) Please comment if there is anything that renewal may depend on:

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Are you evaluating the service to provide information for project funders?

- ○ Yes
- ○ No

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What kind of information are you collecting for this evaluation? (tick all that apply)

- ☐ Information on service activities (e.g. data from routine record-keeping)
- ☐ Quantitative outcomes (numerical data, e.g. from questionnaires)
- ☐ Qualitative outcomes (descriptive data, e.g. from comments, interviews, case studies)
- ☐ Financial information
- ☐ Other

(Optional) Please comment on any key ambitions or targets related to the funding (e.g. client numbers, health or welfare outcomes, cost-benefit):

To what extent is the funding meeting the needs of your service?

- ○ Fully
- ○ Mostly
- ○ Partially
- ○ Not at all

If not, please comment on why funding is not meeting your needs (e.g. too last minute / not enough / requirement to spend on something specific):

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Have you experienced difficulties with any of the following?

- [ ] Unstable, short-term or changing funding streams
- [ ] Insufficient funding available to deliver an optimum service
- [ ] Knowing which funders to approach for project funding
- [ ] Communicating the relevance of the work to different funders' priorities
- [ ] Providing the evidence of impact that funders request or expect
- [ ] Having to compete for funding with other advice organisations
- [ ] Other

(Optional) From your experience, what has helped to leverage funding for this project?

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(Optional) Please comment on how you see things developing with the service, including any future funding challenges or opportunities:

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(Optional) To share any further information or links to published work, please enter below:

(Optional) To share any relevant documents, please upload here:

Select a file or drag here

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Many thanks for taking the time to complete this questionnaire. We will write to notify you of the results as soon as they are available. In the meantime, please feel free to contact us at health-justice@ucl.ac.uk

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Where can I find more information?

Please visit the UCL website:
www.ucl.ac.uk/health-of-public/health-justice-partnerships

Or contact the UCL research team:
health-justice@ucl.ac.uk