HEALTH JUSTICE PARTNERSHIP

UCL

Health Justice Partnership

The Potential of Health Justice Partnerships in Integrated Care Systems

Summary of event discussions

The Legal Education Foundation

In-person workshop, 15th February 2023

UCL Faculty of Laws

Background

Taking action on poverty and health inequality is ever more important for the NHS, as the current cost of living crisis increases hardship among communities. The consequences for health and wellbeing will be felt most keenly among low income and vulnerable patient groups.

Health justice partnerships are targeted interventions that support patients with social and economic circumstances that are root causes of health inequality. They are partnerships between health services and organisations specialising in welfare rights. Advice on welfare rights issues is integrated with patient care, helping people resolve problems relating to benefits, debt, housing, employment and immigration, among others. This can support those in the hardest circumstances to maximise their health and wellbeing.

This one-day in-person workshop provided an opportunity to learn about health justice partnerships and how they are being implemented across the country in a range of NHS settings. We were joined by speakers engaged in service delivery, policy and research, who provided examples and insights from their work.

Summary of discussions

Plenary session 1: Introducing Health Justice Partnerships

Session Aims: To discuss the links between law and health, highlight the opportunities and impacts of Health Justice Partnerships and communicate their importance within current policy objectives.

Chair: Dr Natalie Byrom, Director of Research, The Legal Education Foundation

Speakers:

1. Professor Dame Hazel Genn, Director, UCL Centre for Access to Justice

Summary:
The covid-19 pandemic highlighted existing patterns of health inequality, followed by economic shocks that have increased poverty and its impacts on health. ICSs have a responsibility to address these issues under the Health and Care Act 2022. Today's event is not about describing the problem of health inequalities, but about presenting an intervention that has a role to play in addressing the social determinants of health. The aim of HJPs is to address health-harming social needs, and ensure that patients get the safety net protections they are entitled to by law. This is about what can we do in practical terms to make a difference, and we don't need to invent something

new: we know HJPs are making a positive impact to health and wellbeing for low income and vulnerable groups.
What does the law have to do with health? It is both a determinant of health, and a remedy for health-harming social conditions. The law provides safety net protections in all of the key social determinants of health, e.g. benefits, housing, employment, community care, immigration, etc. People need to know and be able to access their rights, and having advice and support is critical to this. There is a bi-directional relationship: having a legal problem can cause ill health, but having poor health can also create legal problems. People often raise legal issues with healthcare professionals, who are in a position to be 'critical noticers', identifying legal issues and referring on to appropriate service; HJPs provide a mechanism to do this.
HJPs are collaborations between healthcare and welfare rights advice services. They exist internationally and have existed since the 1990's in the UK. Bringing together these sectors supports and transforms community services to provide more holistic care. There are different service models that involve various approaches to collaboration. These are local initiatives, funding is mostly fragile and short-term. UCL had a HJP in East London for two years, which achieved many important impacts for patients at the medical centre, and there is good evidence for their benefits in the academic literature. Today's event is important for informing the work of Integrated Care Systems, which are currently thinking about their strategies for health inequalities. There is a duty to collaborate with other organisations as part of this, and develop cross-sector partnerships. In the legal service context, there is an interest in early resolution and targeting legal assistance to those in need, including through legal services integrated in health settings.
Where now for HJPs? We need coordinated policy and a focus on delivering services in the best way for the public (rather than thinking in departmental siloes). We need to think about how we fund these partnerships and build the evidence base for their benefits further. Additionally, we need interprofessional education so that people are trained to think about collaboration and how we maximise the benefits of services.

2. Natalie Davis, Head of Legal Support Policy, Ministry of Justice

Summary:
The focus of legal support policy is on civil justice (rather than criminal justice).
There are different stages of the user journey in the legal system. Legal support policy is focussed on the first two stages: pre-dispute (recognising legal issues and seeking information) and earlier intervention (seeking advice and exploring options). Other stages include constructive resolution (mediation/ conciliation) and directive resolution (court or tribunal proceedings). The MOJ expects that upstream investment in the earlier stages of the user journey could prevent costs downstream. There will always be a need for court for some people, however there are other options to resolve issues earlier and this is desirable for most people. The MOJ want to ensure people have the information they need to identify their legal problems, break down barriers to action and understand options for moving forward.

In legal support policy, the MOJ is investing in a number of areas. This includes investing into advice organisations, digital interventions, and ways to improve knowledge, skills and confidence. The legal support action plan (2019) sets out a range of actions to do with early intervention. One of these was to pilot, test and evaluate the provision of holistic legal support hubs. Research is being undertaken with Flourish Health and Wellbeing Hub in the Wirral, which launched in November 2022. This provides a range of services under one roof including legal support, and co-location is likely to be an important feature of its effectiveness. They have also commissioned a wider evaluation of HJPs in primary care settings across England. This began with a feasibility study and the research has kicked off in late 2022. The evaluation includes process, impact and economic aspects.

3. Cedi Frederick, Chair, NHS Kent and Medway Integrated Care Board

Summary:
There are 42 ICSs in the country, and all are different in terms of size, scale and perspective. They were established in July 2022, with 4 challenging objectives. Importantly for HJPs, this includes tackling health inequalities and improving population health outcomes. This is the first time the NHS really sees itself as part of an ecosystem, recognising that it can't solve health problems alone. Now is the time for change: the Act provides a legal mandate to do this and people want to do things differently, but it will take time.
Kent and Medway ICS area: it has a quickly growing population, complex politics, changing demography, large differences in life expectancy and quality of health between areas. The ICS is now working together with communities and many partner organisations, opening up discussions they have not had before. For too long, the NHS has been focussed on short-term challenges which occupy the media (waiting lists, GP access, etc.), but in parallel they need to be thinking about the longer-term challenges and they are committed to this. The NHS is not 'integrated' it is 'inter-dependent': there are many silos within it (finances, structures, governance). Health and social care are very separate systems, but highly inter-dependent. We can work through these by building relationships, which should include joint funding, joint posts and more dialogue to bring teams together. They won't get it perfect, but can make it better.
During Covid, we all came to understand the stark health inequalities among communities of colour. The challenge is real, and hopefully will remain at the forefront of our minds. Where HJPs can play a role: only 20% of health is due to health interventions, the rest is due to other factors such as living and working conditions. Poor housing costs the NHS £1.4bn per year, due to the health consequences. ICSs must engage with this conversation, but it is a challenge. The NHS historically has a difficult relationship with the legal profession. The challenge is in bringing many different partners together, who have not worked together before: a very complex thing to achieve, trust and openness is key. It is important that communities can hold the NHS to account, need to strengthen relationship with communities and HJPs can help us do this. In Kent and Medway they are starting to talk about a Movement called 'Together We Can', giving greater voice to the people that organisations are there to serve and empowering them for their futures.

4. Paul Sweeting, Insight and Performance Partner, Macmillan Cancer Support

Summary:
HJP is not a new area for Macmillan: they have been responding to the financial needs of people living with cancer for nearly 100 years, through emergency grants and other support.
A proportion of people diagnosed with cancer will need help with financial issues. Some can help themselves through information on the Macmillan website or getting advice on their telephone helpline. But some will not seek help promptly, or not at all, and we need to reach them earlier. Macmillan has relationships with local advice organisations who proactively partner with cancer care teams to reach people at the point of diagnosis. These arrangements have grown up organically over time, based on local need and opportunities.
How do we identify where there is this unmet need for advice? One place to start is to look at income deprivation. For Macmillan, also where there is high cancer incidence (where these overlap). They have modelled this, and looked in high risk areas to see whether more people are using their advice services. (can't get customer-level data from local advice organisations, but can look at how many people are accessing Macmillan grants). Identified that in some areas, people may be missing out. Don't want a one-size-fits-all approach to developing services.
'Improving the Cancer Journey' programme in Glasgow is a support service that integrates social welfare advice, because that is what many people living with cancer need. It is being rolled out nationally across Scotland. As soon as people are diagnosed, they get an invitation letter to engage with Cancer Care Scotland and get a holistic needs assessment which looks at people's concerns and indicates referral to support. Money and housing are consistently among the top concerns for patients, so they ensured good provision of support with these issues within the programme. Evaluation by Edinburgh Napier University used EQ5D and found significant improvements in health status, correlated with a decrease in concern.

Q&A / discussion session:

- In social prescribing models, a significant challenge is that almost 50% of referrals are for welfare benefits, debt and housing issues, but there is a lack of advice provision in these areas. This risks bringing social prescribing into disrepute, because advice providers have waiting lists that are several months long and the clients can't get through on the basis of referrals. The Bromley By Bow Centre in London is training social prescribing link workers to qualify as welfare rights advisers, but we need significantly more investment in social welfare legal advice if social prescribing is to be effective.
- In Kent and Medway, they are reviewing social prescribing because they're not sure it's working – link workers are all doing different things and are not highly qualified or equipped to deal with the issues properly. Welfare rights issues cannot be left to social prescribing networks, but we should develop more formal health-justice

collaborations, which involve true partnership working and integration to provide the support people need and want (it's a different model). We already have huge expertise within welfare rights officers, we just need more of them. This doesn't preclude additional training for social prescribing link workers, to help them recognise and deal with legal issues (could do both things to increase capacity).

- How can the advice sector engage better with the health sector, to improve partnership working? Get in the room and talk, and reinforce the point that cuts in some areas will create greater costs in others (cuts to the voluntary sector will have health consequences). More people will go without support, which will bleed through into pressures in other areas – there is a need for more joined-up thinking on this.
- What are the prospects for investment from the MOJ? They are currently evaluating pilots to make the case for whether to scale up investment in the advice sector. Greater investment might mean cuts in other areas of the justice system, so they are looking into how to best spend the money. This conversation needs to be started again now, because previously we didn't have integrated care systems, and we need to be thinking more about upstream intervention in health.
- There is a crisis in legal aid, what can be done about this, as people can't get help when they need it? The civil legal aid system is being reviewed, including pilots to extend the scope of civil legal aid. There is a recognition that the cuts since LASPO have been harmful and some further changes are needed.
- How much energy is there behind this HJP movement, to see it through (it has happened in many places before, just not been sustained)? From the ICS perspective, the fact that collaboration is now enshrined in law should help, and we need this to be regulated to ensure that we deliver as a system.

Plenary session 2: Health Justice Partnership case studies

Session aims: To showcase Health Justice Partnerships based in diverse healthcare settings, highlighting their activities and achievements.

Chair: Dr Tammy Boyce, Research and Policy consultant, UCL Health Justice Partnerships team

Speakers:

1. Catherine McClennan, Director, Cheshire and Merseyside Women's Health and Maternity Partnership

Summary:
Cheshire and Merseyside is one of the largest ICS areas. Health inequalities are stark, with some areas amongst the most deprived in the country. This leads to challenges with mortality for women and children. During Covid, they formed the women's health inequality and access to justice working group, a coalition focussing on women's health and maternity outcomes. They were

aware that socio-economic factors were impacting more on women's health locally than the clinical care. They have a track record of working in partnership with non-NHS organisations, and have their own a community engagement team with lived experience.
They have many innovations in this area, including the maternity HJP in partnership with Maternity Action. Based at Arrowe Park hospital on the Wirral, where there are challenges with deprivation. They have a dedicated phoneline and email service, which offers expert advice and legal support as part of the maternity pathway. Addresses employment and benefits issues, with the objectives of making things easier for women and their families to access advice: often they were more focussed money / housing / employment problems than on the health of their baby. For the women it's about reducing stress and accessing the right services, for the midwifery team it's about saving time: people come to them with lots of issues which they don't the time and knowledge to address. The service has achieved good outcomes for women: improved confidence, less stressed, resolved legal issues and improved financial situation. It provides early intervention and prevents situations deteriorating for women.
Key learnings. It's a pilot, they are looking how to sustain it and gain long-term funding. Important that everyone knows what you are doing and why. Have to keep trying to keep it going. Important to have a lead clinical advocate who gets it and can encourage people to engage. Important that it was embedded within a service pathway and team, not just seen as an add-on – part and parcel of the care. Visibility is key too, promoted in the right way, using accessible language. Also a family offer, not just the women: partners come too. Team working and training for midwives is important so they understand what's on offer. They had little time for this, so the legal team went onto wards to talk about it. Not everyone will access a phoneline, the visible presence is also important for access. Takes time to establish and build up the client numbers. Looking for funding to roll out and sustain the work on the back of the pilot, and the project is being taken up in Greater Manchester.

2. Sally Causer, Executive Director, Southwark Law Centre

Summary:
Southwark Law Centre is based in SE London, fairly big law centre providing advice on immigration, housing and other welfare rights.
Project with local hospitals started in 2020 just before lockdown. Initial funding was from Guys and Thomas charity (Samaritan fund), building on a previous project providing second tier advice for healthcare professionals. The earlier work helped to identify the need for complex casework among homeless patients. The service is for frequent attenders at A&E who can't be discharged because they would die on the streets. From 2022, funding for the project has been picked up by the hospital. The funding employs a housing and immigration solicitor. Immigration and asylum accounts for over 50% of queries, housing 30%, many clients need advice on more than one area of law. They provide training for hospital teams on legal issues such as care act assessments, immigration law, NHS charging, no recourse to public funds. Evaluations of the project were carried out in the first two years. Advisors can record legal case outcomes for clients and someone within the hospital can

track what has happened to the patients. The project helped hospital teams to support patients more effectively, a group who are some of the most disadvantaged and would otherwise not access legal advice. Use of hospital resources reduced too: >80% reduction in inpatient admissions and bed days, missed outpatient appointments reduced by a third. Good feedback from patients and hospital staff.
Their evaluation has attracted attention locally and the ICB has begun to fund a similar project based in Lewisham hospital and another for patients with Sickle Cell Disease.
Patient case studies demonstrate the needs and impact of the service (two individual examples presented). Having the support of the hospital teams helped support the casework, e.g. applications to Home Office. Helps to get people on the right track and not allowing them to die on the streets.

3. Melanie Gonga, Director & Head of Legal Practice, Springfield Advice & Law Centre

Summary:
Previously, legal aid went a very long way towards addressing inequalities and access to justice, covering almost all areas of legal advice work. This is no longer the case as the remit of legal aid has become narrower, which means they can no longer work in a holistic, whole-person way. The needs have not disappeared, and this feeds into the cycle of inequalities. There is such a desperate need for HJPs as a way of addressing health inequalities, especially for mental health patients who are particularly marginalised and disadvantaged.
Over the last 15 years, there has been a chronic and extended period of economic recession. In the lead-up to the recession, they already saw clients who were vulnerable for many reasons (health, disability, language/literacy, race, poverty) leading to hardship and crisis. Cuts were always seemingly made to the services that would have benefited clients with mental health issues. Since then, LASPO has cut legal aid for vast areas of social welfare law. There has been a downward tumble for their client group, who experience poorer health outcomes and experiences. Often what started as simple dispute escalates into crisis because things are not resolved. Situations are becoming increasingly difficult (with housing, finances, debt, employment) and people are not getting the assistance they need, either from advice services or other public services to which they are entitled. What are rights worth if they are unattainable, unenforceable, and ineffective and protecting those who are most vulnerable? Advice deserts have emerged, preventative service have been cut. We have invested massively into Brexit, but what have the benefits been for our economy or public services? The poorest have the most to lose from this failure. During the pandemic, if you were poor, Black or had a pre-existing condition, you were more likely to experience hardship and to lose your life. Now there is the cost of living crisis: this client group were already on the poverty line, they are not able to cut back further. The inequality gap is increasing, with knock-on impacts on health and social care.
Springfield Advice and Law Centre is based full time on the site of Springfield mental health hospital, addressing the needs of mental health service users.

Covers five boroughs in SW London. They were wholly funded by the NHS Trust until about 17 years ago, part-funded until 10 years ago. No longer NHS funded, but the NHS provide the offices and facilities at Springfield at other mental health sites (have outreach at a number of sites, including CMHTs and GP practices). The provide benefits, debt, community care and housing law advice services. Setting up the partnerships and outreaches is a continuous process of having conversations as staff turnover, to emphasise the value of their work and its relevance for health. They support patients and provide NHS teams with knowledge and guidance. The service frees up clinician time to allow them to focus on medical issues: if left unattended, legal issues lead to health / care needs down the line.
There is a need for early advice and support alongside healthcare, and today has given hope that we might again be forward-thinking and forward-looking. Integrated and complementary services are needed now more than ever to address health inequalities and its social causes. Clients report being less stressed, having a more positive outlook and being able to look forward in their lives. Healthcare professionals report easing of workload and work-related stress and better time management. Now is the time for action and we can be in this together.

4. Damon Gibbons, Chief Executive, Centre for Responsible Credit

Summary:
The Centre for Responsible Credit was founded in 2010 to focus on lower income households and their use of credit. In 2020, they were asked by Impact on Urban Health to scope out a project to help address health inequalities and long-term conditions, and the financial aspects of that. Health and finances are closely linked and this is well-researched. Local partners included social prescribers in the area. Local authorities have an interest too: if you increase someone's finances, they may be able to pay their council tax or rent better. Five housing associations came onboard. Set up a joint creditor forum, and Financial Shield was born out of discussions with the creditors and Primary Care Network. The PCNs have social prescribers in GP practices who wanted to make referrals, needed someone to refer to. Social prescribing doesn't work as a model if the capacity of local agencies has been shattered by cuts, which is the reality in many areas.
The ambition was to create a sustainable funding model for specialist advice integrated with health. Funded six 'financial support link workers' who were placed in Citizens Advice Southwark and Age UK Lambeth (which hosts the social prescribing, so embedded within the team in that area). They have seen around 1000 people. They have generated referrals proactively through texts sent by GPs to people on their list who are working age and have long-term health conditions. Branded 'Back on Track', people can request an appointment through the website. Social prescribers and GPs can make direct referrals.
Most clients are not previously engaging with advice services. The service is getting people money, more money than it costs to provide the service, on the confirmed outcomes alone (they don't hear the outcomes for many clients). So why doesn't this exist everywhere? Is it to do with evidence? They

developed an evaluation framework, and there has been a reduction in GP appointments (but can't be confident it's due to the project): not for everyone through, not a simple relationship. They looked at outcomes for creditors: 62% of clients have reduced their council tax debt, but it's because debts are being written off (no chance of being recovered).
Would it make any difference if all the evidence existed, that advice services improved health? Why doesn't the money get put in? Because it falls between too many stools, nobody is responsible for it. Council budgets have been cut year on year, and welfare rights is not a statutory service – the priority is to deal with crises, not provide preventative services. Good that ICSs have a responsibility to coordinate, but declining budgets will make agencies reluctant to divert funds from acute services to preventative ones. Need a national 'invest to save' programme of funding for things like HJPs.
There is interest in the project among creditors and energy companies to help people pay bills and take up social tariffs, may come on board. Scale can be an issue – housing associations have stock across very large areas, small scale services won't deliver the scale they hope for. But creditors should pay a contribution, along with the health service and local authorities, there will be benefits for them all from income maximisation.

Q&A / discussion session:

- There is an increase in chronic illness among people of working age, who need to advocate for their employment rights – should HJPs include employer organisations DWP / anyone who can influence employers doing the right thing? Yes, this can be part of the solution. Better partnerships with DWP are needed, often relies on a few good working relationships with individuals. There isn't enough joined up thinking on how it should work, as we live and work longer with poor health.
- How do we get passed the pilotisation of HJPs? Events to bring together expertise like today. Also working together with non-NHS organisations, ICSs to lead on integration and voluntary organisations are fundamental. Need to understand that partnerships are worthwhile, and spread good practice between ICSs.
- There is a need for a national policy solution, but this is unlikely to happen soon. In the absence of this, one of the facilitating factors is using healthcare system resource for tackling inequities (not just money but rooms, staff, understanding, social and political capital, advocacy, data), how can we get the health system to dedicate these resources to that cause? Look at who holds the decision, and who has most influence within that partnership - this will vary across the health service (e.g. healthcare professionals, managers). These are the people who need to be persuaded that this should be prioritised against other things the ICS may prioritise.
- Who do we call on to provide legal expertise within the partnerships, when some areas may not have law centres or their advice services are over-subscribed? This is a common and terrible position to be in, maybe some other organisations could expand their boundaries of operation. Also need to connect locally, people in both voluntary and

statutory services need to reach out and find out what's available. Can't just train up social prescribers, need proper expertise and supervision, we need partnerships with dedicated advice agencies, ideally that cover more than one area of social welfare law. The small-scale nature of things makes it difficult, having to constantly find small bits of funding to keep going – we need more money in legal aid, and to be thinking about the funding in a more structured way.

- On the back of the challenges of the last 15 years, what about climate change: will there need to be specialist legal advice on climate change issues, or could it be provided by organisations that already exist? Climate change can impact people e.g. by flooding or forcing people into migration. It's the next big thing that is starting to materialise. There is different advice people could get, on things like planning and air quality (environmental law), housing quality, accessing services, migration. The law lags way behind the need, has not yet taken account of things like climate change fully. Change will be slow, but there are ways we could use existing law to challenge things that are going on as a result of climate change – need to be creative in making the argument in the absence of legislation.

Plenary session 3 (panel discussion): Implementing Health Justice Partnerships

Session aims: To provide practical information and advice on service design and development, focussing on good practice and how to develop successful partnerships.

Chair: Dr Sarah Beardon, Senior Research and Policy Fellow, UCL Health Justice Partnerships team

Summary:
This session focusses on the practicalities of HJP: how do we go about it and how do we make a success of it. It will be run as a conversation drawing on the collective experience in the room.
There is a new guide produced by the UCL HJP team to support the implementation of HJPs: not a set of instructions, but a starting point for thinking things through. Includes sections on service design, and what to aim for in your projects. One of these is taking a collaborative approach as much as possible: you will need some engagement to get the referrals coming through, but greater communication and teamwork can be beneficial for the clients and help achieve better welfare outcomes. This takes time and is not easy, but worthwhile. The guide also touches on sustainability: this is a particularly challenging area, with many projects existing on short-term funding. There is also a lack of responsibility for resourcing them, being interdisciplinary, multi-agency, preventative services. Doing some evaluation can help make the case for funding, and the guide provides information to help think through the approach to take.

Speakers:

1. Vicky Smyth, Acting Group Manager, Health Improvement, Derbyshire County Council

Summary:
The partnership in Derbyshire has existed for about 30 years, with a Public Health Advisory Service embedded in general practice right across the county (about 100 GP practices). Also have a community wellness element, with advice in community settings (e.g. children's services, libraries, food banks) as not everyone accesses primary care. Derbyshire was one of the first areas of the country to do this work. Started as a pilot in the high peak area, built up over the years. Funding for the service has continued when Public Health moved from the NHS to local authorities. Citizens Advice is commissioned to provide the service (generalist advice and support) and are well linked-in with other services like Derbyshire Law Centre and welfare rights team. Also have a Macmillan advice service in acute settings.
Co-location has been one of the very important elements of the Public Health Advisory Service, advice workers are seen as part of the practice team and have good relationships with primary care, GPs trust and can make referrals easily. They have a focus on long-term health conditions, and these are very closely linked with people's ability to pay the bills so it's an important part of the support. Having a specialist advisor as part of the team makes it easy for GPs to refer, and so address the socio-economic issues that are the root causes of poor health. Positive outcomes of the service: last year worked with >11,000 people, addressed 54,000 issues, secured income of over £13million, and £4.5million of debts written off.
What are some of the things that have gone well for the service?

- *They use paid and suitably qualified advice workers, so they get really good quality service. Social prescribers can be part of the journey and can help generate referrals, but qualified advice workers are very important for resolving the issues.*
- *Having good feedback mechanisms so the GP practices know what's going on*
- *Co-location has been critical*
- *Recognising that each surgery works slightly differently and being flexible with the booking systems*
- *The flexibility of the partnership has been great for the commissioners too, the service specification allows them to manoeuvre to respond to need (e.g. delivery mechanisms switched during Covid and they could respond quickly)*
- *They have brought in additional funding to increase capacity where they can*
- *Linking in with other public health services has been positive, such as work on lifestyles which also incorporates financial inclusion, and food insecurity agendas.*
- *Linking in with other advice and law centres is beneficial to draw in extra legal expertise.*

- *They work with different Citizens Advice offices across the county but making sure there is a consistency of offer.*
- *Citizens Advice is a well-known and trusted brand*
- *Getting the maturity of partnership is important: sharing data, knowledge and support, helping to identify needs and inform how the service develops.*
- *The relationships are critical, the consistency of advisors and people getting to know each other. Also the consistency of the offer, so the service isn't changing all the time, people can get used to it.*
- *The long-term funding has enabled advice workers to feel confident in their job and stay in their job over time.*

What have been the challenges?

- *Covid has been challenging, when they had to change delivery mechanisms and lost the face-to-face contact in GP surgeries*

How have you kept the service going? They have mainstreamed funding of the service, invest over £1million per year from the Public Health budget. What has encouraged them to do this is the consistent high-quality delivery. They have clear KPIs in place, Citizens Advice have systems for collecting that data. Client case studies are useful in making the case too – it's about the benefits to individuals, and the money that comes back into Derbyshire through that.

What does the future hold for your new service? They have just recommissioned the service for another 8 years, they don't want to lose what has been built up over so long. This gives providers longer-term assurances, helps them grow their staff and maintain relationships. There may be scope for doing some work with the ICSs to reduce ill health. Also possibly some opportunities with social prescribing, they can complement each other (but important to maintain the high quality advice as part of that). Also thinking how to link the pathways across the system, work in a joined-up way to get the best outcomes. At the heart is the focus on people and wellness, not just illness.

2. Gary Vaux, Head of Money Advice Unit, Hertfordshire County Council

Summary:
Money advice unit is a welfare rights services, based in adult care services at the council. The partnership focusses on mental health and has been running 9 years. It started almost by chance, following a meeting with a doctor who worked in suicide prevention and was interested in the financial causes of suicide and self-harm. There was some money being given to local authorities to set up local assistance schemes to help people in need: they made the case to spend some of that money on advice work, which would bring in a lot more money for people than giving them one-off grants. This was agreed on and they recruited 4 advice workers who went into the local community mental health teams (CMHTs), where they were welcomed with open arms: mental health teams were concerned by clients' poverty, but also by the amount of time that clinical staff were spending chasing up the DWP. Bringing in advice

workers took the burden off them, and this support from the care teams has helped the service continue over time. They have built up very good relationships of goodwill, and the same 4 advisors are still in post – this continuity has been important too, meaning they can build up personal relationships.
They now have a new project starting in April, funded by the ICS. This is the first time they have had NHS funding. They will be going into the enhanced primary care mental health teams, which will mean slightly different ways of working. It was because they proved the need with the CMHTs that the ICS were willing to fund an extension into primary.
What helped in the early stages? Communicating that they could take the pressure off. They started with three goals: to improve income (which they can easily prove – around £4,000 per claimant), to take pressure off clinical staff, and to improve health (this is the most difficult to measure). Initially used WEMWBS, but it was hard to follow up and get the outcomes recorded – still looking for better ways to do this.

What has gone well with the service?

- *The consistency of the advisors. It is difficult to recruit in welfare rights services at the moment, and don't want to fill the gap with link workers because they are not what's needed (need experienced welfare rights workers and there is a national shortage)*

What have been the challenges?

- *Some practical niggly things, such as advisors not being able to use the photocopier or access the internet while on site in NHS settings.*
- *Started as a 1-year pilot, became 2 years then 5 years. It would be nice to have it mainstreamed so the funding is secure, they have to keep thinking about the next funding round.*
- *Covid caused a huge problem because the staff couldn't go into the health settings. They lost a lot of the corridor conversations and it has taken a while to recover this and build back the relationships. During the 2 years, half the staff in the mental health teams had changed over.*
- *Running on short-term contracts. It is wasteful that local authority funding is allocated for direct financial support rather than advice (which could bring in much more for people in the long run).*

How have you kept it going? They have taken every opportunity to bang the drum about how successful the service is: newsletter, reports, meetings – they publicise it repeatedly. They have had cross-party support within the council and worked hard at building this because they are local authority funded. The PR is important.

What does the future hold for your new service? A new project in the enhanced primary care team in mental health, starting as a 1-year pilot. The cost of living issues are ongoing, poverty will continue to increase so they want to keep looking for new avenues and funding. Also now talking with Public Health about suicide prevention work

Q&A / discussion session:

- The impact of Covid and the shift to remote care, loss of opportunities to pick up on needs when working virtually: how is this being addressed in your services? In Hertfordshire they have moved to a predominantly telephone-based system of interviewing people, it was starting to happen already but Covid accelerated it. You might expect the results to have gone down (e.g. numbers of clients, financial gains per head) but they have stayed exactly the same. It's about getting a balance: telephone / virtual is great for some people, but some of the more complex cases and vulnerable people may need in person. They are still working through this. Some of the mental health clients are much happier dealing with DWP assessments in a phone meeting with the advisers, rather than travelling to an office somewhere which can be intimidating. Most people have phones, some don't have digital access but that is changing with more people having smart phones.
- Have you needed additional skills set to help people deal with mortgage payments due to cost of living? Most clients are in rented accommodation, and there isn't much you can do about mortgage payments. A big issue concern currently is about energy affordability – people are self-disconnecting as they can't pay the bills.
- What is the importance of the independent accredited advice services, as opposed to the council-provided ones? They are necessary and best-placed to do some of the work as part of the broader system.
- Systemic changes are needed, how can statutory services be involved in influencing policy? There is a very strong lobby on poverty and cost of living at the Local Government Association, which they use as a national forum. Citizens Advice have a social policy unit too, so there are routes upwards. This is important because there are certain issues that are affecting large number of people.
- Funding has come up repeatedly today as one of the challenges for HJPs. There is some money is the Additional Roles Reimbursement Scheme pot which is under-utilised and can be used to employ advice workers – see guidance from the Money And Pensions Service. Diverse organisations fund advice services: there is a need to get funders together to talk about how we best use the money and how we can use the limited resources most effectively.

Closing address

Speaker: Matthew Smerdon, Chief Executive, The Legal Education Foundation

The Legal Education Foundation is a grant-making trust, focusing on using the law to improve people's lives. They have supported the Health Justice Partnerships work at UCL over a number of years. A guiding principle for the foundation is about how to put legal support in the settings where needs arise, and the healthcare system is a great example and opportunity for that.

Summary of the day:
The day has been well structured to take us through the subject, starting with an explanation of the case for Health Justice Partnerships, some great examples of integration and a discussion of how to go about it.
We also heard about the context: austerity, covid, cost of living, the scale and complexity of needs around poverty, racial injustice, rights at work, systemic maladministration and discrimination in public services.
Communities, health services and advice services are all under huge pressure. A linking question is how we shift prioritization to prevention: an important question in health and for society more widely. The NHS can't continue on the model of 'fix and repair', sending people back to conditions that made them sick in the first place. How do we work 'upstream'? A national 'invest to save model' was mentioned, and needing to make this case to the treasury. The task of acting early can feel daunting, but we could start by acting one step sooner: late action can lead to tragic outcomes as in the case of Awaab Ishak. What does it take to make this change? What is the change that will take this from local, sporadic, fragile to systemic and at scale? Integrated Care Systems could be part of that change, whereby the work to find interventions to address social determinants of health is now prescribed by law (ICS responsibility to form partnerships to address health inequalities). How do we build on this moment? We connect with people and build relationships, hold events like this one where we can have conversations. We can also purposefully co-locate: get close to each other across the system, whether that's services being based together or people doing joint roles and placements in other sectors. This presents an opportunity to do the storytelling and training, helping to recognize the non-medical services and the legal safety nets that do exist across all the social drivers of poor health. Shifting the work of healthcare professionals to focus on wellbeing and holistic needs assessment so medical staff see this as part of their role – make it part and parcel of the care pathways. HJPs are a specific intervention to address health inequality, they are not a subset of social prescribing albeit that the two can complement each other. What this requires is systematic funding of posts, and funding that doesn't fall between the stools. We drive the exercise with the data and evidence: evidence of the needs and the benefits. Some of that is long-term work to see health outcomes, but some is immediate positive stories that can be told (beds being freed up, appointment times coming down, practitioner stress being reduced). Let's use all the resources that are available to the health system, and look at the places that are already doing it for their expertise – there's a PR component to this, we need to tell the stories of those services. This is about a movement. All ICSs are different, what is the central switch that will impact across a whole network? Making sure all the chairs get the story and the information. The opportunity of ICSs may be a mechanisms towards making a shift towards widespread implementation.

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