

# Health Justice Partnerships in England

## A study of implementation success

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# Contents

	<b>Page</b>
<b>Executive summary</b>	<b>2</b>
<b>Introduction and context</b>	<b>5</b>
Why is civil justice relevant to health?	5
What are health-justice partnerships?	5
What can health-justice partnerships achieve?	6
Why are health-justice partnerships important now?	7
Why was this research conducted?	7
<b>About the research</b>	<b>8</b>
Aims and research questions	8
Study design and setting	8
Data collection and analysis	8
<b>Findings and discussion</b>	<b>9</b>
Overview of the case study partnerships	9
How did the teams work together?	11
What encouraged or prevented engagement?	12
What actions can be taken to facilitate collaborative working?	14
Reflections on wider issues affecting partnership working	15
What were the impacts of partnership working?	16
The benefits of service links	16
The added value of closer collaboration	17
What affected sustainability of the partnerships?	19
What enabled or prevented continued resourcing?	19
What actions can be taken to support sustainability?	21
Reflections on wider issues affecting sustainability	22
<b>Recommendations</b>	<b>24</b>
<b>References</b>	<b>26</b>
	1

# Executive Summary

## Purpose of this document

This report summarises the findings of recent research, exploring how health justice partnerships can be implemented successfully. The report describes how these partnerships can operate and identifies factors which contribute to positive service outcomes. It provides evidence-based recommendations to support good practice.

## Introduction and context

The law provides citizens with rights and entitlements to protect them from destitution and guarantee basic standards for living and working. Social welfare law covers issues relating to welfare benefits, debt, housing and employment, among others.

Health-justice partnerships are collaborations between health services and organisations specialising in welfare rights. The partnerships allow people to access legal advice and assistance through the health service where they are receiving care. These partnerships provide an integrated response to patients' needs.

Welfare rights advice services help people to defend their rights and secure their legal entitlements. This addresses social and economic issues that are harmful to health and are root causes of health inequality.

## About the research

This research was undertaken to explore how health-justice partnerships in England are designed and delivered, and identify factors that could contribute to implementation success. Nine partnerships participated in the research as case studies, representing diverse regions and healthcare settings.

## Findings and discussion

### Collaborative working between teams

Different approaches had been taken to integrating services, including co-location, direct referral systems, and multi-disciplinary team working. The healthcare and welfare rights teams worked together in different ways, which varied from close collaborative teamwork to more limited interactions and communication.

Collaborative working between teams was affected by several factors. These included personal willingness (beliefs and attitudes towards inter-agency working), practical ability (having the knowledge, opportunities, and systems to work together) and confidence (developing the trust, relationships and habits to work in new ways).

Collaborative teamwork could be facilitated by promoting and championing the partnership, providing information and training to build knowledge and skills, creating opportunities for the teams to interact and communicate, and providing regular feedback on the outcomes of referrals. Strong leadership played a critical role in encouraging and facilitating engagement.

## **Impacts of partnership working**

The partnerships led to a range of positive outcomes for patients, staff and organisations. Some of the benefits were due to having links between the services (co-location and referral systems) and the beneficial work of the welfare rights advisors. These outcomes were reported across all the case studies, and included:

- Having a valuable resource to meet patients' welfare needs
- Allowing care teams to focus on caring
- Providing easier access to legal assistance for individuals
- Achieving positive welfare outcomes for individuals
- Supporting and improving mental health
- Providing a more positive patient experience
- Supporting hospital discharge (for inpatient services)

Other impacts came about through closer collaborative working between healthcare professionals and welfare rights teams, which provided a more coordinated approach to supporting individuals. These impacts included:

- Ensuring more consistent and timely access to advice
- Facilitating access to medical evidence for welfare casework
- Producing better success rates for welfare claims
- Providing more seamless support for service users
- Improving staff knowledge and expertise

## **Sustainability of partnerships**

The case study partnerships varied in their age, with examples of up to 30 years of existence. Three partnerships were discontinued during or shortly before the research taking place, with funding issues being behind each service closure.

The maintenance of funding for the partnerships was influenced by several issues. These included funder willingness (views on the importance, quality and value of the service), ability (the availability of funds and other material resources), and confidence to fund (drawing on evidence, reputation and local relationships to inform decision-making).

Sustainability could be supported by evaluating the service effectively to demonstrate its achievements, championing and promoting the service widely, building strong relationships at strategic level, and working with partner organisations to jointly resource the work. Strong and passionate leaders were critical in building and maintaining support for the partnerships, but wider economic circumstances also had significant influence.

# Introduction and context

## Why is civil justice relevant to health?

The law provides citizens with rights and entitlements, which aim to protect people from destitution, ensure access to essential services, and guarantee minimum standards for living and working conditions. These areas of law are collectively referred to as 'social welfare law', and relate to issues such as welfare benefits, debt, housing, employment, education, community care and immigration<sup>1</sup>.

When individuals experience social welfare problems, but cannot defend their rights, this can lead to situations including financial strain, over-indebtedness, homelessness, poor living conditions, exclusion from work or education, and lack of access to public services and support<sup>2</sup>. These social and economic conditions are strongly harmful to health and largely affect the poorer people in society<sup>3</sup>. Indeed, in the health field, they are recognised as 'social determinants of health', which underpin significant inequalities in health across the population<sup>4</sup>.

The law can provide a remedy for individuals facing hardship due to social welfare problems. With appropriate advice and assistance, legal rights and entitlements can be enforced and personal circumstances improved. This provides a powerful means for taking action to address underlying social causes of poor health<sup>5</sup>.

Poor health can also lead to social welfare legal problems. For example, living with a serious physical or mental condition can significantly affect an individual's work capability, income, and support needs<sup>6</sup>. People in poor health may develop social welfare issues related to their health condition, and may present to health services needing assistance with welfare rights.

## What are health-justice partnerships?

Health-justice partnerships are collaborations between health services and organisations specialising in welfare rights (which can include welfare benefits, debt, housing, employment, education, community care and immigration). Welfare rights advice can be provided by different types of organisations, including local authorities, charities, law centres and other pro bono legal services.

The welfare rights advice services are integrated with patient care, allowing people to access legal assistance through the health service they are attending. The welfare rights services may be physically located in the healthcare setting so that people can have advice appointments while on site, and/or they may access the service via a direct referral from a member of their care team. Health-justice partnerships involve communication and joint working between healthcare professionals and welfare

rights advisors, in order to provide a coordinated response to the health and welfare needs of individuals.

These partnerships exist across England in a wide variety of forms, and may be referred to using diverse terminology. They are based in many health settings, including GP practices, hospital departments, hospices, mental health and community health services, among others<sup>7</sup>.

Health-justice partnerships also exist in other UK countries and across the world. Nationwide action has been taken in Scotland and Wales to co-locate welfare rights advice services within healthcare settings<sup>8,9</sup>. National networks are already well developed in Australia<sup>10</sup> and the United States<sup>11</sup>, which provide support and coordination for health-justice partnerships. Further examples can be found in Canada and New Zealand.

## What can health-justice partnerships achieve?

Health-justice partnerships can have different aims and objectives, depending on the population needs and local setting. A recent review of research from across the world gathered evidence on their benefits<sup>12</sup>. The impacts can be summarised under the following themes:

- **Improving access to legal assistance for those in need:**  
Delivering welfare rights advice in health settings can encourage and facilitate help-seeking, and many people using these services would not otherwise access appropriate assistance.
- **Resolving legal problems that are harmful to health:**  
Welfare rights advice services effectively support incomes, reduce financial strain and improve other social and economic circumstances.
- **Supporting and improving mental health and wellbeing:**  
There is good evidence for improvements in mental wellbeing resulting from the improvements in individuals' social and economic circumstances.
- **Supporting and improving patient care:**  
Partnership working provides a more comprehensive and holistic approach to care, patients value the personalised service and continuity of support.
- **Providing a resource for health services and staff:**  
Healthcare professionals value having in-house assistance with social welfare issues, which may reduce workloads and improve job satisfaction.
- **Addressing inequalities and driving systemic change:**  
Some welfare rights services undertake social policy work and legal action, which can address health risks for whole communities.

## Why are health-justice partnerships important now?

The last decade has seen a significant increase in the levels of need for welfare support in the population. A number of factors have contributed to this, including the economic impacts of the 2008 financial crisis, the subsequent cuts to welfare benefits introduced with austerity policies, and more recently the effects of the Covid-19 pandemic<sup>13–15</sup>. Simultaneously, the provision of welfare rights advice services has fallen due to reduced funding for local authorities and cuts to the scope of legal aid<sup>16</sup>. Ensuring access to justice for those with social welfare legal needs has become increasingly challenging. It is therefore important that the remaining welfare rights advice services can reach people efficiently and effectively. Integrating services can help to ensure swift and targeted access in a time and place of need.

In recent years, health policies have advocated for greater cross-sector collaboration with services providing non-medical support for patients. There are various aims for this integration, including to promote health, prevent illness, support independence, reduce health inequalities, personalise care and improve the responsiveness of health services to individual needs<sup>17,18</sup>. Welfare rights advice addresses the most fundamental needs for economic, material and social resources. It helps to improve living conditions and quality of life among more deprived groups, and as such is a critical intervention in the health system response to health inequalities and prevention of ill health.

## Why was this research conducted?

Our previous work had identified health-justice partnerships across the country and provided insight into some of their key features and activities<sup>7</sup>. However, the experiences of practitioners highlighted that there could be significant challenges in delivering and maintaining these partnerships in practice. One commonly reported problem was difficulty developing effective team working between services, so that staff would work collaboratively in supporting individuals. Another was difficulty keeping the service running over time, with resource problems leading to a high turnover rate of projects. These issues seemed to be affecting the ability of partnerships to embed properly and deliver an impactful service, and there was therefore a need to understand in more detail what was causing these difficulties. The aim of the study was to inform recommendations for successful implementation of health-justice partnerships in the English context.

## About the research

This research was undertaken as part of a PhD studentship funded by the NIHR School for Public Health Research (SPHR) and the NIHR Collaboration for Applied Health Research and Care (CLAHRC) North Thames. The research was jointly supervised by academics in the UCL Department of Applied Health Research, UCL Faculty of Laws and King's College London Department of Psychological Medicine.

## Aims and research questions

This research aimed to explore the factors affecting successful implementation of health-justice partnerships, in order to inform recommendations for practice.

The broad research question guiding the work was 'How can health-justice partnerships be implemented successfully?' More specifically, this study aimed to identify factors that influenced differences in the success of health-justice partnerships at an organisational level.

Three outcomes were explored in the study:

- Collaborative working between healthcare and welfare rights teams
- Impacts of partnership working
- Sustainability of the partnerships over time

## Study design and setting

The research used a comparative case study design. Nine health-justice partnerships participated as case studies in the research. They were based in different regions of England, and were chosen to reflect a broad range of health settings, populations and approaches to partnership working.

## Data collection and analysis

Data were collected through one-to-one semi-structured interviews with staff working in the partnerships. This included frontline staff in both healthcare and welfare rights advice services, as well as those in management and funding roles. Data were analysed using qualitative methods (thematic analysis and process tracing).

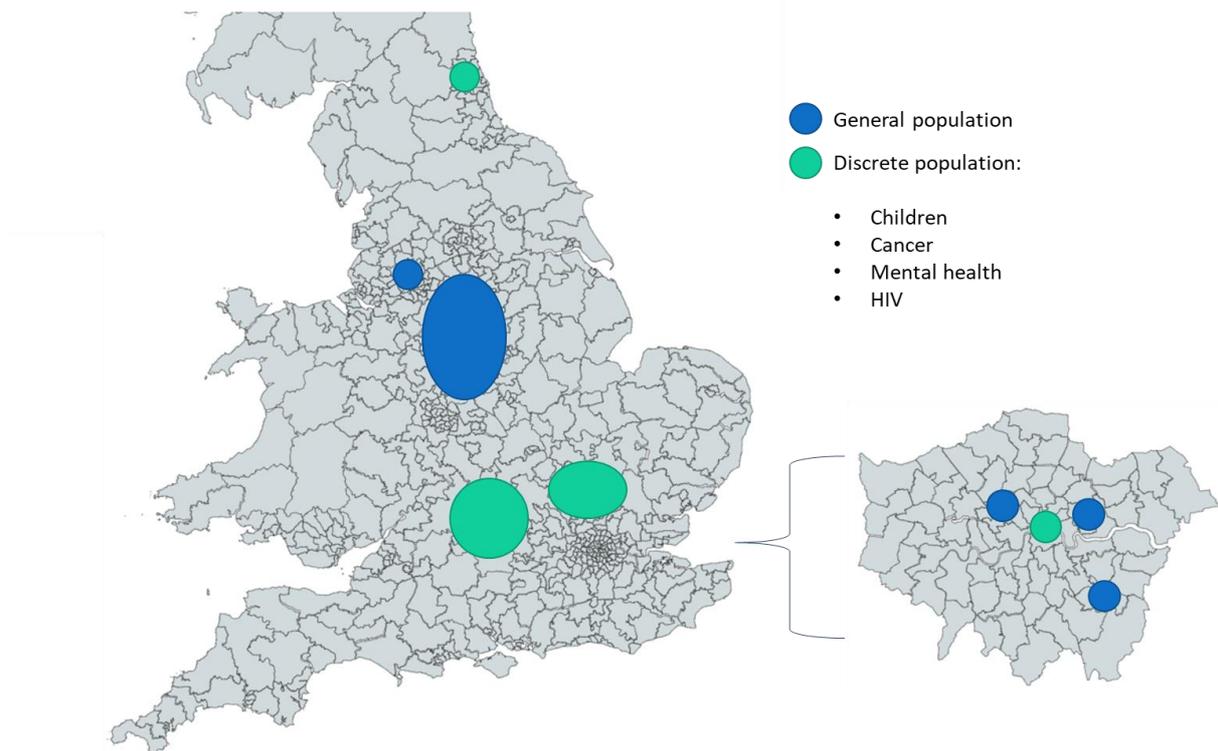
# Findings and discussion

## Overview of the case study partnerships

### Geographical location and population

Services from different regions of England participated in the research, displayed in Figure 1. Some provided a service for the general population and were delivered through primary care (GP practices). Others focused on the needs of a discrete population, which included children and people with cancer, mental health issues and HIV. These services were delivered through hospitals, hospices and community mental health teams.

*Figure 1: Map of case study partnerships*



## Welfare rights issues

Three services specialised in welfare benefits, and the others provided advice on several areas of social welfare law. The most common issues experienced by patients related to welfare benefits, debt and housing.

## Advice delivery

Welfare rights advice was largely provided by charities (six services) but included two local authority services and one law clinic. Advice was largely delivered face-to-face (pre-Covid), however two services were largely remote: one involved placing telephones (free landlines) in each GP practice, offering a direct line to the advice team that patients could use at any time. The other was a call service taking referrals from all local health and social care services as well as patient self-referrals.

## Connections between services

Co-location of the services was common, with welfare rights advisors attending in person to provide appointments for patients in their place of care. All of the partnerships had referral systems to connect patients directly with the welfare rights service. Two also involved multi-disciplinary team working, in which welfare rights advisors became fully integrated members of care teams. Two services were multi-agency partnerships, in which the NHS worked with a number of local charities (including the welfare rights service) to coordinate a range of non-medical support for the population.

## Funding sources

The services were funded by different sources, including charities, local authorities, the NHS, a university, and multiple or joint streams. Some had funding that was renewed annually, others were contracted for between 2 and 4 years.

“We acknowledge that the area we cover is deprived, and that can have a knock-on effect on some people’s health. So if we can increase their financial literacy and make sure they’re aware of their rights and entitlements, we can in some way try and increase the health of the location as well, and do something for the levels of poverty they’re living in”. Advice service manager

## How did the teams work together?

### Activities of partnership working

Table 1 summarises how the healthcare professionals and welfare rights teams worked together on a daily basis. In some cases, this was mostly limited to making or receiving referrals, while in other partnerships there was a more close and collaborative approach to joint working.

*Table 1: Activities of joint working between healthcare and welfare rights teams*

<b>Activity</b>	<b>What was involved</b>
Identifying patient / client needs	Healthcare professionals would identify patients' need for welfare support, through discussions or formal assessments. Welfare rights advisors would sometimes identify unaddressed health needs. This provided a basis for making referrals within the partnership.
Making referrals between the services	Healthcare professionals would connect the patient to the welfare rights service through initiating a referral or booking an appointment. Welfare rights teams could also refer to healthcare where necessary.
Exchanging information about personal needs and circumstances	Information on personal needs and circumstances was often critical in supporting welfare applications. With patients' consent, professionals would work together to source and provide information, including health records and supporting letters.
Making joint contributions to the casework	Professionals would work together in other ways to support an individual's case, including liaising about the situation, discussing appropriate responses and coordinating the input that was needed from each team.
Providing each other with professional advice and support	Welfare rights advisors assisted healthcare teams by explaining welfare regulations, helping them understand situations, and equipping them with information to pass on to patients. Healthcare professionals could also help welfare rights teams to understand the impact of health conditions on someone's capabilities. This allowed both teams to perform more highly in their roles.
Providing feedback on patient / client progress and outcomes	Teams would communicate with each other about the progress a patient was making, and inform the referring professional about outcomes that had been achieved. This informed the ongoing care and support provided.

## What encouraged or prevented engagement?

Figure 2 displays the main factors that influenced whether healthcare professionals and welfare rights advisors would work together closely. These factors included personal attitudes and beliefs, practical issues in joining up services, and other factors such as knowledge, skills and relationships.

Figure 2: Factors influencing engagement in collaborative working



These themes are described in more detail below:

### Willingness

- **Sentiment towards partnership:**  
Staff who had positive views about working in partnership were more engaged in making referrals and participating in other ways. They welcomed the new team members and helped promote and facilitate the partnership.
- **Perceived value of partnership:**  
Staff who valued the partnership engaged well with it, because they saw and understood the benefits for themselves and their patients. Belief in the importance of non-medical interventions and interdisciplinary approaches contributed to positive views.

- **Alignment of purpose:**  
Staff worked together well when they saw collaboration as an acceptable part of their role and an important responsibility in supporting their patients. Clashing professional views and culture could inhibit teamwork.

#### Ability

- **Knowledge levels:**  
Health teams needed to be aware of the welfare rights service and its role in supporting patient care. They also needed to understand what assistance it offered, who would benefit from a referral, and when and how to engage with the welfare rights team.
- **Opportunities to interact:**  
Staff needed opportunities to cross paths, interact and communicate in their day-to-day work. This enabled them to work together practically and facilitated learning and relationship building.
- **Workability of systems:**  
Administrative systems needed to be in place to enable joint working between teams (e.g. patient consent, data security and IT). Ways of working also needed to be as quick and simple as possible to facilitate engagement.

#### Confidence

- **Trust between teams:**  
Staff felt confident working together when they trusted in the competence and professionalism of the other team. This developed with experience of working together and could take some time in the early stages.
- **Quality of relationships:**  
Positive relationships were important, encouraging good communication and collaboration between team members. Difficult relationships could inhibit effective team working.
- **Habits and norms:**  
Interdisciplinary working required new knowledge, skills and habits. Staff engaged well once the new system had become a routine, natural and automatic part of everyday activities.

“(Hospital) social work department, we are actively liaising with them all day every day. So we are in and out of their offices, they come to us all the time, you know the offices are busy with people knocking on the door, ‘Can we just have a little bit of help with this, or can you help me with that’”. Welfare rights advisor

## What actions can be taken to facilitate collaborative working?

- ✓ **Promote the partnership to the relevant teams**  
This raises awareness and acts as a reminder for people. Consider attending and talking at meetings, producing promotional materials or sending regular updates.
- ✓ **Provide opportunities to learn about the partnership**  
This ensures people have a good understanding of the service. Consider offering information and trainings, doing inductions or offering shadowing opportunities.
- ✓ **Create opportunities for the teams to interact**  
This makes communication easier and enables colleagues to build relationships. If day-to-day interaction is not possible, ensure teams are regularly included in relevant meetings, events or away days.
- ✓ **Provide feedback on the outcomes of advice work**  
This ensures that referring professionals understand the positive impacts of the advice service and increases their motivation to refer again in future. Consider providing updates during teamwork or producing regular progress reports.

## Reflections on wider issues affecting partnership working

### Physical and administrative barriers to collaboration

For close collaborative working between teams, the professionals needed to be able to interact and communicate during their day-to-day work. This allowed them to build trusting relationships, discuss their work and share necessary information. There were physical barriers to this in some cases, where teams worked in separate spaces with little opportunity for interaction. This was particularly notable in primary care settings. Creating shared workspaces can be challenging in primary care, but other methods can help to build trust and team identity through informal communication. This includes interdisciplinary team meetings, team building activities and use of technology<sup>19</sup>. There were also administrative barriers to collaboration in some services. For teams to make referrals and exchange patient information, there need to be processes in place for patient consent and secure data exchange. Shared IT systems were used in some places that enabled more secure and efficient access to information.

### Strong leadership for creating system change

Any new system requires behaviour change on the part of staff teams, which can be challenging to introduce and sustain. Strong leadership plays a critical role in enabling this transition. In the partnerships studied, leadership was shown by people in a variety of roles, including frontline staff as well as managers. These people could facilitate team working by motivating colleagues, reminding and encouraging participation, providing information and education, influencing team culture, ensuring inclusion in team activities, managing any relationship issues, and helping with the practicalities of integration. In some partnerships, the welfare rights service was formally branded under a healthcare brand, which conferred an internal identity that seemed to encourage greater trust and openness between colleagues.

## What were the impacts of partnership working?

The research explored the benefits of working in partnerships, which staff had experienced themselves or witnessed in their patients / clients. The passage below describes how these outcomes came about.

“I think the co-location element is important for patients. You know, patients are really delighted when you say you’ve got this service and it’s in the room next door or it’s one floor up – patients really like that, so I think it’s important to them”.

Healthcare professional

### The benefits of service links

Some of the benefits of the partnerships came about because the advice service was present in the healthcare setting, patients were being referred and welfare rights issues were being sorted out. These included:

- ✓ **Having a valuable resource to meet patients’ welfare needs:**  
Working with a dedicated welfare rights service enabled care teams to address welfare rights issues that were impacting on patients’ wellbeing, but were complex to manage and outside their realm of professional expertise.
- ✓ **Allowing care teams to focus on caring:**  
By making referrals to advice teams, care teams were freed from needing to manage time-consuming welfare rights issues and could focus on their caring roles. The convenience and support from in-house welfare rights advisors was greatly appreciated.
- ✓ **Providing easier access to legal assistance for individuals:**  
Being physically present in the healthcare setting, patients could see the welfare rights service and access it unprompted. Others were signposted or referred directly by care teams.
- ✓ **Achieving positive welfare outcomes for individuals:**  
The welfare rights advice services were highly successful in achieving improvements in financial circumstances, living conditions and other socio-economic outcomes for patients.

- ✓ **Supporting and improving mental health:**  
Welfare rights problems caused significant mental distress, and receiving assistance provided immediate relief and reassurance for people. The improvements in financial position and living circumstances also improved mental wellbeing and quality of life. Some patients could engage better with their care once the welfare rights issues had been addressed.
- ✓ **Providing a more positive patient experience:**  
Patients were grateful to have welfare advice available to them at a time of need and without having to seek help from unknown external services. They appreciated the trusted support, convenient access and expert assistance.
- ✓ **Supporting hospital discharge:**  
Hospital discharge could be delayed if patients had outstanding housing and benefits problems. The welfare rights service helped to resolve these issues and speed up hospital discharge.

## The added value of closer collaboration

There were also a range of benefits which occurred due to the healthcare professionals and welfare rights teams working together more closely in their day-to-day roles. These included:

- ✓ **Ensuring more consistent and timely access to advice:**  
When teams proactively identified and referred patients with welfare needs, this meant welfare rights issues were identified more consistently and referred at an early stage.
- ✓ **Facilitating access to medical evidence for welfare casework:**  
Working with healthcare teams enabled welfare rights advisors to source essential medical evidence. This was only possible due to trusting personal relationships and internal communication between teams.
- ✓ **Producing better success rates for welfare claims:**  
By working with healthcare teams, welfare rights advisors could source medical evidence and discuss the needs of individuals. This allowed them to prepare a much stronger legal case, which improved the success rates of welfare claims.

- ✓ **Providing more seamless support for service users:**  
Coordination and discussion between teams meant that patients received help that was more seamlessly integrated with their care, and ensured staff members were fully informed about their needs.
  
- ✓ **Improved staff knowledge of individuals' needs:**  
By communicating and working together on individual cases, staff gained a better understanding of the person's needs and situation. This meant both health and welfare teams were able to provide more efficient and effective support.
  
- ✓ **Improved staff skills and expertise:**  
By working together and consulting each other, both healthcare and welfare rights teams broadened their professional knowledge and became increasingly able to assist patients with related issues.

“If we didn't have that medical evidence, claims are more likely to be refused, and then that's more appeals, which is more worrying obviously for the clients. So if we have effective evidence... evidence from the Clinical Nurse Specialists is really valuable.”  
Welfare rights advisor

## What affected sustainability of the partnerships?

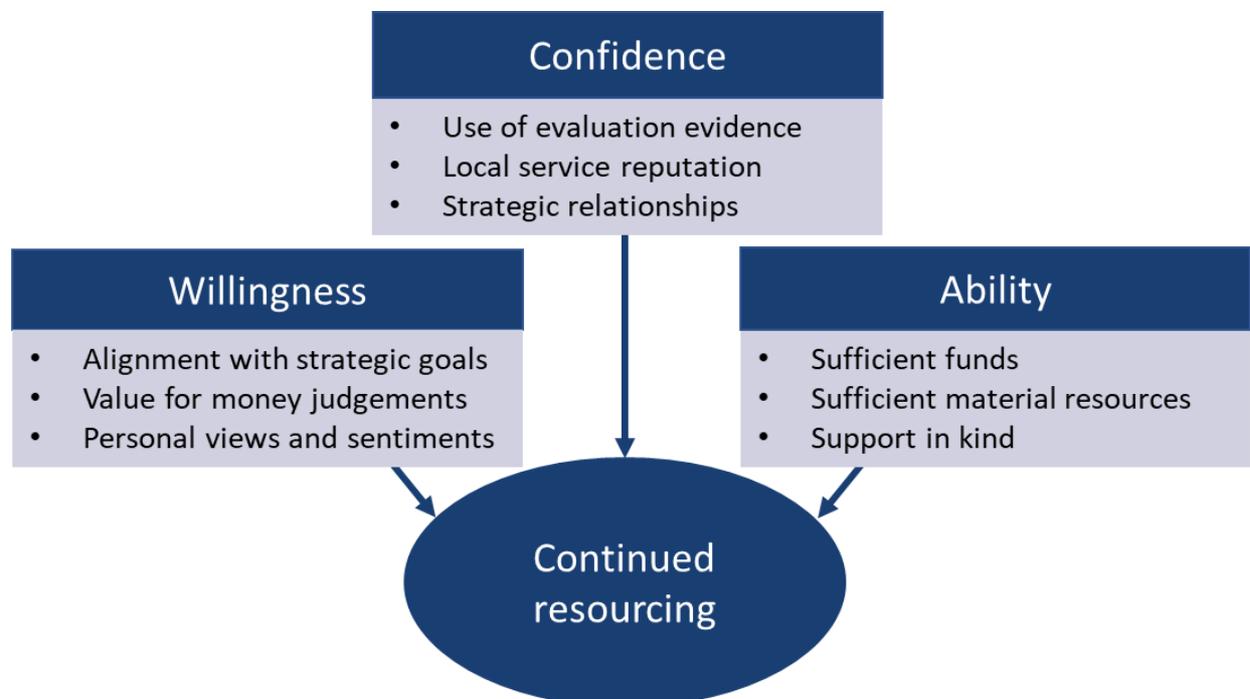
### Experiences of the services over time

The age of the partnerships varied considerably within the group of services studied. Two had existed for between 20-30 years, while three were under five years old. Three of the partnerships had come to an end, during or shortly before the study period. In each of these cases, the service closure was related to funding issues: two had their funding removed and one had their rent raised and could no longer afford to operate in the primary care setting.

Figure 3 displays the main factors that influenced whether resourcing of the partnerships was maintained. These included the attitudes and beliefs of funders, overall availability of resources, and other factors that influenced decision-making such as evidence, reputation, and local relationships.

### What enabled or prevented continued resourcing?

Figure 3: Factors influencing whether resourcing was maintained



These themes are described in more detail below:

#### Willingness

- **Alignment with strategic goals:**  
Funders were supportive when they felt the partnership was contributing to their own strategic aims and priorities. Questions about which organisation should be responsible for funding the partnership could cause tension and discontent.
- **Value for money judgements:**  
Funders views on the partnerships were influenced by whether they felt the service was meeting an important need and delivering high quality, impactful work for the investment.
- **Personal views and sentiments:**  
Funders with positive views on the partnerships had supported them over time and protected budgets through times of change. Negative perceptions of the service had contributed to funding removal.

#### Ability

- **Sufficient funds:**  
Availability of funds was an ongoing challenge that was influenced by wider economic and political circumstances. This could place significant pressure on funders, and many partnerships operated on short-term and minimal funding.
- **Sufficient material resources:**  
Additional material resources were needed to keep the projects going, such as physical space for appointments and sufficient staffing capacity.
- **Support in kind:**  
Contributing non-financial resources made a big difference to partnerships day-to-day operations, such as rent-free space, administrative support, equipment and training.

#### Confidence

- **Use of evaluation evidence:**  
Strong evaluation helped partnerships to demonstrate their impacts. Funders were impressed by evaluations that communicated outcomes that were important to them, which contributed to ongoing financial support.

- **Local service reputation:**  
Some of the partnerships were widely known for their excellent work and well promoted locally (and sometimes nationally). This high profile and positive reputation contributed to support at strategic level.
- **Strategic relationships:**  
Relationships between leaders were important for a strong partnership between organisations. Working together closely ensured the service was developed according to needs and expectations, and any issues were communicated and addressed.

“I’ve kept it going because I can see the impact it has on people. As well as the individual difference it makes to those families, it brings a lot of money into the county... so my heart’s been in it.”  
Commissioner

## What actions can be taken to support sustainability?

- ✓ **Evaluate the service to demonstrate relevant achievements**  
This ensures funders have the evidence they need to back their investment decisions. Funders and providers should work together to set expectations and understand information needs.
- ✓ **Champion and promote the service locally**  
This raises awareness of the partnership and increases local recognition of its importance. Consider promoting the work at meetings or conferences, and through publications or other media.
- ✓ **Build strong relationships at strategic level**  
This helped to build recognition, understanding and support for the service among senior leaders. Aim for regular communication and progress updates, and work together to develop and improve the service.
- ✓ **Consider joint resourcing where possible**  
Where this occurred, joint resourcing by public funders had created a stronger sense of joint ownership and increased the resources available to the partnership.

## Reflections on wider issues affecting sustainability

### **Economic and political circumstances**

Over time, economic and political changes had affected the availability of funds for the partnerships. The situation has become increasingly difficult over recent years: local authorities have faced annual budget cuts, and health services have needed to make efficiency savings in the face of growing financial problems. The Covid-19 pandemic has compounded these difficulties and placed additional pressure on funders. Poorer regions of the country have been impacted to a greater extent.

### **Individual versus collective organisational goals**

In the face of financial pressure, some funders had needed to focus in on narrower goals relevant to their individual organisation's priorities. The research identified that funders could often feel they were pulling more than their fair share of the weight, and that they should not alone be responsible for funding the partnership. These concerns were not identified in jointly funded partnerships, where ownership of the project was collective and the organisations were working together towards broader joint goals for the population. This highlights the potential of joint resourcing to support cross-sector partnership working.

### **Destabilising effects of wider system change**

Inevitably, the frequent changes to health service policies and structures had also affected the stability of partnerships over time. At times these changes were helpful, and some partnerships had been established under initiatives to facilitate collaboration between the NHS and third sector organisations. However, other shifts had been more destabilizing, and some partnerships had been cut back or decommissioned in restructures, including those aimed at making financial savings or introducing new systems like social prescribing. The current move towards Integrated Care Systems strengthens the case for cross-sector collaborative working, but comes with uncertainties for existing partnerships as the systems are designed and introduced.

### **Supportive leadership as a mainstay**

This research highlighted the importance of leadership in ensuring the continuity of partnerships over time. Strong and passionate champions were critical in building and maintaining support for the partnerships. This leadership was shown by people

in different roles, including service managers, funders and senior system leaders. These people played an important role in promoting the work widely, evaluating the services and communicating about the impacts of the partnerships. Supportive leaders could advocate for the partnership at strategic level, influence funding decisions, and in some cases have budgets protected. Strong and enduring leadership had been a critical feature of longstanding partnerships. However, in the most severe financial circumstances it was sometimes not enough to protect projects and even services that were universally valued had been lost due to funding pressure.

# Recommendations

## Recommendations relating to service design

1. Involve local stakeholders in the design and ongoing development of partnerships, to ensure they are responsive to needs and easy to engage with in practice (input from both patients and staff can be valuable).
2. Build referral links with a wide range of healthcare professionals (including nursing, mental health, social work, administrative staff, among others) to broaden access.
3. Where capacity is limited, consider a focus on areas of high need (e.g. geographical pockets of deprivation, or service user groups with high rates of welfare issues).
4. For partnerships aimed at the general population through primary care, aim to ensure equitable access for patients in the region (e.g. could open the service to neighbouring practices or use remote methods to extend reach).
5. Form links among local advice providers for additional capacity and legal expertise, including through volunteer and pro-bono support.
6. For groups with multiple and complex needs, consider embedding welfare rights advisors within multidisciplinary teams to streamline inter-agency working and provide more tailored support.

## Recommendations relating to collaborative working

1. Regularly promote the partnership among healthcare teams locally, to ensure visibility and ongoing awareness.
2. Provide opportunities to learn about the partnership (e.g. trainings, inductions), to develop the necessary knowledge for joint working.
3. Cultivate relationships with healthcare teams (including health and social care professionals and administrative staff), to build trust in the partnership.
4. Seek project champions in the health service, to help promote and encourage engagement among teams.
5. Create regular opportunities for staff to interact, communicate and get to know each other; for example, through interdisciplinary meetings.
6. Provide feedback on the outcomes of referrals to welfare advice, to increase understanding and motivation among referrers.
7. Ensure that processes are in place for information security, confidentiality and consent for information sharing, to enable collaborative working on patient cases.

## Recommendations relating to sustainability

1. Evaluate the service in the light of local funder priorities, to demonstrate relevant impacts.
2. Promote the service locally, to raise awareness of its achievements for the local community / patient group.
3. Seek out prominent health service champions, to support the partnership in strategic discussions.
4. Maintain relationships between organisations at strategic level, to develop and improve the service collaboratively over time.
5. Make the goals of the partnership explicit at the start, to ensure the purpose remains clear through changes in management. Ensure any new goals or revised priorities are communicated.
6. Consider joint funding arrangements between partner organisations (where possible locally), to create a sense of joint ownership and increase the available resources.
7. Partner organisations should jointly contribute non-financial resources to support the partnership, such as rent-free space, administrative support, training or IT equipment.

## Recommendations relating to national action

1. Convene a professional peer network / community of practice, to capture and share learning across services.
2. Develop implementation guidance, to support replication and wider adoption of health-justice partnerships.
3. Develop guidance on evaluation, to support local services in evidencing their impacts.
4. Develop training resources, to support capability and readiness for interdisciplinary working among health and legal teams.
5. Campaign at a national level for greater recognition and support from both health and legal sectors.
6. Conduct further research on issues where evidence is limited, to facilitate buy-in from both sectors. E.g. Early intervention in legal issues, prevention of ill health, reducing pressure on healthcare services, addressing inequalities. Also finer breakdowns, e.g. where there is the greatest benefit (by patient groups / types of issues).

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