Implementation of Health-Justice Partnerships

Integrating welfare rights advice services with patient care

Sarah Beardon

UCL Department of Applied Health Research & UCL Faculty of Laws

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DECLARATIONS

I, Sarah Beardon, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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ABSTRACT

Background: Health-justice partnerships exist to support patients with social welfare legal issues, which occur among more deprived population groups and are significant causes and consequences of illness. Integrating welfare rights advice with patient care is a means towards important policy goals of both health and legal sectors, including improving access to justice, supporting health outcomes and addressing health inequalities. However, myriad approaches exist and there are clear challenges in delivering and sustaining these partnerships in practice.

Methods: This research investigates the question 'How can health-justice partnerships be implemented successfully?' The systematic scoping review examined existing evidence on the impacts and implementation of the partnerships. The comparative case study investigated service design and delivery in practice, drawing on a diverse sample of health-justice partnerships across England. The stakeholder engagement exercise explored professionals' responses to the findings and their priorities to support implementation in future.

Results: 118 publications were included in the review. The strength of evidence for impacts of the partnerships varied across different topics. Evidence on implementation was of low quality but identified prominent factors affecting service delivery. Nine partnerships participated as case studies in the primary research, from various geographical regions and care settings. The extent of collaborative working between health and welfare rights teams was variable and influenced strongly by individual attitudes and capabilities. Close collaborative working contributed to more impactful partnerships. Some partnerships were currently operating, while others had closed. Decisions to discontinue had been influenced predominantly by resource constraints and strategic priorities. Stakeholders were concerned with how best to design partnerships and engage effectively with healthcare organisations, as well as how to evaluate partnerships and fund them sustainably.

Conclusion: This research provides new evidence to support the successful implementation of health-justice partnerships and identifies priorities for future research and policy work in the field.

IMPACT STATEMENT

Health-justice partnerships have potential to achieve a wide range impacts, including positive health and welfare outcomes for individuals, and improved efficiency and effectiveness of participating services. However, successfully implementing these complex systems can be a challenge. Understanding what influences implementation could inform the establishment of new partnerships, encourage their utilisation in day-to-day work and support their long-term survival; this will facilitate the production of their intended benefits.

The first stage in my research involved undertaking a systematic scoping review, which drew together literature from across the world. This review is the first to provide a comprehensive assessment of the evidence on impacts internationally, and the first to assess published evidence relating to implementation of health-justice partnerships. It provides a valuable contribution to knowledge in the field by describing the state of current evidence and identifying gaps in the literature. This could be useful resource for both academic researchers and those looking for information to support implementation in practice.

The primary research was a comparative case study involving diverse health-justice partnerships across England. This study gathered information on the processes and outcomes of implementation through interviews with professionals. It is the first study to explore implementation in different contexts and to investigate causal pathways to implementation outcomes. The results make a significant contribution to knowledge in the field by identifying the major determinants of implementation success. This could be valuable information for those implementing health-justice partnerships in practice, by highlighting important issues that may influence their work and actions that can be taken to maximise positive outcomes. The findings may also be applicable to similar interventions such as partnerships between healthcare and voluntary and community sector organisations more widely. The results could be used in the project planning and initiation stages and could support ongoing improvement and sustainment.

The comparative case study also makes an academic contribution to the implementation science field. The study design and analysis techniques used are not commonly applied in implementation studies but offer a suitable and effective set of tools for investigating causality in complex systems. This may provide a useful example of the methods for researchers addressing similar research questions. To my knowledge, it is also the first study using the General Theory of Implementation to inform the data analysis and interpretation. It provides a worked example of the theory and highlights the areas of good and poor fit with the empirical data.

Throughout my PhD I have presented findings at academic conferences. I have also presented at meetings with professionals interested in the health-justice field and have blogged about my work for a wider target audience. This has begun the dissemination work, which I will continue with the future study outputs. My ambition is that the research will be used to inform the implementation of both new and existing partnerships, particularly supporting effective interdisciplinary collaboration and long-term sustainability. This will contribute to the successful operation of partnerships, which could in turn have benefits for patients and staff and lead to improved outcomes for poorer and more disadvantaged groups.

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LIST OF ACCRONYMS

GP: General Practice / General Practitioner

GTI: General Theory of Implementation

HJP: Health-justice partnership

ICS: Integrated Care Systems

LASPO: Legal Aid, Sentencing and Punishment of Offenders Act 2012

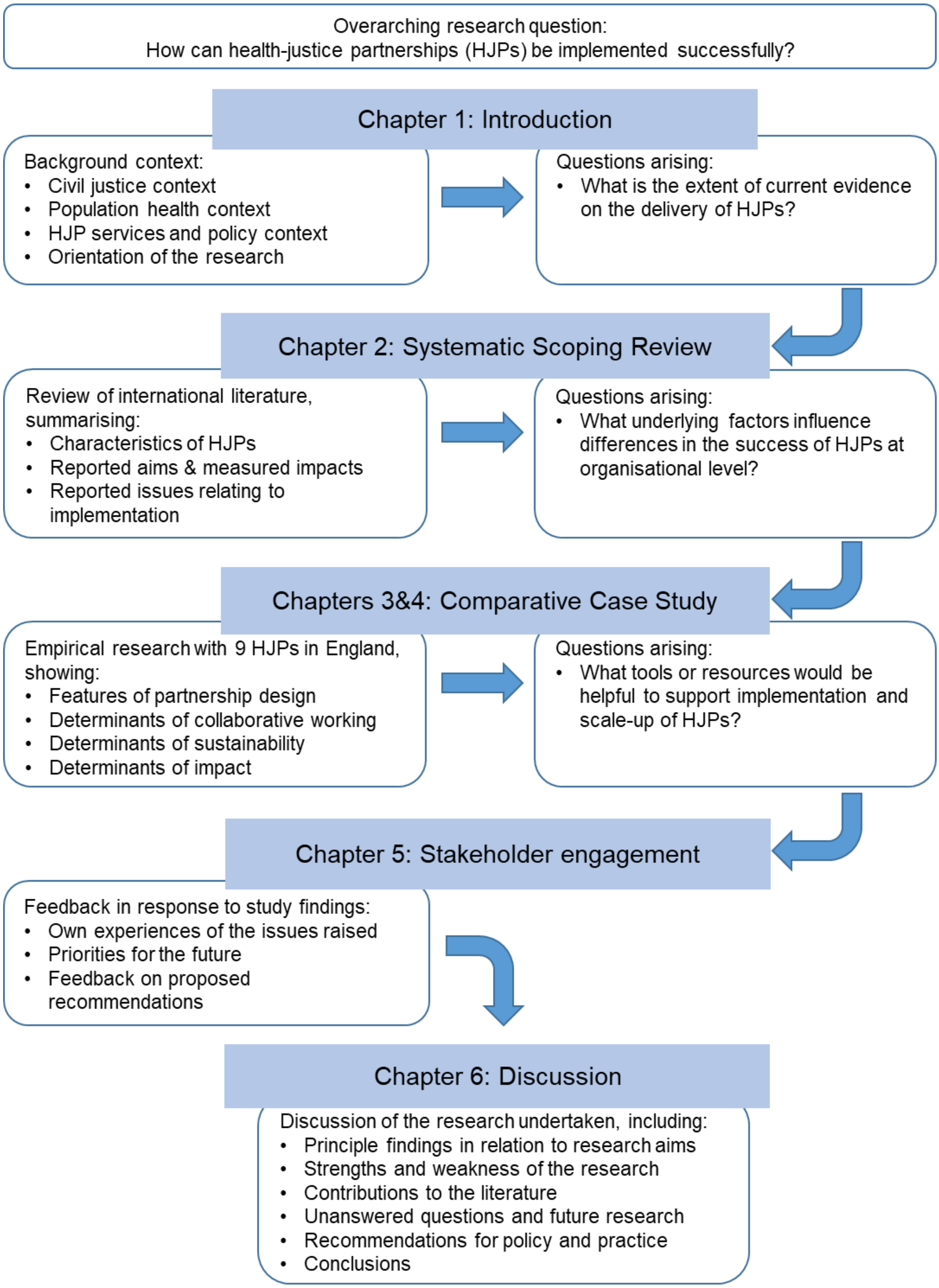
MDT: Multi-disciplinary team

NHS: National Health Service

NPT: Normalisation Process Theory

OECD: Organisation for Economic Co-operation and Development

THESIS OUTLINE



Overarching research question:
How can health-justice partnerships (HJPs) be implemented successfully?

Chapter 1: Introduction

Background context:
- Civil justice context
- Population health context
- HJP services and policy context
- Orientation of the research

Questions arising:
- What is the extent of current evidence on the delivery of HJPs?

Chapter 2: Systematic Scoping Review

Review of international literature, summarising:
- Characteristics of HJPs
- Reported aims & measured impacts
- Reported issues relating to implementation

Questions arising:
- What underlying factors influence differences in the success of HJPs at organisational level?

Chapters 3&4: Comparative Case Study

Empirical research with 9 HJPs in England, showing:
- Features of partnership design
- Determinants of collaborative working
- Determinants of sustainability
- Determinants of impact

Questions arising:
- What tools or resources would be helpful to support implementation and scale-up of HJPs?

Chapter 5: Stakeholder engagement

Feedback in response to study findings:
- Own experiences of the issues raised
- Priorities for the future
- Feedback on proposed recommendations

Chapter 6: Discussion

Discussion of the research undertaken, including:
- Principle findings in relation to research aims
- Strengths and weakness of the research
- Contributions to the literature
- Unanswered questions and future research
- Recommendations for policy and practice
- Conclusions

CHAPTER 1. INTRODUCTION

1.1 OVERVIEW

This PhD investigates health-justice partnerships, which are partnerships between healthcare and legal services that integrate welfare rights advice with patient care. These partnerships exist across the UK and the world. They are established with a variety of ambitions and have potential to achieve a range of impacts for individuals and organisations, which include important goals for both health and legal sectors. This chapter introduces the relevant background in relation to both civil justice and population health issues. It then introduces health-justice partnerships, including the rationale for integrated services, policy context and practice examples. Finally, the chapter presents the aims and focus of the current research, which is concerned with the implementation of health-justice partnerships.

1.2 CIVIL JUSTICE CONTEXT

1.2.1 Civil and social welfare law

The law in England and Wales can broadly be divided into civil and criminal law, which are managed separately in the legal system(Rab, 2021). Criminal law deals with issues of crime and punishment, while civil law is concerned with matters of everyday life and sets out the rights and duties of individuals, companies and the state. This project focusses on social welfare law, which is not itself a distinct subdivision of law, but is a term used to cover laws and regulations that deal with needs, rights (e.g. employment law) and access to services and benefits (e.g. benefits legislation). Social welfare law covers rights and entitlements designed to protect individuals from hardship and ensure a reasonable standard of living. It governs matters relating to welfare benefits (entitlements to social security), debt (management of personal and business debt), housing (housing conditions, homelessness and entitlement to public housing), employment (rights at work and access to redress for unfair treatment), education (including admissions, exclusions and special educational needs), community care (access to care and support services for people with health and social care needs), immigration and asylum (nationality, residency and human rights) and consumer protection (fraud and mis-selling, faulty goods and services) (Advice Services Alliance, 2017; HM Government, 2021b). Social welfare law provides protective rights and entitlements in these areas, ensuring that people can live and work in adequate conditions, have sufficient support when they face hardship, and are treated fairly in their personal and working lives.

1.2.2 Civil justice problems and their distribution

‘Justiciable problems’ are those for which the law provides solutions or some form of remedy(Genn, 1999). National surveys of justiciable problems in civil law have been conducted in England and Wales since the late 1990s(Genn, 1999) and show some consistent patterns in relation to their incidence. Experiencing a civil justice problem is relatively common, with around a third of the population reporting at least one problem in an eighteen month period(Balmer, 2013; Franklyn *et al.*, 2017). However, civil justice problems are not evenly distributed in the population and are more likely to be experienced by certain groups considered more vulnerable to social and economic disadvantage; this includes people who are unemployed, those receiving state benefits, lone parents and those with a long-term illness or disability(Balmer, 2013; Franklyn *et al.*, 2017). People with mental health issues are also more likely to report civil justice problems: data from 2014-15 shows that 52% of respondents with mental health issues reported at least one legal problem compared to 27% of other respondents(Balmer and Pleasence, 2018). Many people who experience civil justice problems have more than one problem at the same time, with estimates showing between 40% and 50% (Balmer, 2013; Franklyn *et al.*, 2017). Certain problem types tend to cluster together and are more likely to co-occur; this includes a prominent economic cluster (welfare benefits, debt, housing and employment issues) and a family cluster (domestic violence, relationships breakdown and divorce)(Balmer, 2013). Again, surveys have shown that the experience of multiple civil justice problems is more common among low-income groups and people considered vulnerable to disadvantage, including those with longstanding limiting illnesses or disabilities. For example, it has been estimated that 47% of those reporting five or more legal problems were ill or disabled(Balmer, 2013).

In relation to social welfare, common justiciable problems include issues with welfare benefits (missing out on entitlements or being wrongfully denied them), problem debt (being unable to pay debts and household bills), housing (being homeless or living in housing in a poor state of repair) and employment problems (having precarious employment or being excluded from the labour market). These issues tend to be experienced in clusters among people who are economically deprived(McKeever, Simpson and Fitzpatrick, 2018) and people who live with multiple forms of disadvantage(Clements, 2020). Additionally, there is a strong association with health. People with longstanding illnesses and disabilities are more likely than others to report problems with welfare benefits and personal debt(Franklyn *et al.*, 2017). Life-limiting illness can lead to the development of social welfare legal problems such as issues with employment and eligibility for income support(Nosowska, 2004; Zevon *et al.*, 2007). It is estimated that almost one in five (18%) people with mental health problems in England are in problem debt (compared with 5% of people without mental health problems) and the likelihood of being in problem debt increases with the severity of mental disorder symptoms(Holkar, 2019).

1.2.3 Legal needs and access to justice

For many people, some sort of advice and/or support about legal rights and entitlements is necessary to put them in the position to pursue legal remedies. A 'legal need' arises when the law cannot be mobilised to address the legal issue and the problem persists or remains unresolved(Genn, 2019).

While exact estimates have varied, surveys consistently show that a large proportion of people (upwards of 40%) do not seek formal advice or representation when faced with civil justice problems, but instead may try to handle the problem alone, seek informal help from family and friends, or do nothing(Genn, 1999; Balmer, 2013; Franklyn *et al.*, 2017; YouGov, 2020). Many do not regard their issues as being 'legal' in nature, instead perceiving them to be 'economic' or 'financial', or put down to 'bad luck' or 'part of life'; this means they are less likely to seek out the necessary legal assistance(Balmer, 2013; Franklyn *et al.*, 2017; YouGov, 2020). Many people are unaware of their eligibility for welfare support unless alerted, including people with life-limiting illness and those experiencing destitution(Nosowska, 2004; McKeever, Simpson and Fitzpatrick, 2018). The anxiety and shame associated with welfare issues can also discourage people from responding to their problems and seeking support(Pereira *et al.*, 2015). Others believe nothing can be done about the problem, are unable to afford the costs of legal advice or feel anxious about legal processes(Genn, 1999).

The most recent legal needs survey showed that of those who try to obtain help, more than one in ten are unsuccessful (13%)(YouGov, 2020). Those who seek help unsuccessfully are more likely to be from ethnic minority backgrounds and those on lower incomes(YouGov, 2020). Low levels of public knowledge and awareness of legal services is one of the barriers to accessing advice. People seek advice on legal issues in a wide range of places, including jobcentres, food banks, local councils or MPs, social workers and healthcare professionals(McKeever, Simpson and Fitzpatrick, 2018). People give up seeking a resolution if they are unaware of available advice services or cannot find relevant information to understand their options(Pereira *et al.*, 2015). There are also practical barriers to accessing advice services, even when these are known of. Legal advice agencies can be inaccessible due to limited opening hours, long waiting times, difficulty getting through on the telephone and uncomfortable physical surroundings(Genn, 1999). Some have limited capacity in terms of appointments or cannot cater for the wide range of legal problems that people in hardship experience(McKeever, Simpson and Fitzpatrick, 2018). Poor health and mobility issues can physically prevent people reaching local advice agencies(Pereira *et al.*, 2015), while poor mental health can reduce the likelihood of people seeking help due to finding it hard to talk about problems or lacking the energy, social support or mental bandwidth(Barnes *et al.*, 2017). Personal and economic resources are also needed to seek help, including enough money to travel, time to invest in the process, access to the internet and printing facilities, and support with childcare among other things(McKeever, Simpson and Fitzpatrick, 2018; Newman, Mant and Gordon, 2021). People experiencing social welfare legal problems are often focussed on surviving the immediate consequences and lack the mental bandwidth to think strategically about problem resolution(McKeever, Simpson and Fitzpatrick, 2018).

More recently, digital exclusion has become a prominent consideration as legal processes are increasingly handled remotely and online. Government reform of the justice system has expanded digital services, including online applications and claims processes, online dispute resolution and remote court and tribunal hearings(The Lord Chancellor, The Lord Chief Justice and The Senior President of Tribunals, 2016). Use of remote services also increased rapidly during the Covid-19 pandemic due to the public safety measures. This has promoted concern about digital equality in access to justice, as people in greatest need are least likely to have access to the necessary technology(Byrom, Beardon and Kenrick, 2020). Remote justice services have created difficulties for people who lack access to IT or are not computer literate, as well as those who need additional support due to illness or disability. Organisations providing free legal advice for social welfare issues report that up to half of their clients would need ongoing digital assistance, as well as legal advice, to access justice online; however, the sector currently has insufficient resources to meet this demand(Sechi, 2020).

1.2.4 Social welfare trends in the UK

The last decade has seen significant developments in the UK welfare system, both due to the austerity measures introduced after the global financial crisis and more recently in response to the Covid-19 pandemic. Since 2012, the welfare system has been undergoing radical reform with the aims of reducing welfare expenditure, simplifying the benefits claim process and encouraging people into paid work(Department for Work & Pensions, 2015). Six working age means-tested benefits are being rolled into a single payment called ‘Universal Credit’. Nationwide roll-out of Universal Credit is still ongoing and is expected to be complete by mid-2024(Brewer *et al.*, 2019). The early stages of the roll-out were marred by practical difficulties with the digital system and strong criticism particularly relating to the five-week wait to receive the first payment(The Comptroller and Auditor General, 2018). Other aspects of the welfare reforms have included an intensified conditionality and sanctioning regime, and changes to assessment and entitlement to incapacity and disability-related benefits(Hudson-Sharp *et al.*, 2018).

The economic situation and policy responses have been reflected in rising rates of poverty and social welfare issues among certain population groups. Problem debt increased in the years following the global financial crisis, with county court judgements more than doubling between 2013 and 2018(Narayan, 2020). This has particularly affected the poorer regions of the country where average wages are low and welfare receipt is high, and can be attributed to low rates of pay growth and cuts in welfare support introduced with austerity(Narayan, 2020). Rates of in-work poverty have increased and household incomes have fallen for people on the lowest incomes in the UK, due to reductions in benefits rates in real terms(Joseph Rowntree Foundation, 2021). There is evidence that the welfare reforms have had many adverse impacts, including increased debt and borrowing, destitution, homelessness and use of food banks(Hudson-Sharp *et al.*, 2018). Families with disabled adults and disabled children have faced the largest financial loss compared to any other household type; other groups disproportionately impacted include women, ethnic minorities and people with mental health conditions(Hudson-Sharp *et al.*, 2018). Research has shown that Universal Credit disproportionately reduces incomes among poorer adults and people in persistent poverty, including those with disabilities(Brewer *et al.*, 2019).

Welfare spending was boosted significantly under the temporary national pandemic support measures, the most significant of which being the Coronavirus Job Retention Scheme and Self-Employment Income Support Scheme. Universal Credit was also given an uplift of £20 per week for all claimants, to provide emergency support for those on the lowest incomes. The number of people on Universal Credit increased rapidly with the onset of the pandemic in March 2020, with a large spike in new claims in the following weeks and months(HM Government, 2021a). Welfare spending is expected to remain higher than forecast before the pandemic, including due to increased need for disability benefits in the population(Office for Budget Responsibility, 2021). Despite the additional support, the pandemic has affected incomes and employment opportunities, particularly for people already in financial difficulty(Bank of England, 2021). At least a quarter of households experienced a fall in income at the beginning of the pandemic, and the impacts have been greater on lower-income households and the self-employed, who were less likely to see their incomes recover during 2020 and 2021(Bank of England, 2021). The legal advice sector has seen an increase in the demand for advice on social welfare legal issues in response to the pandemic, particularly relating to employment and debt problems(Newman, Mant and Gordon, 2021). This demand is likely to continue rising as the economic impacts are felt and interim government support is withdrawn.

1.2.5 Legal services and policy context

A variety of services exist in England to help people secure their rights under social welfare law. These services vary in their level of legal expertise and the extent of assistance they provide. Legal assistance can include giving advice (diagnosing the issue, explaining the options and providing brief help to take action), undertaking casework (challenging decisions, negotiating and corresponding with third parties) and providing representation at courts and tribunals(Advice Services Alliance, 2017). Specialist assistance is offered by some private law firms (profit-making services) for people eligible for legal aid(The Law Society of England and Wales, 2022) and by law centres, which are community-based not-for-profit legal practices that specialise in social welfare law and target their assistance at those least able to pay(Law Centres Network, 2021). Other sources of not-for-profit legal advice include local authority welfare rights units and a wide range of charities, of which prominent national examples include Citizens Advice, Macmillan Cancer Support, Shelter, Age UK and Youth Access. Within the not-for-profit sector, legal assistance is often provided by advisors who are not legally qualified but are specially trained in welfare rights issues.

Funding for not-for-profit legal advice services has historically come from a wide range of sources, including public funding (largely through local authorities, as well as legal aid and other government grants), charitable donations and fundraising, commercial sponsorship and lawyers acting pro-bono(The Low Commission, 2014b). However, since the introduction of national austerity measures, the advice sector has faced an increasingly harsh funding environment. There were significant cuts to government funding for local authorities in the decade from 2009/10, resulting in shrinking council budgets and consequently large falls in service spending(Phillips and Simpson, 2018). This has led to a considerable reduction in the number of welfare rights units, with local authorities increasingly relying on charitable provision(The Low Commission, 2014b).

Simultaneously, the Legal Aid, Sentencing and Punishment of Offenders (LASPO) Act 2012 removed many areas of social welfare law from the scope of legal aid funding, including most welfare benefits, housing, debt employment, and non-asylum immigration law matters(Ministry of Justice, 2012). This reduction in scope led to a corresponding reduction in funding for advice organisations with legal aid contracts, limiting their ability to provide specialist legal help(Organ and Sigafoos, 2018). This impact was felt by charities as well as law centres and private law firms; for example, around half of Citizens Advice services previously held legal aid contracts, and lost around £19 million to fund qualified staff as a result(Organ and Sigafoos, 2018). The deep cuts to both legal aid and local authority funding caused half of all law centres and not-for-profit legal advice services in England and Wales to close in the six years from 2013(Bowcott, 2019). In 2019, it was shown that over half of all local authorities in England and Wales were 'legal aid deserts' in relation to housing, having not a single legal aid contract to provide advice for people facing eviction and homelessness(The Law Society of England and Wales, 2019).

Studies on the impacts of LASPO have shown that more disadvantaged and marginalised groups have been affected disproportionately. This pattern is particularly marked in relation to people experiencing mental health conditions: half (50%) of people facing legal problems removed from legal aid scope had mental health problems, a far higher proportion than among those facing civil legal problems more generally (36%), or the population as a whole (18%)(Balmer and Pleasence, 2018). Other groups experiencing negative impacts to a greater extent included migrants and refugees, children and young people, people with learning disabilities and those with serious illness(Amnesty International, 2016; Youth Access, 2018). An enquiry into the impacts of LASPO by the Justice Select Committee concluded that the act had harmed access to justice(House of Commons Justice Committee, 2015). There was an underspend in legal aid following the reforms (particularly in social welfare matters) because eligible people were not able to access it; contributing factors included lack of public information, a dysfunctional telephone gateway for debt advice, as well as reduced capacity of legal services.

Following a post-implementation review of LASPO, the government published its plan for the future of publicly funded legal services, which emphasized the importance of supporting early resolution of legal problems by embracing new technology and thinking innovatively about how to improve service delivery(Ministry of Justice, 2019). The proposals included piloting and evaluating digital products and approaches, as well as holistic legal support hubs in community settings, in order to improve efficient access to legal assistance.

1.3 POPULATION HEALTH CONTEXT

1.3.1 Law as a social determinant of health

The World Health Organization defines the social determinants of health as ‘the conditions in which people are born, grow, live, work and age’, which are themselves driven by social, economic and political power(Commission on Social Determinants of Health, 2008). These conditions strongly shape the health of individuals and populations. While often the term is used in relation to individuals’ ability to adopt health-promoting behaviours, a large body of evidence now shows that health outcomes are fundamentally determined by socioeconomic factors (‘the causes of the causes’)(Braveman and Gottlieb, 2014). There are significant differences in health (both mental and physical) across population groups, which consistently follow a social gradient. The Marmot reviews demonstrated that the lower a person’s social position, the worse their health: the most deprived people died on average between seven and ten years earlier than the least deprived (Marmot *et al.*, 2010; Marmot, Allen, Boyce, *et al.*, 2020). Following a similar pattern, the rates of poor mental health increased with each deprivation quintile(Marmot *et al.*, 2010).

Heath status across a wide range of indicators is associated with early childhood development and education, employment and working conditions, housing and neighbourhood conditions, standards of living, and the ability to participate equally in the benefits of society(Marmot *et al.*, 2010). Rates of common mental disorder are associated with low income, material disadvantage, unemployment, low educational attainment and social isolation, as well as individual demographic characteristics(World Health Organization and Calouste Gulbenkian Foundation, 2014). Exposure to conditions that are disadvantageous to health starts before birth and accumulates throughout life, with patterns emerging before age five in relation to emotional and behavioural difficulties(World Health Organization and Calouste Gulbenkian Foundation, 2014). Inequalities in health result from the compounding effect of multiple forms of disadvantage(Commission for Equality in Mental Health, 2020).

The central importance of law within the social determinants of health is rarely recognised within public health discourse(Genn, 2019). Yet the law is a powerful tool for public health and safety, governing strong and equitable health systems, enforcing public goods such as clean air and water, and regulating consumption of alcohol, tobacco and foodstuffs(Genn, 2019; Gostin *et al.*, 2019). It also plays an essential role in shaping social and economic circumstances, by embedding formal rights within legislation such as entitlements to basic provisions, services and social protection(Commission on Social Determinants of Health, 2008). As outlined above, social welfare law specifies rights that largely concern the needs of low income and disadvantaged groups, and as such has the power to remedy health-harming social and economic situations. At the individual level, the law can be used to secure needed welfare benefits, manage debts, avoid homelessness, prevent loss of employment and ensure access to appropriate education for people with special educational needs and disabilities.

1.3.2 Impacts of welfare rights issues on health

People experiencing civil legal problems commonly develop mental and physical health problems as a result. One survey showed that stress-related illnesses and other mental health consequences were reported by a fifth of adults experiencing a legal problem; and specifically, benefits and employment problems led to stress or other mental health issues for 30% and 28%, respectively (Franklyn *et al.*, 2017). Another estimated that benefits, debt, employment and rented housing problems all led to adverse consequences for health and wellbeing on more than 40% of occasions(Balmer, 2013). A nationally representative survey found that that both low income and debt were associated with an increased risk of mental illness, but that the effect of income was largely mediated by debt(Jenkins *et al.*, 2008). People report a range of physical and mental health conditions due to their debt experience, including insomnia(71%), low energy(70%), headaches(66%) and physical pain(42%)(Paparella, 2015) and that experiencing debt leads to new and increased use of antidepressants and other medications(Royal Society for Public Health, 2018). According to the 2014 Adult Psychiatric Morbidity Survey, people experiencing problem debt are three times more likely to have considered suicide compared to those not in problem debt (13% and 4% in the last year, respectively) and 23% of those attempting suicide in the last year were in problem debt(Bond and Holkar, 2018).

A wide range of evidence demonstrates that safe, warm and stable housing is critical to health across the life course(Parliamentary Office of Science & Technology, 2018). Children growing up in poor housing conditions are more likely to have mental health problems and respiratory problems, to contract dangerous infections like meningitis and tuberculosis, and to have poorer learning and development outcomes(Harker, 2006). Housing instability in childhood is associated with an increased risk of health problems in later life, including poorer overall health, psychological distress and harmful health behaviours (smoking, heavy drinking and drug use)(Brown *et al.*, 2012). Homelessness impacts on both mental and physical health: homeless people have severely reduced life expectancy, with mortality ratios many times higher than the general population for death by alcohol, drugs, suicide, HIV and hepatitis, respiratory diseases, heart attacks and falls(Thomas, 2012).

Population-level evidence has shown the harmful health effects of welfare reforms. Following the UK government's cuts to housing benefit in 2011, symptoms of depression increased significantly among people affected by the changes, compared to a control group of private renters not receiving the benefit(Reeves *et al.*, 2016). Starting in 2010, a UK programme began to reassess the work capability of all recipients of out-of-work disability benefits. An ecological study of the impacts of this programme over the following three years found that for each 10,000 people reassessed in each area, there were approximately an additional 6 suicides, 2700 cases of reported mental health problems, and the prescribing of an additional 7020 antidepressant items(Barr *et al.*, 2016). The reassessment process was associated with the greatest increases in these adverse mental health outcomes in the most deprived areas of the country, because of greater numbers of people in receipt of disability benefits. A quasi-experimental study on the roll-out of Universal Credit showed that the prevalence of psychological distress increased significantly among eligible people at the time the new benefit was introduced, compared to those not eligible(Wickham *et al.*, 2020). Claimants have reported the transition to Universal Credit causing significant levels of mental distress, to the point of experiencing suicidal thoughts(Cheetham *et al.*, 2019).

1.3.3 Mechanisms of health impact

Welfare problems can impact health directly through acute mental distress, and in the longer term through the effects of chronic stress, poor living conditions, unhealthy behaviours, social isolation and reduced engagement and compliance with healthcare.

Financial and economic difficulties can lead to fear and anxiety, lack of hope for the future, increasing despair, diminished self-esteem and a sense of worthlessness (Barnes *et al.*, 2016; Bond and Holkar, 2018). A survey of people experiencing debt showed that more than half of respondents agreed with the statements "I feel scared" and "I am not worth much as a person" all or most of the time(Paparella, 2015). These mental health effects can trigger self-harm and suicidal behaviour(Barnes *et al.*, 2016; Bond and Holkar, 2018). Engaging with intimidating and bureaucratic welfare processes, such as assessment panels and tribunals, can also cause extreme anxiety(Shefer *et al.*, 2016). Explanations for the mental health impacts of welfare reform may include stress associated with loss of income, the claims process, and intensified conditionality and sanction regimes(Craig and Katikireddi, 2020). Chronic stress leads to elevated levels of stress hormones, which have a harmful effect on physical health in the long term(Webster Marketon and Glaser, 2008; Kyrou and Tsigos, 2009).

Income reductions due to welfare cuts can require people to reduce their spending on essential food and utilities, leading to poorer nutrition and negative effects on physical health from cold homes(Moffatt *et al.*, 2016; Shefer *et al.*, 2016). The stress and worry associated with debt affects health behaviours, causing people to smoke and drink more, do less exercise, eat and sleep poorly and take illegal substances(Royal Society for Public Health, 2018). Debt also affects social wellbeing by causing isolation, preventing people participating in social activities and negatively affecting family life(Royal Society for Public Health, 2018). It has been hypothesised that economic adversity reduces ‘mental bandwidth’, meaning people are focussed on immediate coping strategies and less likely to make decisions in their long-term interests such as adopting healthy behaviours and engaging with preventative healthcare(Mullainathan and Shafir, 2013).

Harmful effects of housing conditions can occur through excess cold, damp and mould, poor air quality, physical risks and accidents, overcrowding and lack of space(Parliamentary Office of Science & Technology, 2018). Homelessness can impact on health through poor sleep, inadequate diet and hygiene, and vulnerability to health-harming behaviours(Thomas, 2012).

Welfare problems also impact people’s ability to access and utilise treatment; in a survey of mental health practitioners, 87% reported that welfare problems force clients to cancel or miss mental health appointments; 84% said that welfare problems make clients struggle to complete their mental health treatment, and 86% thought that clients struggle to recover over a course of treatment due to welfare issues(Fairak, 2018). Experiencing debt can also make it harder for people to access needed healthcare, due to being unable to take time off work or afford transport to get to appointments(Royal Society for Public Health, 2018).

1.3.4 Impacts of welfare rights issues on health services

In the opposite direction to that described above, health problems can create legal needs and have significant impacts on individuals’ financial and wider life circumstances. Recent analysis of the Understanding Society survey showed that the diagnosis of a long-term condition can reduce economic security due to needing reduced working hours, more flexible working, or to leave work altogether(Webster and Morrison, 2021). Living with health conditions in the long term can reduce economic security as a consequence of unemployment, reliance on low-paid and insecure work, or on welfare benefits(Webster and Morrison, 2021). A study by Macmillan Cancer Support found that more than 80% of people with cancer were affected financially, on average incurring costs of £570 a month(Macmillan Cancer Support, 2013). Research has also shown that people with mental health problems face financial disadvantage due to reduced employment prospects (in part due to discrimination and inflexibility among employers), and being in lower-paying work and on low level benefits(Bond and D'Arcy, 2020).

People needing welfare support because of illness and disability often turn to health professionals for assistance, who are increasingly asked to provide medical information for welfare claims and to appeal against removal of benefits(Iacobucci, 2014b). GPs report spending around a fifth of their consultation time (19%) on social issues that are not principally to do with health(Caper and Plunkett, 2015). Welfare-related workload has increased due to recent welfare reforms, as doctors have seen an increase in the numbers of people presenting to them with problems connected to housing, unemployment and debt(Iacobucci, 2014b, 2014a). This welfare-related demand can take health professionals away from their clinical roles and add to workloads and stress levels(Fairak, 2018; Afolabi *et al.*, 2021). Welfare problems can also impact on engagement with care, affecting patients' ability to attend appointments and complete their course of treatment(Fairak, 2018).

The health symptoms caused by civil justice problems also drive patient presentations and pressure on health services. It has been estimated that 80% of people experiencing physical health consequences and 26% of those experiencing stress-related ill health sought medical treatment (including from GPs, hospitals, mental health services and others), with significant financial costs for the health service(Pleasence, Balmer and Buck, 2008). A survey of people experiencing debt problems showed that 47% had visited their GP as a result of mental or physical health problems caused by their debts; a further 6% had visited hospital and 5% had visited an Accident & Emergency department(Paparella, 2015). Recent changes to the welfare system have led to a steady stream of patients with mental health issues triggered or made worse by their financial circumstances(Arie, 2018). In a survey of chairs and chief executives of mental health trusts, almost all respondents (92%) reported that changes to the benefits system and the introduction of Universal Credit were increasing demand, alongside other issues such as financial hardship and homelessness(NHS Providers, 2019). This means that staff capacity is diverted into supporting service users with greater numbers of non-clinical issues such as negotiating the benefits system. Problems with housing and benefits can prolong hospital stays by preventing discharge(Afolabi *et al.*, 2021).

1.3.5 The role of health services in addressing welfare issues

When patients develop social welfare legal needs due to their health condition, many do not receive appropriate legal assistance or experience significant delays obtaining it. An early study in this area found that a third of patients receiving regular home visits from primary care professionals were entitled to, but not receiving, welfare benefits(Jarman, 1985). Subsequent studies have shown that patients can experience significant challenges accessing appropriate and timely legal assistance. Lack of awareness about welfare rights is common, with patients not knowing what support they are entitled to(Chapple *et al.*, 2004; Nosowska, 2004; Moffatt, Noble and Exley, 2010). Some do not know where to start with the welfare claims process and have difficulty navigating the available information(Close *et al.*, 2021). These barriers can lead to patients not claiming their entitlements or waiting months or years before doing so(Chapple *et al.*, 2004; Nosowska, 2004; Close *et al.*, 2021). Failure to alert patients to possible entitlements, or signpost to advice services, can result in significant loss of potential income and unnecessary hardship for patients(Nosowska, 2004). Health professionals are well placed to detect people experiencing social welfare issues, and report that many problems presenting initially as physical or mental health complaints are in fact underpinned by social difficulties including with welfare benefits, housing and employment(Popay *et al.*, 2007). Facilitating access to advice can therefore be considered appropriate to their role, particularly where lack of such advice is detrimental to health(Jarman, 1985; Nosowska, 2004).

However, research has shown barriers to such action. A study in mental health settings found that 61% of people accessing mental health services who were in financial difficulty were not asked about it, partly because mental health practitioners lacked confidence to raise financial issues with patients, feeling they would be sensitive and private matters(Clarke, 2017). Many patients were also reticent to raise financial issues due to embarrassment or feeling the mental health team could not help, did not have time or would not care(Clarke, 2017). The issues needed specialist knowledge to resolve, but a minority of health services had in-house advice services, so were unable to respond in an integrated way(Popay *et al.*, 2007; Caper and Plunkett, 2015). Mental health practitioners also reported having difficulty identifying appropriate advice services that would be accessible to people with mental health problems and able to provide specialist and tailored support, particularly in the context of public service cuts where advice service capacity is limited(Clarke, 2017).

Recommendations from research in this area propose that practical assistance with welfare rights issues should be made available to patients consistently and at the earliest opportunity in healthcare settings, to meet patient needs and ensure people do not miss out on their entitlements(Nosowska, 2004; Fairak, 2018). Health services can play a role by making existing pathways to support more visible and accessible to patients, as well as commissioning advice services as part of care pathways(Popay *et al.*, 2007). The British Medical Association advises that doctors can contribute to tackling poverty by signposting patients at risk of hardship to non-medical support services(British Medical Association, 2017). The Primary Care Guidance on Debt and Mental Health recommends actions that can be taken by primary care practitioners, including asking people about debt and signposting to advice services, making direct contact with advice agencies to support patients with the process, and offering space on the premises for advice agencies to provide outreach(RCGP & RC PSYCH, 2009).

1.4 HEALTH-JUSTICE PARTNERSHIP

1.4.1 The rationale for integrated services

Partnerships between healthcare and legal services have developed across the world, in response to the close relationships between health and social welfare issues described in the sections above(Regenstein, Trott and Williamson, 2017; Beardon and Genn, 2018; Forell and Nagy, 2019). The rationale for linking service provision focusses on the following main principles:

- Improving access to legal assistance for those in need:

Placing legal services in healthcare settings targets them towards people at a time when welfare assistance may be needed (e.g. due to new or ongoing health issues) and in a location where people may raise or discuss welfare issues (which may otherwise go unidentified and unaddressed). Given that welfare rights issues can be both a cause and consequence of illness, the patient population is more vulnerable to legal need. At the same time, they are less likely to act to resolve legal problems(Bradley, 2011) and may be less capable of accessing advice services due to their illness or caring responsibilities(Moffatt, Noble and Exley, 2010). Integrated legal services therefore facilitate access for those in need of support and also aim to reach people when problems are at an earlier stage and can be more easily remedied(The Low Commission, 2014a).

- Resolving health-harming legal problems:

Social welfare legal problems are significant determinants of health that disproportionately affect more deprived people in society. Because they are underpinned by legal rights and entitlements, the law can be leveraged as a tool to resolve them. Legal assistance works to secure critical entitlements such as adequate benefits and appropriate housing, and to guard against crises such as homelessness, loss of income or employment termination(Genn, 2019).

- Supporting health and wellbeing:

By addressing health-harming social and economic conditions, welfare rights advice services have potential to support and improve health (both physical and mental), through improving social and economic circumstances, reducing stress and anxiety and improving ability to self-care(Allmark *et al.*, 2013). Integrated legal services can remedy existing welfare rights problems that may be impacting on health, avoid escalation of problems that may lead to health issues, and prevent problems developing as a result of poor health(Genn, 2019). By nature, welfare rights advice services assist more deprived groups, and therefore could play an important role in addressing health inequalities(Genn, 2019). Health-justice partnerships can also act at the community and population level by advocating for systemic change to laws and policies which affect the social determinants of health(Teitelbaum, Theiss and Boufides, 2019).

- Supporting health services:

Patients frequently present to health services needing help with welfare issues. These are beyond the expertise of health professionals to manage but can strongly affect health, drive health service use and prevent good engagement with care. Having a partnership with a free legal service means there is a dedicated, in-house service to which health service providers can easily refer, allowing them to respond effectively to patient's needs. This has potential to reduce non-health workload and free up clinical time(Burrows *et al.*, 2011; Fairak, 2018) and support efficient hospital discharge(Afolabi *et al.*, 2021). By supporting health and wellbeing, health-justice partnerships may also reduce the need for (and therefore use of) health services.

1.4.2 Policy context in England

In recent years, health policies have advocated cross-sector collaboration and greater use of non-clinical interventions to promote health, prevent illness, support independence, reduce health inequalities, personalise care and increase the responsiveness of health services to individual needs. This goes a step further than previous policies aimed at improving integration within health services and between health and social care(Department of Health, 2006). The NHS Five Year Forward View and the NHS Long Term Plan emphasised the importance of developing partnerships with voluntary and community sector organisations and working alongside them to promote wellbeing and prevent ill health(NHS, 2014, 2019). The most recent White Paper sets out proposals for Integrated Care Systems (ICS), which will become statutory in 2022. ICSs will support place-based joint working between the NHS, local government, community health services and other partners including the voluntary and community sector, and will have a ‘duty to collaborate’(Department of Health and Social Care, 2021). This approach aims to provide more joined up care for patients and to take more coordinated action on prevention and health inequalities(Department of Health and Social Care, 2021). As part of the personalised care agenda, ‘social prescribing’ has become widespread across England(NHS, 2020). This allows health services to refer to a link worker, who assesses individual needs and connects people with support in the community such as volunteering, arts activities, group learning, gardening, befriending, cookery, healthy eating advice and a range of sports(Buck and Ewbank, 2020). Welfare rights advice services have not been central to the discourse around social prescribing or included systematically in the development of social prescribing schemes, despite the critical nature of services to secure adequate income and housing in the pursuit of addressing health inequalities(Genn, 2019).

Over the last decade, poverty rates have risen and health inequalities have widened, with life expectancy falling in the poorer regions and communities(Marmot, Allen, Boyce, *et al.*, 2020; Rashid *et al.*, 2021). The Covid-19 pandemic has brought health inequalities further into the national consciousness, through a succession of reports showing higher incidence and mortality rates among more deprived and lower income groups(Marmot, Allen, Goldblatt, *et al.*, 2020; Public Health England, 2020; Suleman *et al.*, 2021). Examples across history demonstrate that population health inequalities can be reduced by the actions of governments, through expanding social security safety nets and reducing poverty, improving healthcare access among poorer groups, and enhancing social and political inclusion(Bambra, 2021). In the UK this will require significant progress at the national policy level, however action can be taken immediately to ensure low income groups can secure their rights and benefit from existing legal entitlements(Genn, 2019). The Covid-19 pandemic has increased the levels of legal need in the population and the demand for advice and support with welfare issues; however, the advice sector has limited capacity to meet this need given its already tenuous funding situation(Newman, Mant and Gordon, 2021). It is therefore important that legal assistance is targeted towards those most in need, such as those in poor mental and physical health. Developing health-justice partnerships is a means towards the joint policy goals of improving access to justice and tackling health inequality.

1.4.3 Health-justice partnership services

Health-justice partnerships are diverse in their characteristics, but broad definitions have been proposed to capture the essence of the approach. Health Justice Australia states that health-justice partnerships are 'collaborations to embed legal help into healthcare services and teams'(Forell and Boyd-Caine, 2018). The National Center for Medical-Legal Partnership (the equivalent terminology in the USA) states the medical-legal partnerships 'integrate civil legal aid services alongside health care services'(Regenstein, Trott and Williamson, 2017). While no equivalent organisation represents these partnerships in the UK, a seminal article established that 'health justice partnership broadly describes collaboration between legal and health professionals in which access to free legal support is provided in health settings'(Genn, 2019). For the purposes of this research, the defining feature of health-justice partnerships is that social welfare legal assistance is provided free of charge for patients in the healthcare setting or accessed via the healthcare provider. The legal assistance is provided in-house through a two-way partnership between health and legal services, rather than patients being navigated to external sources of help via linking schemes (which involve no direct communication, coordination or relationships between organisations).

In England, health-justice partnerships have existed for decades with the first published example dating from the early 1980s, which involved a legal service for patients of a psychiatric hospital in South London(Springfield Advice and Legal Representation Project, 1986). Over the years, various studies have been undertaken to identify and describe these partnerships(Bateman, 2008; Parkinson and Butterick, 2015), with the latest evidence from 2018(Beardon and Genn, 2018). These mapping studies have shown that approaches to designing partnerships are diverse: they exist in many health settings, focus on a variety of welfare issues, involve different types of advice provider and utilise different approaches to inter-agency working. For example, some partnerships integrate welfare rights advisors within care teams, offer advice at particular points in the care pathway, use referral systems or simply co-locate services. This diversity reflects the fact that partnerships have been developed bottom-up, in response to local needs and priorities and in the absence of national policy or guidance. Additionally, these studies have highlighted challenges with implementation: prominently, funding is short-term and the turnover rate of projects is high; there can also be significant challenges in getting health and legal teams to work collaboratively in identifying, referring and jointly supporting individuals.

1.5 ORIENTATION OF THE RESEARCH

The passage above highlights the convincing rationale for health-justice partnerships, which have potential to achieve a range of positive impacts that are important to both health and legal sectors. While health-justice partnerships exist across England, there are myriad approaches and clear practical challenges for inter-agency working between healthcare and legal services. There is therefore a need to understand how to approach implementation, in order to successfully deliver and sustain these partnerships and maximise the intended benefits.

1.5.1 Implementation science

Implementation of complex interventions in healthcare

Complex interventions are those that involve several interacting components(Craig *et al.*, 2006). Many things can make an intervention complex; for example, having a number of different elements in the intervention package itself, requiring personal behaviours that are numerous or challenging (in both delivering or receiving the intervention), generating different outcomes for different target populations, operating across groups and organisational levels, or working differently in different settings(Craig *et al.*, 2006). In health service delivery, few interventions are truly simple as they will require new ways of thinking, acting or organising practice: even what may appear to be a simple process will have many moving parts(May, 2013). However, there is a wide range in the complexity in healthcare interventions. Health-justice partnerships are likely to be on the more complex end of the spectrum, involving inter-organisational (and interdisciplinary) communication and collaboration, legal assistance that will vary from person-to-person depending on their needs and circumstances, and therefore likely different outcomes according to the local population and setting.

Implementation is the process of putting a plan, system or policy into action(Cambridge Dictionaries, 2021). Implementation is not an outcome itself, but rather a continuous process in which people act to make things happen, in interaction with other people, processes and contexts(May, 2013). Understanding implementation of complex interventions is important for improving health service delivery: while research continually produces findings that could improve efficiency and effectiveness, change cannot be achieved unless the evidence is adopted into practice(Eccles and Mittman, 2006). Innovations in healthcare are typically slow to spread(Horton, Illingworth and Warburton, 2018) and rarely achieve widespread uptake within health systems due to a variety of practical and social barriers, even where there is robust evidence of their benefits(Greenhalgh and Papoutsi, 2019). There are also challenges with replication, whereby an intervention may work more smoothly or effectively in one setting than another(Greenhalgh and Papoutsi, 2019). This can introduce variation in performance, with implications for the quality of care across the health system(Horton, Illingworth and Warburton, 2018). Understanding implementation is therefore essential in developing widespread, impactful and sustainable services. This is important in the health-justice partnerships field, where the nature of interventions is diverse, geographical coverage is variable and turnover rate is high. Research into implementation is needed to understand what facilitates and inhibits the development, maintenance and impacts of the partnerships.

Implementation research

Implementation research is an interdisciplinary field, and has been defined as ‘the scientific inquiry into questions concerning implementation—the act of carrying an intention into effect, which in health research can be policies, programmes, or individual practices (collectively called interventions)’(Peters *et al.*, 2013). It can consider any aspect of implementation, including processes and outcomes of implementation, factors affecting implementation, and the introduction, spread and sustainability of interventions. The intention of implementation research is to understand what, why, and how interventions work in ‘real world’ settings and to test approaches to improve them(Peters *et al.*, 2013). With this is mind, implementation research has an emphasis on practical application rather than simply on knowledge production.

Given the complex nature of interventions in healthcare settings, research into implementation requires the use of methods that are sensitive to this complexity. A wide variety of qualitative, quantitative, and mixed methods techniques can be used in implementation research, and multiple methods and information sources may be needed to understand an implementation problem(Peters *et al.*, 2013). Implementation studies often explore the effect of context because they seek to understand how interventions work in real world conditions, rather than trying to control for these conditions or remove their influence as determinants(Peters *et al.*, 2013). Context in healthcare can include a wide variety of factors, including the local physical environment and patient group, organisational culture and climate, organisational structures and support, social relations, financial resources and leadership(Nilsen and Bernhardsson, 2019). Implementation studies also tend to focus on generating 'mechanistic' evidence to understand how and why change efforts are effective (or not)(Greenhalgh and Papoutsi, 2019). A 'mechanism' in implementation science has been defined as a 'process or event through which an implementation strategy operates to affect desired implementation outcomes'(Lewis *et al.*, 2020). Mechanisms therefore describe causal pathways for how desired outcomes are achieved(Lewis *et al.*, 2020). Another prominent feature of implementation research is the application of theoretical approaches, which can be used to better understand and explain the reasons for implementation success or failure(Nilsen, 2015). A wide variety of theories, models and frameworks exist for guiding implementation studies or projects(Birken *et al.*, 2017).

Focus of the study

In contrast to much of the implementation science literature, this research does not investigate the uptake of a new innovation: health-justice partnerships have existed for decades and currently operate across the country in many places(Beardon and Genn, 2018). However, there is much variation in existing practice and performance, which provides an opportunity to explore the determinants of implementation success. The research investigates how health-justice partnerships are designed and delivered, and what factors affect successful implementation outcomes (further discussed in Chapter 3 under 'Theoretical framework'). In the primary research study (see Chapter 3 for methodology), the variation between services is used to help identify key causal influences on implementation outcomes.

1.5.2 Aims and research questions

In undertaking this PhD research, I aimed to generate new evidence that could inform the successful implementation of health-justice partnerships. The focus was on generating evidence that could be applied in practice by those working in service delivery, management and policy.

Research question development

The research questions were developed with input from stakeholders. I wrote up a brief research proposal, which included the background to the study and an initial set of research questions (see *Appendix 2A*). This proposal was mailed to six of my existing professional contacts who worked in policy, service delivery and funding of health-justice partnerships in the UK. These stakeholders were invited to respond, commenting on the following questions:

1. How relevant do the questions seem to you overall?
2. How useful do you think the answers would be in practice?
3. If you could choose a priority question from the list, which would it be?
4. Are there any questions that seem less useful or relevant to you?
5. Are there any other questions that you would add to these?

Responses were received from five people. Their feedback indicated that the questions largely seemed useful and relevant, and their comments provided details to help focus them further. For example, the feedback indicated which questions stakeholders found more or less useful, particular issues they would be interested in understanding, and important topics that were potentially missing. The responses were discussed with the study supervision team and the questions were amended in the light of the feedback. The final research questions guiding the study are presented below.

Final questions and objectives

Overarching question: How can health-justice partnerships be implemented successfully?

Sub-questions:

1. What is the extent of current evidence on the delivery of health-justice partnerships?
2. What underlying factors influence differences in the success of health-justice partnerships at an organisational level?
3. What tools or resources would be helpful to support the implementation of health-justice partnerships in practice?

Accordingly, the objectives of the research are:

- To assess the extent of current evidence relating to the implementation of health-justice partnerships
- To explain how successful implementation outcomes are generated (identify generalisable determinants of success)
- To inform the development of outputs to support implementation in practice

1.5.3 Overview of methodology

The overarching question runs as a theme throughout the research, which examines what it means to be successful in implementing health-justice partnerships, and how that success can be arrived at.

Sub-question 1 is investigated in the Systematic Scoping Review (Chapter 2). The review synthesises international literature in the field and explores what is currently known about the delivery of health-justice partnerships, including the service characteristics, impacts and implementation processes.

Sub-question 2 is investigated in the Comparative Case Study (Chapters 3 and 4). The study involves diverse health-justice partnerships across England and uses qualitative interview data. It explores how successful implementation outcomes are generated, by identifying key causal contexts and mechanisms. The study is informed by the General Theory of Implementation (described in Chapter 3), which is used to propose and test potential causal influences.

Sub-question 3 is investigated through a stakeholder engagement event (Chapter 5). The event gathered feedback from stakeholders about their needs and priorities for future activity in the field, and identifies outputs that would be useful to support implementation in practice.

CHAPTER 2. SYSTEMATIC SCOPING REVIEW

2.1 INTRODUCTION

The systematic scoping review was undertaken to map international evidence on health-justice partnerships across a range of topics, to gain broad insight into current research in the field. Previous reviews have focussed on specific geographical regions, have not investigated implementation, or have not used systematic review methods(Abbott, 2002; Adams *et al.*, 2006; Beeson *et al.*, 2013; Martinez *et al.*, 2017). Therefore, this review adopted a broad scope in order to capture the full range of relevant evidence and inform plans for subsequent research.

2.2 AIMS

The review aimed to assess the extent of current evidence on the delivery of health-justice partnerships. The following research questions were explored:

1. What types of services are reported on, that integrate social welfare legal assistance with patient care?
2. What are the reported objectives of the partnerships, and what is the evidence of achievements against them?
3. What is known about the processes and outcomes of implementation? For example, key challenges and facilitating/inhibiting factors.

2.3 METHODS

2.3.1 Scoping review approach

Scoping reviews involve undertaking broad assessments of available evidence in areas where the literature has not previously been characterised(Munn *et al.*, 2018). The method used for this scoping review followed the steps outlined in published guidance (Arksey and O'Malley, 2005; Levac, Colquhoun and O'brien, 2010).

2.3.2 Literature sources

I gathered literature from a wide range of sources using a systematic search strategy. The search covered both academic databases and grey literature sources, shown in *Appendix 1A*. I chose academic databases that covered the fields of medicine, healthcare, public health, policy and law. I also searched the websites of all the organisations known to myself and the supervision team whose work had relevance to the topic; this encompassed the US and Australian national centres for health-justice partnership, legal charities, legal services' networks and public bodies in health, social care and law. Finally, I scanned the reference lists of included studies to identify additional papers that had been cited in relevant literature.

2.3.3 Search terms

I used the following key concepts to develop the keyword search terms: 'social welfare legal advice' AND 'healthcare' OR 'health-justice partnership'. The full keyword search strategy is presented in *Appendix 1B*. I developed the keyword search term combinations in Ovid Medline, and tested the effectiveness of different combinations by checking whether they captured key papers in the field, identified through existing reviews and known authors. I chose the final combination of keywords to maximise the number of relevant records retrieved and applied this search strategy across all the databases. Indexing terms were added to the search in each database, according to their individual systems. Examples of indexing terms used are presented in *Appendix 1C* and included 'Civil rights', 'Legal services', 'Social welfare', 'Health services' and 'Delivery of healthcare'. I used the same keywords individually to search the websites for grey literature.

2.3.4 Inclusion and exclusion criteria

Included publications were limited to those reporting on partnerships within the study scope, as defined in *Table* 2-1. I screened the records according to the selection criteria, presented in full in *Appendix 1D*. I sought literature for the dates January 1995 – December 2018, covering the period since early examples of health-justice partnerships were reported up to the time of study. I limited the publications to those reporting information that was relevant to the research questions of the review. For the peer-reviewed academic literature, I included studies from any OECD country; however, due to time constraints I only searched for grey literature in the regions where this activity was already known to myself and the supervision team (Australia, the United Kingdom and North America).

Table 2-1: Definition of partnerships within scope for the review

	Include	**Exclude**
Areas of social welfare law addressed	Consumer / General contract Community care Debt Education Employment Family Housing Immigration Welfare benefits	Non-social welfare legal issues, for example criminal law
Types of legal assistance provided	First line advice Form filling and letter writing Casework support Tribunal representation	Information or advocacy only (not advice)
Links with healthcare delivery	Physical link (e.g. co-location) Functional link (e.g. via referral pathways, social prescribing schemes, joint commissioning or contracting)	Legal services with no defined link to healthcare service Signposting only between healthcare and legal service

2.3.5 Study selection

After retrieving records from the academic databases, I exported them to Endnote software and removed the duplicates. I selected records for inclusion based on the relevance of the title, followed by the abstract. For publications with relevant abstracts, I sought and assessed the full text versions. Grey literature rarely contained abstracts, therefore the full texts were assessed in the first instance. I recorded the reasons for exclusion during the full text assessment. A second reviewer checked the accuracy of the selection process by repeating the assessment with a random 10% sample of the full texts obtained. We compared results from our separate screenings, and where differences were found they were discussed and a decision made on the publications in question. After identifying what the differences in our processes were, I repeated the original selection to ensure no publications had been wrongfully excluded or included.

2.3.6 Quality assessment

The quality assessment tool I developed for this body of literature is presented in *Appendix 1F*. It was not easy to apply existing tools given the unique combination of disciplines and the diversity of research designs and literature types included. I reviewed quality assessment frameworks to identify quality ratings that could be applied across the papers as a whole; these included frameworks from the medical, legal and interdisciplinary fields(Centre for Evidence Based Medicine, no date; Critical Appraisal Skills Programme, no date; Department for International Development, 2014; Jenkins, Partin and Wise, 2015; Belcher *et al.*, 2016; Mårtensson *et al.*, 2016; Van Gestel, Byland and Lienhard, 2018). Firstly, I listed items from these checklists in full, and excluded any that were too specific to a particular method or discipline. I grouped the remaining items according to their similarity of meaning, and assessed whether they could be applied appropriately to the included papers. This process of reduction resulted in a series of 16 statements relating to the following aspects of the papers: 'Context', 'Methods', 'Reporting', and 'Formal assessments'. I rated each criterion using the following scores: 0 = 'No evidence', 1 = 'Some evidence', 2 = 'Good evidence'. I then summed the scores to give an overall value on the scale of 0 – 34, and converted this to a broader rating category: 0-10=Low, 11-20=Low/Medium, 21-30=Medium/High, 30+=High.

2.3.7 Data extraction

I extracted key information from the final full texts and entered them into a spreadsheet for analysis. The headings I used in the data extraction table were informed by the research questions, to ensure all relevant information was retrieved. Data extraction headings are presented in *Appendix 1E* and include characteristics of the publications and research studies, descriptions of services, reported outcomes and implementation-related information.

2.3.8 Data analysis

I used a narrative synthesis to characterise the literature and summarize key findings of the studies. This method uses a descriptive, text-based approach to synthesise findings from included literature and summarise the current state of knowledge on a topic(Popay *et al.*, 2006). It is appropriate to use in systematic reviews with a wide range of research questions and was the most feasible given the diverse nature of the publications.

Firstly, I examined the characteristics of the literature by charting the basic features of the papers, for example their geographical origin, discipline, publication and study type. I then explored the content of the papers in relation to the research questions of the review:

1. I described the characteristics of the partnerships according to their main design features (target populations, healthcare settings, legal services, service links and shared activities). In the description, I highlighted the diversity in partnerships' design and activities, including any clear geographical variation.
2. I categorised the stated aims/objectives of the partnerships and counted the frequency of each theme reported in the included publications. I summarised data

on the measured outcomes narratively against each objective, presenting the quantity and quality of evidence for each theme.

3. I analysed evidence relating to implementation thematically, using inductive (data-driven) thematic analysis(Braun and Clarke, 2006). A coding framework was developed to represent the content of the literature, ensuring all the relevant detail was captured. This stage was repeated by a second reviewer with 10% of the included articles to ensure a consistent approach to coding. Differences in our coding were identified and discussed, and a final version of the coding framework was agreed.

2.4 RESULTS

Searches of academic databases, grey literature and other sources returned 3,687 records, of which the full text of 469 articles were screened against inclusion and exclusion criteria. The selection process led to a final sample of 118 publications included (*Figure 2-1*). Of these, 77 were primary studies reporting service outcomes and 66 reported evidence on the implementation of partnerships.

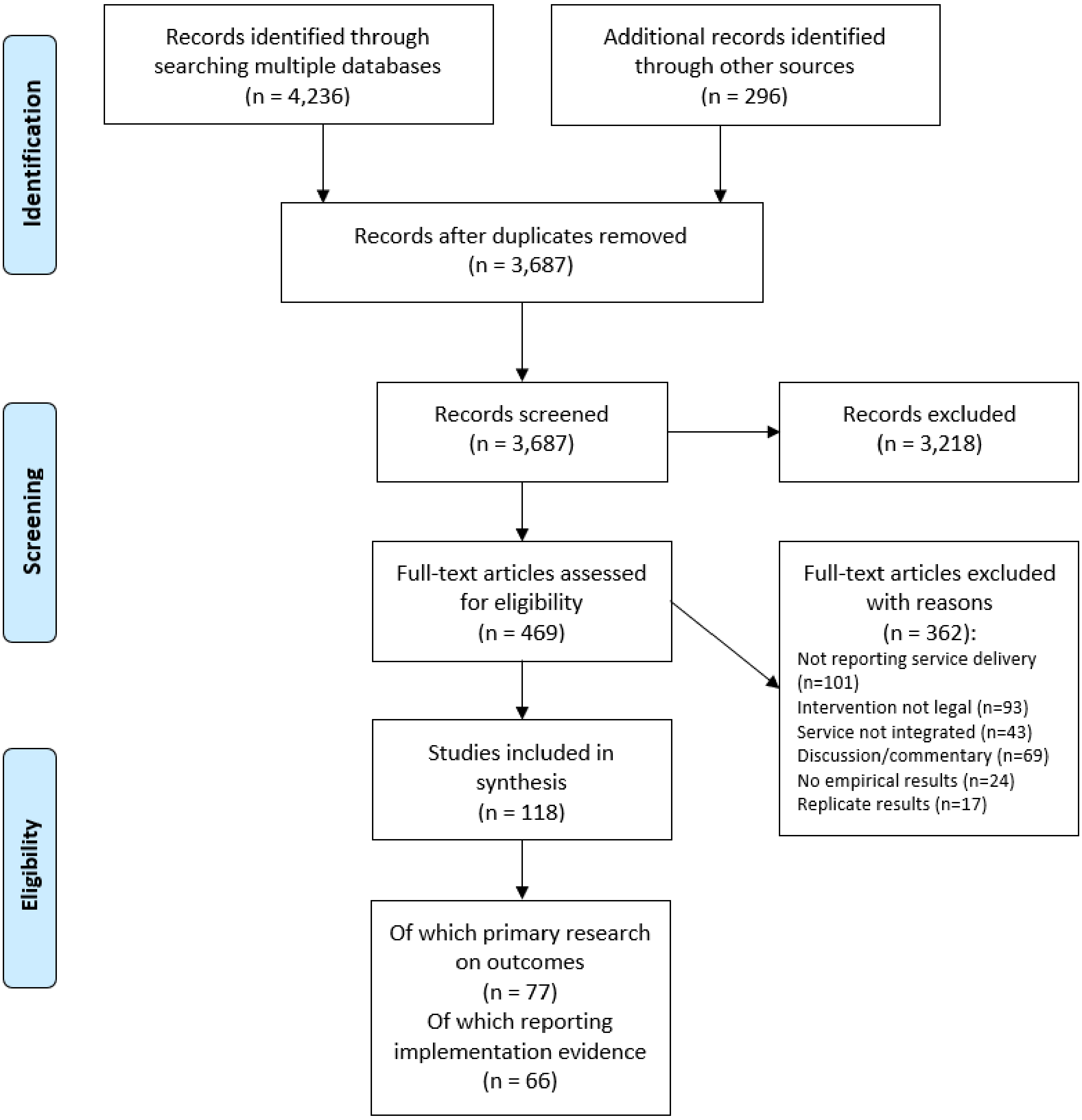
2.4.1 Publication characteristics

Table 2-2 presents characteristics of the included publications. They originated predominantly from the UK (n=60) and USA (n=43). The majority reported primary research studies (n=87) and were published in peer-reviewed journals (n=69).

Table 2-2: Characteristics of included publications

		Count (Total N=118)	%
Country of origin	UK	60	51
	USA	43	36
	Australia	9	8
	Canada	4	3
	Ukraine	1	1
	New Zealand	1	1
Study type	Primary research	87	74
	Descriptive report	23	19
	Evidence review	4	3
	Other	4	3
Publication type	Peer-reviewed journal article	69	58
	Organisational report	42	36
	Other grey literature	7	6

Figure 2-1: Literature search and screening process



2.4.2 Partnership characteristics

Target populations

In all geographical regions there was wide range of target populations, but with a prominent focus on low-income and economically disadvantaged groups. Many of the services were open to any local patient or resident who would benefit from legal assistance. Others focussed on people with specific health conditions such as cancer(Fleishman *et al.*, 2006; Moffatt, Noble and White, 2012), mental health(Frost-Gaskin *et al.*, 2003), physical and developmental disabilities(Powell *et al.*, 2004; Zisser and van Stone, 2015), major trauma(Seligman *et al.*, 2017), asthma(O'Sullivan *et al.*, 2012), those in palliative care(Levy and Payne, 2006; Rodabaugh *et al.*, 2010), with drug dependency and HIV(Carey and Tolopilo, 2008). Some services were provided for specific population groups, such as the young(Jackson *et al.*, 2012), the old(Toeg *et al.*, 2003; Justice Connect Seniors Law & cohealth, 2016), pregnant women(Atkins *et al.*, 2013), ethnic minorities(Moffatt and Mackintosh, 2009), military veterans(Tsai, Middleton, Retkin, *et al.*, 2017) and the homeless(Tsai, Middleton, Villegas, *et al.*, 2017). In the USA it was common to have income eligibility thresholds to access the legal service, commonly having an income at or below 200% of the federal poverty level (twice the poverty line threshold)(Pettignano, Caley and McLaren, 2012; Pettignano *et al.*, 2013; Pettignano, Bliss and Caley, 2014; Rosen Valverde *et al.*, 2018). This was not reported in other regions.

Healthcare settings

Legal services operated in a wide variety of healthcare settings in all geographic regions, as described by national mapping studies. In a survey of 148 health-justice partnerships in England and Wales, half (49%) were in primary care including GP practices and other community health centres; 34% were in mental health services and 34% in hospitals(Beardon and Genn, 2018). A survey of 275 healthcare organisations with medical-legal partnerships in the US showed they were largely hospital-based, with 33% in general hospitals and 17% in children's hospitals; a further third (33%) were in federally-qualified health centres (state-supported primary healthcare services based in underserved communities)(Regenstein, Trott and Williamson, 2017). An Australian survey of 48 health-justice partnerships found that almost half were in hospitals (45%), 29% were in community-based or public health services and 15% in Aboriginal health services(Forell, 2018).

Legal services

Types of legal support ranged from providing legal information and brief advice to more in-depth advice with casework, advocacy and representation at courts and tribunals. In all geographical regions, legal assistance commonly focussed on financial issues (such as income support and debt management) and housing issues (such as homelessness, instability and disrepair). In England and Wales there was a prominent focus on welfare benefits, with 93% of partnerships providing support with this issue(Beardon and Genn, 2018); other common areas were housing (64%), debt (64%), health and community care (52%), employment (52%) and family law (48%)(Beardon and Genn, 2018). Australia and the US had a greater focus on personal stability and family violence issues: 92% of partnerships in the USA provided assistance with personal and family stability(Regenstein, Trott and Williamson, 2017), and in Australia most legal services provided assistance for domestic and family violence (88%), family and civil law issues (77%)(Forell, 2018).

Legal assistance in these partnerships was provided almost entirely by charitable and non-profit organisations. In England and Wales, services were mostly delivered by nationwide charitable organisations (62%) and by welfare rights advisers employed by the health service (15%) and local authorities (3%). Only one example of a private law firm operating this kind of partnership is known in the UK(Eynon, Dinsmore and Dench, 2010). In the US, civil legal aid organisations were the most common legal service providers (71%), followed by university law schools (20%) and other types of organisations including private law firms (9%)(Regenstein, Trott and Williamson, 2017). In Australia, community legal centres (independent non-profit organisations) were most common (68%) followed by legal aid commissions (government-provided legal assistance) (26%) (Forell, 2018).

Service links and shared activities

Co-location was a common means of connecting health and legal services, with nationwide surveys showing that 66% of partnerships in England and Wales and 84% of partnerships in the USA were physically co-located (Regenstein, Trott and Williamson, 2017; Beardon and Genn, 2018). Remote systems also operated, such as having dedicated telephone advice lines for patients and staff of health services(Sherratt, Jones and Middleton, 2000). Some partnerships had integrated services by embedding legal advisers into multi-disciplinary care teams(Atkins *et al.*, 2014; Martin *et al.*, 2015; Beardon and Genn, 2018) or integrating legal assistance into patient care pathways(Parsonage, 2013).

Referrals between the partner services were reported universally, but joint working could involve a range of other activities as presented in *Table 2-3*.

Table 2-3: Examples of collaborative working activities reported in the literature

Partnership activity	**References**
Screening for and documenting legal needs of patients in order to make referrals.	(Hoskins *et al.*, 2005; Parsonage, 2013; Regenstein *et al.*, 2018)
Working together to prepare information for welfare applications.	(Greasley and Small, 2005a; Zelhof and Fulton, 2011; Sinclair, 2017)
Joint case management discussions happening in multi-disciplinary care teams that included both health and legal professionals.	(Noone and Digney, 2010; Beck *et al.*, 2012; Pettignano, Bliss and Caley, 2014; Martin *et al.*, 2015; Justice Connect Seniors Law & cohealth, 2016)
Shared assessments of health and welfare needs and joint management plans.	(Newman, 2012; Gabbay *et al.*, 2017)
Joint clinics, where a patient would see a medical and legal professional together in the same appointment.	(Newman, 2012; Justice Connect Seniors Law & cohealth, 2016)
Inter-professional advice or “secondary consultation”. Most commonly this involved legal professionals providing information regarding social welfare issues to healthcare professionals. This was information they could pass on to patients or use to identify when referrals to legal services would be necessary.	(Noone and Digney, 2010; Zelhof and Fulton, 2011; Gyorki, 2013; Wright *et al.*, 2015; Justice Connect Seniors Law & cohealth, 2016; Forell, 2018)
Welfare rights advisors preparing tools for health professionals to adopt, such as templates for supporting letters.	(Sherr *et al.*, 2002; Gyorki, 2013)
Talks or training sessions for healthcare professionals to raise awareness of legal issues and understand when to refer.	(Lishman-Peat and Brown, 2002; Moffatt, Noble and Exley, 2010; Teufel *et al.*, 2012; Gyorki, 2013; Turik, 2016)

Screening for legal needs was commonly reported in publications from the USA, being undertaken by 84% of healthcare providers with legal service partners(Trott and Regenstein, 2016). Screening was not common in UK partnerships although examples of such systems exist(Hoskins and Smith, 2002; Toeg *et al.*, 2003; Parsonage, 2013) and was not described by studies from other regions.

There were examples of close collaborative working practice, with health and legal professionals working together to address patients’ health and welfare issues in a coordinated way. This included undertaking shared patient assessment and case management(Gabbay *et al.*, 2017), offering joint medical-legal clinics (joint patient consultations) (Newman, 2012), holding joint meetings to discuss cases(Beck *et al.*, 2012; Pettignano, Bliss and Caley, 2014; Martin *et al.*, 2015), and developing joint treatment plans with input from both medical and legal professionals(Newman, 2012; Gabbay *et al.*, 2017). There were also examples of health and legal services supporting each other with secondary consultation (advice between professionals relating to patient/client cases)(Noone and Digney, 2010; Gyorki, 2013; Justice Connect Seniors Law & cohealth, 2016).

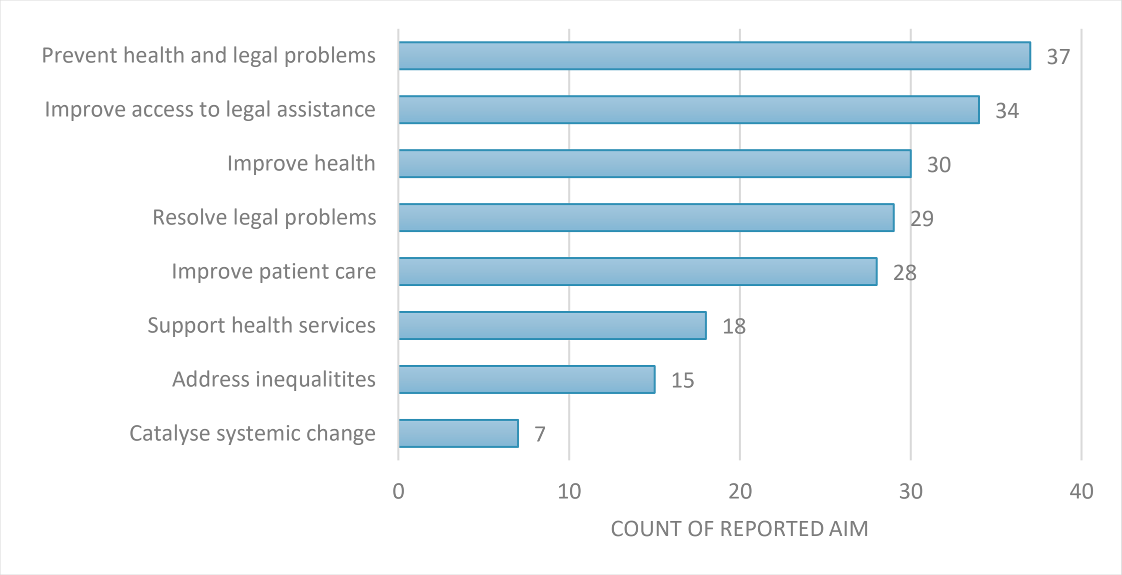
Providing training for healthcare professionals was common in partnerships across the world, aiming to help them identify legal issues and understand when and how to make referrals. Some partnerships run by universities offered inter-disciplinary education and joint clinical training opportunities for students of medicine and law(Robert Pettignano, Caley and Bliss, 2011; Ryan *et al.*, 2012; Klein *et al.*, 2013).

2.4.3 Impacts evidence

Partnership objectives

The reported objectives of the partnerships fell into a number of broad themes, as described below. The prevalence of different objectives reported in the publications is presented in *Figure 2-2*. (Papers often noted multiple aims, therefore the figure total is greater than the overall number of publications).

Figure 2-2: Prevalence of reported objectives



A summary of the aims in each theme is presented below:

1. Prevent health and legal problems: To address underlying causes of ill health (health-harming socioeconomic and environmental factors), prevent ill health and deterioration, provide early legal intervention and prevent crisis situations developing.

2. Improve access to legal assistance: To facilitate access to legal assistance, reach those in greatest need and those who may otherwise have difficulty obtaining legal help.
3. Improve health: To improve health (both physical and mental), improve wellbeing and quality of life, support recovery, alleviate stress and its impact on health.
4. Resolve legal problems: To address legal problems, alleviate poverty and social disadvantage, help enforce rights and improve uptake of welfare entitlements.
5. Improve patient care: To provide a high standard of support, improve integration and fill gaps in care, respond holistically to inter-connected issues through collaborative working, increase knowledge and capacity of services by combining expertise of professions.
6. Support health services: To address non-medical needs of patients, provide a resource for healthcare professionals, free up clinical time, improve efficiency and reduce demand on healthcare.
7. Address inequalities: To reduce social and health inequalities and increase social inclusion by addressing underlying disparities in socioeconomic conditions.
8. Catalyse systemic change: To use legal advocacy to address systemic issues affecting the health of populations.

Measured outcomes

77 publications reported results of primary research assessing outcomes of health-justice partnerships. These are considered in the following narrative synthesis, presented according to the service objectives. Broad characteristics of the 77 studies are presented in Table 2-4 and details of each paper are presented in *Appendix 1G*.

Table 2-4: Characteristics of primary studies reporting service outcomes

Characteristic		Count (N)
Healthcare setting	Primary care	36
	Hospital care	18
	Community care	12
	Multiple	11
Study type	Observational	73
	Experimental	2
	Quasi-experimental	1
	Other	1
Data type	Mixed methods	36
	Quantitative	31
	Qualitative	10
Research design	Retrospective record review	36
	Cross-sectional study	24
	Pre-post follow-up	13
	Modelling	2
	Comparative case study	1
	Unspecified	1
Quality rating	Low	7
	Low/Medium	25
	Medium/High	33
	High	12

Prevention of health and legal problems

Several high quality qualitative studies conducted in the UK primary care context found that additional income gained as a result of welfare rights interventions was commonly spent on settling bills such as fuel payments, and affording more or better quality food(Abbott, 1999; Abbott, Hobby and Cotter, 2006; Moffatt, Mackintosh, White, Howel and Sandell, 2006; Moffatt and Scambler, 2008; Moffatt and Mackintosh, 2009; Burrows *et al.*, 2011). The extra income enabled people to get out more, participate in daily activities and maintain social contact by covering the costs of transport and social activities(Abbott, 1999; Abbott, Hobby and Cotter, 2006; Moffatt, Mackintosh, White, Howel and Sandell, 2006; Moffatt and Scambler, 2008; Moffatt and Mackintosh, 2009) and for some, it enabled access to paid-for health services such as dentistry, eye care and home help(Abbott, 1999; Moffatt and Scambler, 2008; Burrows *et al.*, 2011). Successful welfare claims were a gateway to other forms of non-financial help, such as free prescriptions, respite care, meals on wheels and home modifications(Moffatt *et al.*, 2004). Reduced financial pressure had benefits for personal independence and eased strain on family relationships(Moffatt *et al.*, 2004; Moffatt and Mackintosh, 2009). High quality quantitative surveys of clients accessing welfare rights advice in UK primary care settings found self-reported improvements in knowledge, empowerment and confidence as a result of the interventions(Kite, 2016; Woodhead, Khondoker, *et al.*, 2017). Qualitative evidence reflects this: interview studies identified increased confidence and empowerment resulting from welfare rights interventions(Carey and Tolopilo, 2008; Jackson *et al.*, 2012; Release, 2012; Carrick, Burton and Barclay, 2017), leading to improved ability to use other services(Carrick, Burton and Barclay, 2017), coming off drugs and entering education and training(Release, 2012), being more open with healthcare staff about their situations(Jackson *et al.*, 2012), and being able to focus on their health(Carey and Tolopilo, 2008). A small-scale survey conducted in the USA showed significant reductions in the proportion of families avoiding healthcare for their children due to financial concerns(Weintraub *et al.*, 2010).

Access to legal assistance

High-quality studies conducted in UK primary care found that people referred to advice by healthcare professionals would not otherwise have sought assistance(Galvin, Sharples and Jackson, 2000; Sherratt, Jones and Middleton, 2000; Moffatt *et al.*, 2004). Qualitative evidence showed that healthcare-based provision facilitated access for certain groups such as older people(Sherr *et al.*, 2002; Abbott and Hobby, 2003; Hoskins *et al.*, 2005) and those in poor mental and physical health(Galvin, Sharples and Jackson, 2000; Greasley and Small, 2005a; Carrick, Burton and Barclay, 2017). Studies of service user experiences identified that the healthcare environment was conducive to seeking welfare advice because it felt familiar and trusted, discreet and confidential, less stigmatised, often less far to travel and somewhere people felt comfortable discussing anxieties(Galvin, Sharples and Jackson, 2000; Sherratt, Jones and Middleton, 2000; Sherr *et al.*, 2002; Greasley and Small, 2005a; Burrows *et al.*, 2011). Referrals from primary care staff encouraged help-seeking, legitimising the receipt of welfare assistance as part of a wider holistic approach to care(Abbott, 1999; Sherratt, Jones and Middleton, 2000; Moffatt *et al.*, 2004). The trusting relationship with healthcare professionals facilitated patients' engagement with legal advisers(Sherr *et al.*, 2002; Carrick, Burton and Barclay, 2017; Sinclair, 2017). Studies conducted in UK cancer services highlighted that patients with serious illness may not have the physical or mental strength to pursue legal processes, or may assume they are not entitled to help unless alerted by healthcare professionals(Moffatt, Noble and Exley, 2010; Moffatt, Noble and White, 2012). Quantitative outcomes reflect similar themes: surveys of clients accessing welfare support in UK primary care estimated that 66% would not have accessed assistance had they not been referred by a healthcare professional(Citizens Advice and the Royal

College of General Practitioners, 2018), and that almost half (45-49%) of HJP clients would be unlikely to seek advice elsewhere(Kite, 2016; Fiveways, 2017). Features of the healthcare setting that clients rated ‘very important’ to them included closeness (78%), a place they trusted (80%), a place they knew (73%), and that it was anonymous (43%)(Kite, 2016). In a USA paediatric hospital setting, 85% of clients had not used legal resources before accessing the service, and 79% had not been aware of legal resources(Weintraub *et al.*, 2010).

Health improvement

Experimental studies of health outcomes had only been conducted in the UK primary care setting: two papers reported pilot randomised controlled trials, of which one was insufficiently powered for statistical analysis(Gabbay *et al.*, 2017). The other found little evidence of any changes over time (at 24 months following the intervention) or differences between intervention and control groups across a range of health, behavioural and psycho-social outcomes; however, study design limitations may have affected the potential to demonstrate change(Moffatt, Mackintosh, White, Howel, Sandell, *et al.*, 2006). A quasi-experimental study explored the effects of co-located welfare rights advice in primary care compared with a propensity score-weighted comparison group(Woodhead, Khondoker, *et al.*, 2017). This study showed an improvement in mental wellbeing among individuals whose situation improved as a result of advice, significant reductions in rates of common mental disorders among women and participants of a Black/Black British ethnicity, and improvements in stress levels.

Uncontrolled prospective studies have been conducted in a variety of settings. In UK primary care, improvements in mental health and emotional role functioning were found where income had increased as a result of financial interventions(Abbott, 1999; Abbott, Hobby and Cotter, 2006). A small-scale study conducted in a hospital setting in the USA showed significant reductions in asthma severity and medication usage for adult asthma patients receiving a housing intervention(O’Sullivan *et al.*, 2012). In a family medicine clinic in the USA, perceived stress among adult patients or carers reduced significantly following receipt of legal assistance, and this change was strongly associated with the level of concern regarding legal issues(Ryan *et al.*, 2012). In veterans’ medical centres in the USA, veterans receiving a greater level of input from legal services showed greater improvements in mental health and general health scores(Tsai, Middleton, Villegas, *et al.*, 2017).

Qualitative studies conducted with patients receiving legal assistance in a variety of healthcare settings internationally have reported reduced feelings of stress and anxiety(Moffatt *et al.*, 2004; Moffatt and Scambler, 2008; Moffatt and Mackintosh, 2009;

Moffatt, Noble and Exley, 2010; Burrows *et al.*, 2011; Jackson *et al.*, 2012), improved mental stability(Moffatt *et al.*, 2004; Burrows *et al.*, 2011), greater peace of mind and reassurance(Moffatt, Mackintosh, White, Howel and Sandell, 2006; Moffatt and Scambler, 2008; Moffatt, Noble and Exley, 2010), hope(Jackson *et al.*, 2012), better sleeping(Moffatt *et al.*, 2004; Burrows *et al.*, 2011), improved wellbeing and quality of life(Moffatt and Scambler, 2008; Moffatt and Mackintosh, 2009) and increased ability to cope with ill health(Moffatt and Scambler, 2008; Moffatt and Mackintosh, 2009). Two papers developed theories of change as to how welfare advice interventions may lead to improved health(Moffatt, Noble and White, 2012; Carrick, Burton and Barclay, 2017). The models in the papers propose that legal assistance brings about improved circumstances (material, financial and practical) which leads to reduced stress and anxiety, improved ability to focus on health and participate in daily life, and ultimately better mental and physical wellbeing. There were fewer indications in the qualitative studies of perceived impacts on physical health. One good quality paper from a UK primary care setting described patients reporting heathier behaviours, including reduction or cessation of smoking, improved diet and physical activity, reversal of weight loss and changes in medication(Moffatt *et al.*, 2004), but no other studies have confirmed these findings.

Resolution of legal problems

Two studies have assessed legal outcomes against a comparison group, both focussing on welfare rights interventions in the UK primary care setting; they found significantly greater improvements in financial strain(Woodhead, Khondoker, *et al.*, 2017) and financial vulnerability(Moffatt, Mackintosh, White, Howel, Sandell, *et al.*, 2006) in the following months for people receiving the intervention. Studies conducted in a variety of settings have highlighted high success rates for legal assistance in obtaining welfare support and increasing the incomes of recipients(Abbott, 1999; Frost-Gaskin *et al.*, 2003; Langley *et al.*, 2004; Abbott, Hobby and Cotter, 2006; Levy and Payne, 2006; Moffatt and Scambler, 2008; Moffatt, Noble and White, 2012). Internationally, reports consistently showed significant amounts of money were received as a result of legal assistance, as lump sums and regular ongoing contributions to income (Sherratt, Jones and Middleton, 2000; Hoskins and Smith, 2002; Reading, Steel and Reynolds, 2002; Frost-Gaskin *et al.*, 2003; Toeg *et al.*, 2003; Langley *et al.*, 2004; Powell *et al.*, 2004; Greasley and Small, 2005b; Hoskins *et al.*, 2005; Levy and Payne, 2006; Moffatt, Mackintosh, White, Howel and Sandell, 2006; Moffatt and Scambler, 2008; R. Pettignano, Caley and Bliss, 2011; Moffatt, Noble and White, 2012; Teufel *et al.*, 2012; Sinclair, 2017). Other financial outcomes included preventing benefits stoppage(Frost-Gaskin *et al.*, 2003), managing debts(Reading, Steel and Reynolds, 2002; Sinclair, 2017), reducing use of credit cards(Woodhead, Khondoker, *et al.*, 2017) and obtaining access to healthcare insurance(Rodabaugh *et al.*, 2010; Pettignano *et al.*, 2013). Qualitative research has highlighted the importance of this financial assistance in easing difficult situations and helping to mitigate the financial consequences of illness(Moffatt *et al.*, 2004; Moffatt, Noble and White, 2012). Other legal issues resolved successfully through HJP interventions internationally included housing circumstances and homelessness(R. Pettignano, Caley and Bliss, 2011; Beck *et al.*, 2012; Klein *et al.*, 2013; Pettignano *et al.*, 2013; Woodhead, Khondoker, *et al.*, 2017), education(R. Pettignano, Caley and Bliss, 2011; Beck *et al.*, 2012; Klein *et al.*, 2013; Pettignano *et al.*, 2013), family stability(R. Pettignano, Caley and Bliss, 2011; Pettignano *et al.*, 2013), employment(R. Pettignano, Caley and Bliss, 2011), wills and power of attorney(Teufel *et al.*, 2012), utility shut-offs(Taylor *et al.*, 2015) and food supports(Weintraub *et al.*, 2010; R. Pettignano, Caley and Bliss, 2011).

Improvement of patient care

Feedback gathered from project staff in a variety of international settings suggests that health-justice partnerships provide a more rounded service for patients, addressing interconnected health and welfare issues in a comprehensive way(Fleishman *et al.*, 2006; Bateman, 2008; Burrows *et al.*, 2011). Partnership working between health and legal services helped to resolve issues affecting health and wellbeing and was felt to make a positive contribution to patient care(Galvin, Sharples and Jackson, 2000; Hernández, 2016). Patients reported valuing the continuity of support, familiarity and personalised service(Burrows *et al.*, 2011). Those with serious illness felt that proactive assistance with social welfare rights issues was an important part of non-medical care, and should be made available to support patients(Moffatt, Noble and Exley, 2010). Studies reporting views of clinicians have highlighted that being able to offer legal support can improve patients' confidence and trust in the health service and contribute to stronger doctor-patient relationships(Fiveways, 2017; Sinclair, 2017).

In the USA where access to health insurance is not universal, legal services had obtained insurance cover for patients and intervened against complex insurance denials, thereby facilitating access to needed healthcare(Rodabaugh *et al.*, 2010; Pettignano *et al.*, 2013). A qualitative study from the Ukraine found that providing legal assistance in harm reduction services for drug users led to increased engagement with preventative healthcare among this group(Carey and Tolopilo, 2008).

Support for healthcare services

Studies had investigated whether health-justice partnerships could reduce pressure on health services by reducing care utilisation. The only experimental study investigating this outcome did not have sufficient statistical power to show significant changes(Gabbay *et al.*, 2017). A quasi-experimental controlled study found no significant changes in primary care consultation rate in response to a welfare rights intervention in the UK(Woodhead, Khondoker, *et al.*, 2017). Evidence from uncontrolled follow-up studies did not show a consistent pattern: two studies suggested reductions in service use, in response to a housing intervention for asthma patients delivered in a hospital setting in the USA (O'Sullivan *et al.*, 2012) and welfare rights advice delivered in a UK primary care context(Palmer *et al.*, 2010). However, others have found no significant changes, including in response to welfare rights advice in UK primary care(Abbott, 1999) and legal assistance for low income families in a children's hospital in the USA(Weintraub *et al.*, 2010). One study identified instances of earlier discharge from a UK hospital: financial awards had enabled patients to secure suitable accommodation and necessary care packages to return home from intensive care(Eynon, Dinsmore and Dench, 2010).

Health-justice partnerships focusing on patient access to health insurance in the USA have been found to generate significant sums of money for hospitals through health insurance reimbursements(Thorne, 2008). This supports return on investment by the healthcare partner and allows patients to engage with preventative health care, reducing the likelihood of future health emergencies(Thorne, 2008).

High quality studies exploring perspectives of healthcare professionals in the UK and Canada report that partnerships with legal services can be a beneficial resource to support them in their work: clinicians reported that these partnerships provide an opportunity to address patients' non-medical issues outside their expertise(Abbott, 1999; Greasley and Small, 2005a; Burrows *et al.*, 2011; Carrick, Burton and Barclay, 2017) and that this was potentially time-saving as it meant they did not have to address legal issues themselves and could focus on individuals' health and care needs(Greasley and Small, 2005a; Burrows *et al.*, 2011; Jackson *et al.*, 2012; Carrick, Burton and Barclay, 2017). Healthcare professionals have been found to report better job satisfaction as a result of partnerships with legal services, due to feeling able to perform their role more effectively(Carrick, Burton and Barclay, 2017) and feeling satisfied at providing a good service for patients(Abbott, 1999; Greasley and Small, 2005a; Jackson *et al.*, 2012).

Addressing inequalities

Studies had not specifically investigated whether health-justice partnerships were effective in reducing health or social inequalities. One study investigated differential mental health outcomes across gender, ethnicity and health status; it found that women and participants of a Black/Black British ethnicity were particularly likely to benefit in terms of common mental disorders as a result of a welfare rights intervention in UK primary care(Woodhead, Khondoker, *et al.*, 2017). Targeting housebound patients resulted in greater financial benefit for this group than for patients attending surgery-based welfare rights advice sessions(Sherratt, Jones and Middleton, 2000).

Catalysing systemic change

Health-justice partnerships occupy a unique position at the intersection of health and rights(Noble, 2012), which enables them to identify patterns of discriminatory or harmful practices and community-level health risks(Carey and Tolopilo, 2008; Kremer, Lowell and Zolezzi-Wyndham, 2015; Regenstein *et al.*, 2018). Case studies from the USA demonstrate a number of ways in which partnerships have addressed population-level health risks, including through action against landlords to improve living conditions(Beck *et al.*, 2012), changes in legislation that include new health and safety laws(Pettignano, Bliss and Caley, 2014), provision of adequate services for people with disabilities and mental illness(Zelhof and Fulton, 2011), and extra protection for vulnerable groups facing utility shut-offs(Sege *et al.*, 2010). Contributing to court cases, government enquiries and public consultations is another way that partnerships have exerted influence at systemic level. Examples from countries across the world highlight the impact of these activities in contributing to changes in the welfare eligibility laws(Wright *et al.*, 2015), giving voice to vulnerable groups in the legislation process(Release, 2012), informing organisational responses to family violence and elder abuse(Ball, Wong and Curran, 2016) and contributing to human rights work for families and children(Focus Consultants, 2017).

2.4.4 Implementation evidence

Table 2-5 presents the characteristics of the 66 papers presenting information on partnership implementation. They originated predominantly from the UK (n=30) and USA (n=23). Half were published in organisational reports or other grey literature (n=33). The majority of the publications reported primary research (n=44), however information on implementation was more often presented as part of the background project description (n=36) than as a topic of investigation. Analysis of implementation evidence was mostly descriptive, presenting how services were delivered, things that went well or less well with the project, and the factors that seemed to help or hinder partnerships (mostly without specifying in relation to what outcome). Few studies (n=9) had gone beyond this to evaluate implementation and explain underlying reasons for observed success of failure. None drew on implementation theory or used comparative analysis to understand the determinants of implementation success.

Table 2-5: Characteristics of publications reporting implementation evidence

Characteristic		**Count (Total N=66)**	**% (1d.p)**
Country of origin	UK	30	45
	USA	23	35
	Australia	8	12
	Canada	4	6
	Ukraine	1	2
Publication type	Organisational report	33	50
	Academic journal article	29	44
	Other grey literature	4	6
Study type	Primary research	44	67
	Service description	19	29
	Mixed approach	3	5
Study's focus on implementation evidence	Part of project description	36	55
	Topic of investigation	30	45
Analysis of implementation evidence	Descriptive*	57	86
	Evaluative**	9	14
Application of implementation theory	Yes	0	0
	No	66	100

*Describes implementation processes
**Seeks to explain implementation outcomes (observed success or failure)

Information presented in the literature is summarised narratively below, under the following themes: 'Partnership design', 'Resources', 'Management', 'Professional culture', 'Communication', 'Individual factors' and 'Joint working'.

Partnership design

Responsiveness to needs of patients and healthcare professionals:

Customizing the service to local patient and community needs was important, ensuring the partnership was delivering something valuable for both patients and staff (Noone and Digney, 2010; Noble, 2012; Woodhead, Collins, *et al.*, 2017). Partnerships had been planned to meet local needs by prioritizing areas of high deprivation(Arad Research, 2015) and healthcare settings accessed by socioeconomically disadvantaged people(Focus Consultants, 2017). Delivery methods had also been tailored to the needs of target groups, for example by using home visits for housebound patients(Hoskins and

Smith, 2002). Where services have not been based on evidence of need, this has contributed to the failure of partnerships due to low uptake(Bateman, 2008).

To ensure that partnerships were well-used by healthcare professionals, it was important that they were designed in a way that was receptive to staff needs and complemented the way they worked(Citizens Advice and the Royal College of General Practitioners, 2018). Involving staff in the development of partnerships helped identify needed interventions, refine service delivery processes, improve ownership among staff and therefore willingness to engage in partnership working(Sinclair, 2017). Services had been designed in response to pressures on healthcare professionals, such as high levels of welfare demand among patients and the absence of easily accessible advice services(Greasley and Small, 2005b; Abbas, 2007).

Ease of use for patients and healthcare professionals

To get engagement from healthcare professionals, it was important that the referral process be quick and obstacle-free(Turik, 2016) and that engagement did not create unnecessary administrative burdens(Citizens Advice and the Royal College of General Practitioners, 2018). There was some concern among healthcare administrators about the potential workload involved in making appointments and referrals(Greasley and Small, 2005a; Fiveways, 2017). Some projects had also generated additional workload for healthcare teams, such as needing to produce medical evidence for welfare claims(Toeg *et al.*, 2003) or undertaking complex and time-consuming psychosocial assessments, which were potentially unfeasible within standard appointments(Gabbay *et al.*, 2017). While some healthcare professionals felt any additional work was outweighed by the benefits of helping patients(Greasley and Small, 2005a), for less motivated teams this could inhibit engagement(Abbott, 1999; Toeg *et al.*, 2003; Community Sense, 2015).

Healthcare professionals wanted the service to be easy to access for patients (including self-referral where appropriate) and to have easily-accessible information to provide to patients about the support offered(Community Sense, 2015).

Clarity of processes for joint working

When developing a partnership, it was important that the processes for joint working were clear so that staff understood the system and their role within it(Gyorki, 2013). This included developing clear and effective processes for intake, assessment and referral; for example, considering issues such as eligibility, method of referral, who can refer, how appointments will be booked and how information will be shared(Gyorki, 2013; Justice Connect Seniors Law & cohealth, 2016). Professional boundaries and expectations needed to be negotiated early(Justice Connect Seniors Law & cohealth, 2016; Health Justice Australia, 2018) and the roles and responsibilities of healthcare and legal staff in the partnership needed to be clearly delineated, in areas such as confidentiality(Citizens Advice Bureau, 1995) and provision of welfare information for patients(Bird, 1998).

Governance arrangements needed to be established, considering issues such as the nature of the relationship between organisations, shared management structures, obligations, insurance and deliverables(Justice Connect Seniors Law & cohealth, 2016). Health-justice partnerships often involve formalised agreements between the healthcare and legal service providers(Regenstein *et al.*, 2018). Such contracts can memorialize the details of the shared understanding between services and help provide clarity around operational processes(Pettignano, Bliss and Caley, 2014). These agreements outline the defining aspects of the partnership such as joint goals, staffing, privacy and confidentiality protections(Regenstein *et al.*, 2018), eligibility, working practices, evaluation and quality standards(Citizens Advice Bureau, 1995) and the roles and responsibilities of each partner organisation(Pettignano, Bliss and Caley, 2014).

Opportunities for interaction between staff in the partner services

Opportunities for staff in the partner services to get to know each other and work together was important for developing integrated working practices(Noone and Digney, 2010). Co-locating services was intended to create opportunities for informal communication and thereby facilitate collaborative care(Gabbay *et al.*, 2017; Woodhead, Collins, *et al.*, 2017). Physical proximity could encourage relationship building and teamwork(Greasley and Small, 2005a; Noone and Digney, 2010; Justice Connect Seniors Law & cohealth, 2016; Tran, Quintana and Lee, 2016) and make communication easier between professionals(Focus Consultants, 2017; Tsai, Middleton, Villegas, *et al.*, 2017). However, opportunities for interaction were sometimes limited even where services were co-located; for example, due to competing workload(Abbott, 1999; Gabbay *et al.*, 2017), being on-site sporadically(Gabbay *et al.*, 2017), physical separation of services(Woodhead, Collins, *et al.*, 2017) and high staff turnover(Woodhead, Collins, *et al.*, 2017). Regular interaction was important to maintain awareness of the service among healthcare staff(National Suicide Prevention Alliance, 2017). Lack of opportunities for interaction reduced awareness of the service and engagement among healthcare professionals(Abbott, 1999; Woodhead, Collins, *et al.*, 2017).

Resources

Sufficient funding and material resources

Partnerships needed sustainable sources of funding to operate effectively and to scale up more widely(Regenstein *et al.*, 2018). However, they commonly operated under resource constraints and struggled to attract and maintain funding(Carey and Tolopilo, 2008; Regenstein and Trott, 2016). Lack of funding had prevented partnerships from being established(Harding *et al.*, 2002; Parkinson and Butterick, 2015) and failure to secure ongoing funding was a common reason for partnerships to fail(Bateman, 2008; Martin *et al.*, 2015). Across the world, sources of funding for health-justice partnerships were diverse and largely insecure(Regenstein, Trott and Williamson, 2017; Beardon and Genn, 2018). Investment by healthcare commissioners was highly variable(Parkinson and Butterick, 2015) which may relate to legal services not being considered a funding priority, even where their value is recognised(Arad Research, 2015). While these partnerships were innovative in finding ways to operate, funding shortages inhibited their sustainability and ability to plan strategically(Carey and Tolopilo, 2008).

To deliver legal services on-site, confidential space was needed within the healthcare setting(Arad Research, 2015) and obtaining appropriate space could be difficult(Arad Research, 2015; Tran, Quintana and Lee, 2016). Managing demand for the legal services could be challenging where need was high and capacity limited(Bateman, 2008; Tran, Quintana and Lee, 2016). There was concern among some healthcare professionals that the service could become overwhelmed if capacity was insufficient to take on referrals(Community Sense, 2015).

Staff knowledge for joint working

In order for healthcare professionals to engage and refer patients to legal services, they needed to understand the rationale and processes for doing so(Klein *et al.*, 2013). Healthcare professionals wanted to learn about what the legal service could provide, when to make a referral and what was expected of them in their roles(Sherratt, Jones and Middleton, 2000; Palmer *et al.*, 2010). Providing training ensured that healthcare staff could identify legal needs and make referrals appropriately(Bateman, 2008; Gyorki, 2013; Pettignano, Bliss and Caley, 2014; Justice Connect Seniors Law & cohealth, 2016; National Suicide Prevention Alliance, 2017). Some legal services also offered consultancy for healthcare staff, enabling them to deliver basic welfare information to patients and thereby increase the reach and impact of the partnership(Moffatt, Noble and Exley, 2010; Gyorki, 2013; Beardon and Genn, 2018). Some health-justice partnerships had developed interdisciplinary education and training programmes for professionals, trainees and students(Robert Pettignano, Caley and Bliss, 2011; Pettignano, Caley and McLaren, 2012; Klein *et al.*, 2013). These provided theory and practice-based learning for both health and legal disciplines, enhancing skills for inter-professional working and collaborative problem solving(Newman, 2012; Noble, 2012; Klein *et al.*, 2013).

Management

Leadership

Projects were commonly governed by interdisciplinary advisory groups, comprising managers and representatives from the organisations involved, as well as other community stakeholders(Bliss, Caley and Pettignano, 2011; Robert Pettignano, Caley and Bliss, 2011; Klein *et al.*, 2013; Wright *et al.*, 2015; Jones, Bloch and Pinto, 2017; National Suicide Prevention Alliance, 2017). These leadership committees oversaw important projects operations, including service design, development, fundraising, ongoing evaluation and improvement(Pettignano, Bliss and Caley, 2014; Kremer, Lowell and Zolezzi-Wyndham, 2015; Tran, Quintana and Lee, 2016; Turik, 2016; Sinclair, 2017).

Having champions with passion and influence played an important role in developing and maintaining partnerships(Noble, 2012; Klein *et al.*, 2013). Internal project leaders could give the partnership credibility, facilitate introductions and provide guidance in developing the collaboration(Bliss, Caley and Pettignano, 2011). They also played a role in promoting the service internally and facilitating opportunities for communication between staff(Woodhead, Collins, *et al.*, 2017). Closer collaborative working needed to be actively encouraged, in view of differing professional cultures and expectations(Coppel, Packham and Varnam, 1999). Strong management support for the partnership encouraged and enabled staff to engage in the joint activities(Justice Connect Seniors Law & cohealth, 2016; Focus Consultants, 2017). Where there was a lack of top-down support to encourage partnership working, this hindered progress(Parkinson and Butterick, 2015).

Planning

Solid preparation was important for developing partnerships successfully(Noble, 2012). Many factors needed to be considered in the planning process, including project scope, local needs and partner suitability(Noble, 2012), service objectives, roles and responsibilities, resourcing, communication and evaluation(Bliss, Caley and Pettignano, 2011), and practicalities such as eligibility, referral methods and booking systems(Gyorki, 2013). Undertaking a legal needs assessment prior to developing a partnership ensured the service was targeted and appropriate(Gyorki, 2013; Justice Connect Seniors Law & cohealth, 2016). Engaging healthcare teams in the development of the partnership was important to ensure it would work according to their needs, preferences and existing practices(Pettignano, Bliss and Caley, 2014; Turik, 2016; Sinclair, 2017) and contributed to a sense of ownership among practitioners(Sinclair, 2017). Service models needed to be flexible to respond to the often unique needs of each healthcare organisation(Turik, 2016). Partnerships had sometimes started out as pilots, which enabled evaluation and adaptation of the service model and application for further support of successful projects(Abbas, 2007; Teufel *et al.*, 2009; Kremer, Lowell and Zolezzi-Wyndham, 2015).

Evaluation

Evaluation was central to the successful operation of partnerships, contributing to their sustainability by providing evidence of efficacy and value to funders(Lishman-Peat and Brown, 2002; Noble, 2012). Using outcome metrics that reflected priorities for both partner organisations was important for demonstrating the project's worth and justifying continued investment over time(Noble, 2012). Evaluation was also one of the challenges for services, being a complex research task(Beardon and Genn, 2018). Nationwide mapping studies have identified that monitoring practices were variable and many projects collected no data on legal case outcomes(Bateman, 2008; Beardon and Genn, 2018). Lack of research evidence on the health outcomes specifically had affected the ability of health-justice partnerships to gain funding and support from healthcare organisations(Focus Consultants, 2017). Routine monitoring and evaluation was undertaken by services to ensure key quality requirements were met(Citizens Advice Bureau, 1995) and outcomes for patients were secured(Community Sense, 2015). It also helped to determine how well the partnership was working and identify improvements to the service deign and processes(Sinclair, 2017). Providing evaluation evidence to healthcare teams ensured they would understand the work of the legal service and its achievements for their patients(Release, 2012).

Professional culture

Joint goals of collaborating organisations

Developing a clear understanding of shared values and a mutual long-term vision for the partnership was felt to have contributed to the sustainability of inter-agency working(Noble, 2012; Tran, Quintana and Lee, 2016), while a lack of focus about what services to provide had contributed to their failure(Bateman, 2008). Having shared goals also helped to develop understanding, good will and commitment to the partnership among teams(Beardon and Genn, 2018).

Partnerships with legal services had been set up in response to health services recognizing a need to address poverty as a health concern(Pettignano, Bliss and Caley, 2014; Jones, Bloch and Pinto, 2017), to meet non-medical needs among patients(Toeg *et al.*, 2003; Wong *et al.*, 2013; Wright *et al.*, 2015) and to reduce the welfare-related workload on health professionals(Abbas, 2007; Sege *et al.*, 2010). Priorities relating to deprivation and inequality had led public health authorities to develop such schemes(Abbott, 1999; Burrows *et al.*, 2011; Zelhof and Fulton, 2011; Carrick, Burton and Barclay, 2017; Fiveways, 2017). In the US, financial returns from private health insurance claims have been a significant driver of healthcare organisations forming partnerships with legal services(Thorne, 2008).

Strong working relationships

Developing strong working relationships between colleagues was reported to be fundamentally important for successful day-to-day service delivery and could make or break a partnership(Bateman, 2008; Release, 2012; Citizens Advice and the Royal College of General Practitioners, 2018). Effective partnerships had invested substantial time in nurturing relationships both formally and informally, which had built up trust between the teams and opened up opportunities to collaborate(Bateman, 2008). Staff worked well together when they knew and trusted each other(Noone and Digney, 2010; Tran, Quintana and Lee, 2016; Sinclair, 2017). Close working relationships facilitated awareness of the welfare intervention among healthcare professionals(Toeg *et al.*, 2003), produced a regular flow of referrals(Bateman, 2008), encouraged open communication(Tran, Quintana and Lee, 2016) and increased and collaborative working on patients' cases(Greasley and Small, 2005a). Legal services also relied on the goodwill of healthcare professionals for practical matters, such as making room space available in the health setting(Arad Research, 2015). Healthcare professionals could be fearful and suspicious before they understood the purpose and work of the legal service(Bird, 1998; Zelhof and Fulton, 2011). Mistrust or antipathy between legal and health professionals could be a significant issue to overcome(Noble, 2012).

Communication

Dialogue between healthcare and legal professionals

Good communication between the services facilitated integrated working(Klein *et al.*, 2013), while lack of communication was a barrier(Noone and Digney, 2010). Ongoing dialogue between the professionals was central to delivering interdisciplinary collaborative care, which was sometimes the core purpose of the partnership(Zelhof and Fulton, 2011; Gabbay *et al.*, 2017). Regular communication helped healthcare professionals to learn about common legal issues that might affect patients' health or care(Zelhof and Fulton, 2011) and encouraged efficient referrals to the service when urgent issues were identified(Release, 2012). Staying in regular contact enabled discussions to be had about delivery of the partnership, and helped identify what was working well and what needed to improve(Zelhof and Fulton, 2011; Release, 2012).

The absence of a common language could be a challenge, with jargon from the different professions hindering communication(Noble, 2012; Gyorki, 2013). Messaging the work effectively to all stakeholders was therefore important(Noble, 2012). Using language that was familiar to healthcare professionals, and framing the communication in a context they would understand, was helpful in increasing understanding and engagement with the partnership(Gyorki, 2013; Gabbay *et al.*, 2017).

Feedback on referrals to legal advice

Healthcare professionals strongly felt a need for feedback on the referrals they made to the legal service(Greasley and Small, 2005a), which allowed them to check attendance and see how patients were progressing(Bird, 1998; Release, 2012), and to know what to expect if they were contacted about the case(Jackson *et al.*, 2012). Providing feedback highlighted the positive impacts for patients(Greasley and Small, 2005a; Klein *et al.*, 2013), which helped ensure their continued cooperation and support of the project(Bateman, 2008; Arad Research, 2015). It also increased awareness and understanding of the legal service among healthcare professionals, facilitating engagement and referral(Greasley and Small, 2005a; Gyorki, 2013; Pettignano, Bliss and Caley, 2014; Woodhead, Collins, *et al.*, 2017). Where no feedback was received, healthcare professionals were unsure of the value of the partnership(Greasley and Small, 2005a) and this was perceived as a negative issue in partnerships(Bateman, 2008). While potential confidentiality issues were recognised, a basic level of feedback was felt to be warranted and would not compromise patient privacy(Sherratt, Jones and Middleton, 2000; Greasley and Small, 2005a).

Information sharing between healthcare and legal organisations

Sharing of information and data between the partner organisations was often necessary, for example where specific health information was needed to support welfare claims(Palmer *et al.*, 2010), where shared assessments were undertaken(Gabbay *et al.*, 2017), where cases were discussed by interdisciplinary teams or at joint clinics(Pettignano, Bliss and Caley, 2014; Justice Connect Seniors Law & cohealth, 2016) and where legal needs screening systems were in place(Regenstein *et al.*, 2018). Sharing information maximized what could be done for the client, particularly for complex cases(Bird, 1998). It provided advice workers with a comprehensive view of clients' circumstances(Sinclair, 2017), avoided duplication and ensured consistency in addressing clients' needs(Bird, 1998) and helped ensure coordination and quality of care across systems(Justice Connect Seniors Law & cohealth, 2016; Regenstein, Trott and Williamson, 2017).

Confidentiality procedures could restrict collaborative working(Bird, 1998; Noble, 2012). While confidentiality issues were not insurmountable, good policies and procedures needed to be set up to safeguard client privacy(Wong *et al.*, 2013; Ball, Wong and Curran, 2016). Partnerships sometimes negotiated data sharing agreements for this purpose(Regenstein *et al.*, 2018). Sharing of confidential information between organisations could only take place with client consent(Beck *et al.*, 2012; Wong *et al.*, 2013; Pettignano, Bliss and Caley, 2014; Carrick, Burton and Barclay, 2017; Tsai, Middleton, Retkin, *et al.*, 2017).

Individual factors

Awareness of the legal service among healthcare professionals

Healthcare professionals needed to be aware of the legal service in order to engage in collaborative working(Noone and Digney, 2010; Community Sense, 2015). Creating a visible presence meant the legal service was more likely to be considered as part of the care team(Gyorki, 2013; Health Justice Australia, 2018). Where awareness was limited, this resulted in low levels of referrals to the legal service(Community Sense, 2015; Woodhead, Collins, *et al.*, 2017). A number of issues could reduce visibility and awareness of the service, including high rates of staff turnover in health settings(Abbott, 1999; Woodhead, Collins, *et al.*, 2017), use of locum staff(Community Sense, 2015), large numbers of frontline staff and large patient list sizes(Woodhead, Collins, *et al.*, 2017), difficulty getting promotional information to reach frontline staff(Community Sense, 2015) and services being located physically apart(Woodhead, Collins, *et al.*, 2017). Publicising the service was an ongoing requirement to ensure continued engagement(Moffatt, Noble and Exley, 2010; Arad Research, 2015).

Commitment of individuals at all levels

Many reports presented evidence of positive perceptions among healthcare professionals of working alongside legal services(Coppel, Packham and Varnam, 1999; Harding *et al.*, 2002; Pettignano, Caley and McLaren, 2012; Release, 2012; Turik, 2016; Regenstein, Trott and Williamson, 2017; Citizens Advice and the Royal College of General Practitioners, 2018). Healthcare professionals considered the legal service to be a benefit to the care team, undertaking important work which was beyond their own capability(Sherratt, Jones and Middleton, 2000) and contributing expert knowledge of the welfare system which they relied upon in supporting patients(Galvin, Sharples and Jackson, 2000). However, while healthcare professionals generally welcomed and appreciated collaborations with advice services, not all were enthusiastic or committed(Greasley and Small, 2005a; Bateman, 2008). Resistance from some clinicians had prevented co-location of services in medical practices(Arad Research, 2015). Projects had been hindered by staff being unwilling to work together or having competing interests(Noone and Digney, 2010), healthcare professionals not being interested(Abbott, 1999) or not recognizing the value of the advice service to their patients and practice (Parkinson and Butterick, 2015). Reasons for reluctance included not wanting to do the administrative work involved and not thinking it was appropriate to their role to discuss social issues with patients(Abbott, 1999).

Commitment to the partnership within both health and legal organisations was a key facilitator of integrated services(Noone and Digney, 2010; Regenstein *et al.*, 2018). Creating buy-in during the planning process was important in establishing partnerships(Noble, 2012) and developing collective commitment early on ensured potential barriers were efficiently overcome later(Sinclair, 2017). The commitment of leaders and funders was also important for integration of services(Noone and Digney, 2010). Having strategic level support from health authorities helped welfare services to become better integrated and more sustainable, because they were accepted into the healthcare setting(Bateman, 2008; Parkinson and Butterick, 2015; Beardon and Genn, 2018). Funding for partnerships had been turned down where support from healthcare commissioners was lacking(Arad Research, 2015).

Joint working

Engagement and cooperation in partnership activities

Reports cited the importance of collaboration, cooperation and active contribution of both services in making a success of health-justice partnerships(Bateman, 2008; Health Justice Australia, 2018). Partnerships could falter if they did not become part of routine service delivery(Regenstein *et al.*, 2018). Legal services relied on the engagement of healthcare professionals to generate referrals by promoting the service or identifying and connecting patients in need of legal assistance(Abbott, 1999; Jackson *et al.*, 2012; Arad Research, 2015). Gaining and maintaining the engagement of healthcare professionals was one of the greatest challenges for partnerships(National Suicide Prevention Alliance, 2017; Beardon and Genn, 2018). Even where participating professionals were supportive of the project and aspired to work collaboratively, this did not always happen in practice due to factors such as staff turnover, competing workload and staff being located separately(Gabbay *et al.*, 2017; National Suicide Prevention Alliance, 2017; Woodhead, Collins, *et al.*, 2017). Ongoing promotion and reminders were therefore needed to maintain engagement(National Suicide Prevention Alliance, 2017; Woodhead, Collins, *et al.*, 2017).

2.5 SUMMARY

2.5.1 Study overview

The review aimed to assess the extent of current evidence and provide a starting point for further investigation. Using the systematic scoping review approach, I synthesized a broad range of literature from across the world relating to health-justice partnerships. In the results, I firstly described the main characteristics of the services, to explore the diversity of relevant activity and orient the study in the international context. Secondly, I summarised the reported objectives of the partnerships to determine their key ambitions, and assessed the strength of evidence for outcomes against each one; this provided insight into the state of current evidence on the impacts of health-justice partnerships. Lastly, I explored evidence relating to implementation, to identify key issues and factors that may facilitate or inhibit service delivery.

2.5.2 Summary of findings

Service characteristics

The literature demonstrated the diversity and adaptability of health-justice partnerships, which serve a wide range of target populations across many different health settings. There is a prominent focus on poor and underserved communities, with legal assistance being provided by charitable and non-profit organisations. Legal issues commonly centre around financial and housing problems, but can relate to many areas of social welfare law. Legal services can be integrated with patient care in different ways, ranging from simple mechanisms to connect patients (such as co-location and referral) to closer collaborative ways of joint working.

Impacts evidence

The stated aims of the partnerships included: preventing health and legal problems, improving access to legal assistance, improving health, resolving legal problems, improving patient care, supporting health services, addressing health inequalities and catalysing systemic change.

The most consistent evidence for impacts was in relation to the aims of improved access to assistance (reaching more vulnerable groups and those less likely to seek legal help) and resolution of legal problems (leading to improved social and material circumstances). Studies have not examined prevention of ill health as an outcome, though improvements in various social determinants have been identified in addition to the resolution of health-harming legal needs; for example, increased ability to afford fuel and food, improved access to health and care services and greater social participation.

High quality qualitative evidence suggested that individuals experience improvements in mental wellbeing as a result of improved material and social circumstances brought about through legal assistance. However, large or significant changes have not been measured in quantitative studies. In the two randomised controlled trials included, methodological challenges had limited the validity of the results. One high quality quasi-experimental controlled study had been published, which found improvements in mental wellbeing as a result of legal advice among individuals whose situation improved. Other quantitative research on health impacts included uncontrolled prospective follow-up studies that identified improvements in health measures where legal interventions led to improved circumstances; however, without appropriate comparison groups these results were less reliable.

Qualitative evidence showed that integrated legal services could contribute to high quality patient care, providing comprehensive support to address interconnected issues, improving capacity to respond to patient needs and contributing to a positive patient experience. Outcomes for healthcare professionals have also mainly been assessed qualitatively; results highlighted that legal services can be a valued resource, helping clinicians address non-medical issues and allowing them to focus on patients’ health. Evidence for impacts on health service utilisation shows mixed results in both quantitative and qualitative evaluations and demonstrates no consistent pattern.

Only two studies had measured differential outcomes across demographic groups, that may indicate effectiveness on health inequalities: these indicated greater improvements in mental wellbeing among women and people of Black ethnicity, and greater financial gains among housebound patients.

Case studies from across the world show that health-justice partnerships can contribute to law reform and policy change, addressing community-level health risks and bringing about far-reaching changes for the populations they serve. This activity is less commonly reported, but is a powerful tool for promoting population health that utilises their unique expertise at the intersection of health and rights.

Implementation evidence

Information about implementation in the literature was mainly presented descriptively, without clear definition of the intended implementation outcomes or explanation of determinants. However, a number of recurring themes were identified, relating to factors that appeared to influence success in service delivery.

It was important to tailor partnerships to the needs of patients and healthcare professionals (responding to significant local issues), and design it in a way that was easy to access and engage with for both groups. To enable joint working between health and legal teams, there needed to be clear working processes and opportunities for professionals to interact and communicate. Awareness of the partnership among healthcare professionals could be a challenge due to physical separation and high staff turnover, and ongoing promotion and awareness-raising was needed to maintain visibility. It was important that staff had the necessary knowledge to engage in joint working, which could be improved through interdisciplinary training and secondary consultation. Positive perceptions and personal motivation to participate in partnership working seemed to have a strong influence on levels on engagement. Strong working relationships and trust between teams facilitated goodwill, increased communication and ensured a regular flow of referrals. Ongoing dialogue, feedback and information sharing were a central part of delivering integrated care for individuals and were important to maintain for effective joint working.

Resource constraints were prevalent, including insecure and limited funding, low staffing capacity and premises problems. Lack of investment was a common reason for discontinuation of partnerships. Shared goals and commitments between the partner organisations contributed to goodwill and ongoing sustainability of partnerships. Strong management provided an essential grounding for the partnerships and contributed to both smooth operation of day-to-day activities and ongoing sustainability of projects: strong and enthusiastic leaders were a driving force in establishing partnerships and played an important role encouraging and supporting engagement from teams on the ground; solid planning ensured that service delivery process were well designed and developed; and effective evaluation provided the evidence needed to improve the service and communicate its achievements to investors and healthcare teams.

2.5.3 Questions arising

The evidence presented in this review provides insight into the diversity of health-justice partnerships internationally, and demonstrates their relevance to current health and legal policy (through their aims and impacts). The literature also highlighted key implementation challenges. An important issue therefore, is how to implement partnerships successfully in order to achieve the intended benefits.

A diverse range of factors were identified in the literature that seem to influence implementation processes. However, the roles and relative importance of these factors in determining implementation outcomes is not clear, and research to date has not used implementation science theories to investigate potential causal pathways. Additionally, the evidence from the literature was gathered in diverse international settings, and is therefore not specific to any given context in which implementation might take place.

This leads to the research question that is investigated in the following chapters, focussing on services in England: ‘What underlying factors influence differences in the success of health-justice partnerships at an organisational level?’

CHAPTER 3. COMPARATIVE CASE STUDY METHODOLOGY

3.1 INTRODUCTION

The primary research presented in the following chapters seeks to fill gaps in the evidence relating to implementation of health-justice partnerships across England. It investigates the causal influences on implementation outcomes, with the aim of generating evidence that will have utility in informing service delivery. This chapter outlines the research methodology used. It involves a comparative case study of health-justice partnerships, representing diverse contexts and service models in England. The study draws on an implementation theory (see the 'Theoretical framework' section below) to guide data collection and analysis, supporting the production of findings that can be generalised beyond the immediate case studies to inform wider implementation efforts.

3.2 AIMS

The comparative case study was designed to answer the second research question of the PhD: 'What underlying factors influence differences in the success of health-justice partnerships at an organisational level?'

The objectives of the study are:

- To develop theoretical propositions for successful implementation, specifying likely determinants of implementation outcomes.
- To gather empirical evidence on the operation of diverse health-justice partnerships across England.
- To examine causal pathways leading to the observed implementation outcomes, through analysis of case study data.
- To identify conditions that are necessary and/or sufficient for success.

3.3 THEORETICAL FRAMEWORK

3.3.1 Rationale

Theories can act as a guiding structure for the collection and analysis of research data and allow for generalization of findings from one context to another(Foy *et al.*, 2011). The use of explanatory theory provides a conceptual understanding of how complex programmes operate and why they may succeed or fail, offering an informed starting point for investigations(Nilsen, 2015). This study drew on an implementation theory to help predict factors that would be likely to influence implementation of health-justice partnerships, building on knowledge that has been generated in similar settings (implementation of complex interventions in healthcare). The aim was to maximise the insight that could be gained and improve the rigor of the study.

An abundance of implementation theories exist and their use is often haphazard(Birken *et al.*, 2017). A taxonomy of theories, models and frameworks in implementation science has been developed(Nilsen, 2015). Based on this taxonomy, the category that was most appropriate for the purpose of this research was theories which aimed to *understand and/or explain what influences implementation outcomes*. One of these, the Normalisation Process Theory (NPT) seemed an appropriate starting point(May and Finch, 2009): with its focus on collective action and the embedding of complex interventions into routine practice, the NPT offers a good basis for understanding the collaborative working aspect of health-justice partnerships; however, it did not represent some of the common determinants of implementation success highlighted in the literature, such as resource constraints. Further development of the NPT has led to the proposal of a General Theory of Implementation (GTI)(May, 2013). The GTI extends the NPT by linking it with constructs from relevant theories in sociology, psychology and behaviour, to provide a more comprehensive explanation of implementation processes of complex interventions(May, 2013). This theory was therefore selected to guide the next stages of the research.

3.3.2 The General Theory of Implementation

The GTI is a framework that explains implementation processes as interactions between ‘expressions of agency’ (the things people do to make something happen) and ‘dynamic elements of context’ (the resources that people draw on to realise that agency). There are four core constructs of the GTI: ‘Capability’, ‘Capacity’, ‘Potential’ and ‘Contribution’. The meaning of each construct is summarized in *Table 3-1*.

Table 3-1: Core constructs of the General Theory of Implementation

Construct	**Dimensions**
Capability (agency)	The qualities of the complex intervention: whether the intervention can be made workable and integrated into routine practice by those enacting it.
Capacity (context)	Social-structural resources available to agents: material resources, knowledge and information resources, social norms and roles.
Potential (context)	Social-cognitive resources available to agents: individual intentions and shared commitments.
Contribution (agency)	What agents do to implement a complex intervention: ongoing collective action to embed and integrate a practice.

For use in research or practice, the GTI is operationalized by developing proposition statements: statements relating to each core construct of the theory, which describe and/or predict how implementation processes play out in the given setting.

3.3.3 Theoretical propositions

Methods

I developed theoretical propositions by re-analysing evidence gathered in the scoping review that related to implementation:

- Building on the initial inductive analysis, I organised codes under themes representing the GTI constructs ('Capability', 'Capacity', 'Potential' and 'Contribution').
- I developed proposition statements for each construct, representing the existing evidence that related to each one.
- I carried out an additional round of coding to determine relationships between themes in the data. The aim of this was to identify any important influencing factors that were not captured within the theory and might be important to investigate in the study.

Results

The proposition statements relating to implementation processes (as outlined by the GTI) are presented below:

Capability

Proposition: Capability for partnership working depends on aspects of the service design:

i) Responsiveness to needs of patients and healthcare professionals
ii) Ease of use for patients and healthcare professionals
iii) Clarity of processes for joint working
iv) Opportunities for interaction between staff in the partner services.

Explanation:

The literature highlights the importance of systems being designed so they are appropriate for the local setting, straightforward and easy to use. Having clear working processes and opportunities to interact facilitates communication and engagement between staff.

Influencing factors to investigate:

Careful planning, including involvement of patients and staff, is likely to be important in ensuring the service model is appropriate and fits well with existing practice. Formalised agreements between participating organisations could improve clarity of roles and responsibilities, and co-locating services could create opportunities to interact.

Capacity

Proposition: Capacity for partnership working depends on the resources available:

i) Sufficient funding and material resources
ii) Awareness of the legal service among healthcare professionals
iii) Staff knowledge of the rationale and processes for joint working
iv) Strong working relationships

Explanation:

Evidence from the literature highlights the importance of sufficient funding to sustain partnerships, as well as sufficient time, space and staffing capacity for the day-to-day work. Knowledge and awareness are necessary for staff to understand the system and how to participate in it, while strong relationships encourage collaborative working.

Influencing factors to investigate:

Funding sources and arrangements may influence the resources available to partnerships, as well as joint goals and funder buy-in. Training and promotional activities could increase knowledge and awareness, and opportunities to interact and provide feedback could help in developing strong relationships.

Potential

Proposition: Potential for partnership working depends on the intentions of those involved:

i) Commitment of individuals at all levels
ii) Joint goals of collaborating organisations

Explanation:

The literature highlights the importance of individual commitment and motivation for staff to cooperate and actively participate in working with the opposite service. Developing a shared vision and joint goals was important for clarity of purpose and long-term sustainability.

Influencing factors to investigate:

Factors identified in the literature which increased positive perceptions included providing feedback on referrals (including through service evaluation), having opportunities to work together to build trust and understanding, and having local champions to encourage participation. Formalised systems and joint resource contributions may increase a sense of ownership.

Contribution

Proposition: Embedding and integration of partnership working requires professionals' continued contributions:

i) Engagement and cooperation in partnership activities
ii) Dialogue and communication between healthcare and legal professionals
iii) Information sharing between healthcare and legal organisations
iv) Feedback on referrals to legal advice.

Explanation:

As outlined above, Capability, Capacity and Potential create the conditions necessary for collaboration, but implementing partnership activities depends on ongoing work and efforts on the part of staff members. Systems of working are normalised through a continuous process of understanding, engaging, enacting and appraising the work being done.

Influencing factors to investigate:

Effective communication underpins the core processes of collaborative working. Regular communication, contact and feedback helps to maintain awareness, increase understanding and consolidate relationships. It also enables ongoing monitoring of processes to allow adaptation and improvement of the system which will increase its sustainability and effectiveness over time.

Proposed implementation outcomes

Implementation outcomes fall outside the scope of the theory, which focusses on implementation processes. Implementation outcomes are distinct from service and client (patient) outcomes, and have been defined as 'the effects of deliberate and purposive actions to implement new treatments, practices and services'(Proctor *et al.*, 2011). A taxonomy of implementation outcomes proposes eight conceptually distinct but interrelated implementation outcomes: acceptability, appropriateness, feasibility, adoption, fidelity, penetration, implementation cost and sustainability(Proctor *et al.*, 2011).

Outcomes that would indicate implementation ‘success’ have not previously been defined in the literature on health-justice partnerships, however evidence from the Systematic Scoping Review provides an informed starting point: the findings highlighted barriers and enablers of integrated service delivery, which largely related to two issues: i) collaborative working between health and legal teams (achieving a good level of engagement, referral and communication between health and legal teams); and ii) sustainability of the partnerships (having sufficient resources to support the partnerships and enable their continued operation over time). Collaborative working corresponds most closely to ‘adoption’ in the taxonomy above, which indicates uptake and utilisation of an intervention.

It is known that implementation can influence programme outcomes, with well-implemented projects achieving greater levels of effectiveness(Durlak and DuPre, 2008). Impacts are therefore relevant to investigate in the study, because they may depend on the implementation success.

Three outcomes were therefore chosen to take forward for investigation, defined below:

Collaborative working

Collaborative working refers to the active participation of frontline staff from both organisations in the shared activities of the partnership, whereby patients are proactively referred and the staff teams communicate and coordinate care in consultation with each other.

Sustainability

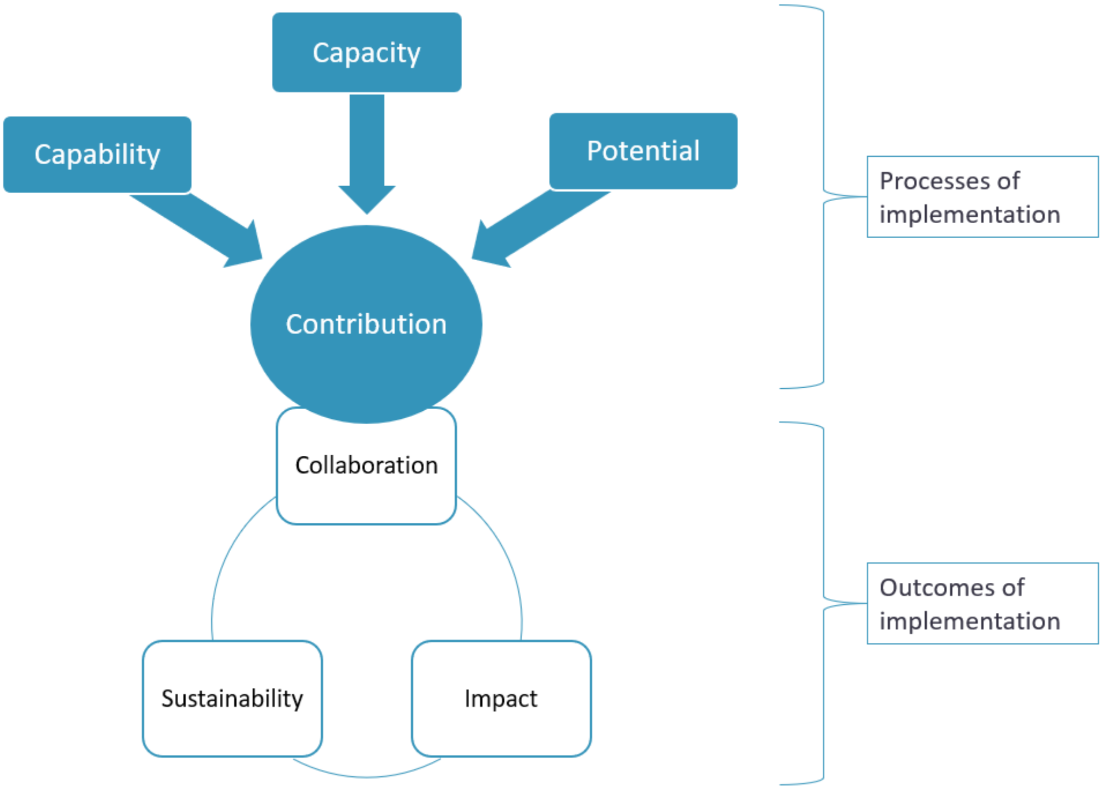
Sustainability refers to the longevity of the connection between partner organisations and the ongoing continuity of the partnership over time.

Impact

Impact refers to the difference that the partnership makes for patients, staff and organisations, focussing on outcomes attributable to the connections between health and legal services.

Figure 3-1 provides a graphical display of the implementation processes and outcomes that were investigated in the study. The way in which the outcomes are observed and measured in the empirical study is specified below in the ‘Definition of concepts’ section.

Figure 3-1: Implementation processes and outcomes for investigation



3.3.4 Application of the theory

This theoretical basis was used to inform both data collection and analysis:

- The interview topic guide was developed using the theoretical propositions (and understanding of potential influencing factors) to ensure that relevant questions were being asked and that information was collected comprehensively.
- The GTI was used at the more advanced stages of analysis (see the sections on Qualitative Comparative Analysis) to select appropriate conditions to test regarding their relationship to implementation outcomes.

3.4 STUDY DESIGN

3.4.1 The rationale for case-based research

In case-based research, the unit of analysis is the ‘case’ (a whole and complex entity) rather than the ‘variable’ (a disembodied attribute). What constitutes a ‘case’ is defined differently depending on the field on inquiry, but in general terms is a bounded system of a phenomenon of interest(Patton, 2015a). Case studies are detailed and rich accounts focussing on individual entities (e.g. a person, organisation, programme) undertaken with the aim of understanding the case holistically and in the context of its natural setting. Cases represent complex dynamic systems, whose trajectories depend on interactions between all of the parts within the whole, as well as interactions with external systems(Byrne, 2009). Correspondingly, case-based research seeks in-depth understanding and draws largely on qualitative data to gain the necessary depth of insight.

Despite being contextually specific, case studies are normally undertaken with the aim of understanding the features of a wider population which the case represents(Seawright and Gerring, 2008). Case studies are useful for both generating and testing theory through the detailed narratives they provide of the social world(Levy, 2008). Development of theory from case studies can generate understanding that goes beyond the single case(Welch *et al.*, 2011). However, the findings of single case studies may be limited in the extent to which they can be generalised given the specificity to an individual example and lack of comparative evidence.

3.4.2 Comparative case studies

Comparative case studies extend the investigation beyond a single case. This approach retains the focus on in-depth, holistic, qualitative understanding that is necessary to explain complex systems, while also allowing greater scope for analysis and generalisation(Ragin, 1987). Different cases of the same phenomenon are compared to identify patterns of similarity and difference and thereby infer causality. Cases are selected based on a particular logic of comparison that allows such inference, for example exploring different outcomes in similar contexts, or similar outcomes in different contexts(Levy, 2008).

Comparative case studies examine causality by combining within-case and cross-case analysis. Alone, within-case analysis can explore causal pathways playing out in individual case examples, which provides important mechanistic evidence for how a condition may lead to an outcome(Beach, 2017). However, findings may lack external validity. Combining this with cross-case analysis allows generalisations to be made beyond the single case, by identifying whether patterns hold true across the sample or whether there are alternative explanations in different contexts. Together these analyses form a strong basis for inferring causality in complex systems(Blatter and Haverland, 2012).

A case-based approach was deemed appropriate for the current study, given the need to gain an in-depth understanding of implementation in complex environments. The comparative case study design was selected because comparison offered the best opportunity to answer the research question: comparing case studies with different implementation outcomes enabled identification of the factors which determined those differences.

3.4.3 Definition of concepts

The cases: ‘Health-justice partnerships’

The cases of interest to this investigation were ‘health-justice partnerships’. As set out in the introduction (Chapter 1), a broad definition is adopted for the purposes of this study in order to encompass the full range of relevant approaches in which welfare rights advice is integrated with patient care. They are defined as: two-way partnerships between health and legal services in which social welfare legal assistance is provided for patients in the healthcare setting or through the healthcare provider.

Table 3-2 sets out the characteristics which defined the cases that were relevant to include in the study. Any National Health Service care setting could be included. Legal services were limited to those able to undertake casework, to ensure a high standard of legal expertise and practical assistance. Health and legal services could be linked physically and functionally in the partnership, but only those involving direct communication and coordination were included in the definition. For example, eligible partnerships included co-located models (where advice appointments were provided on the healthcare premises), referral-based systems (where healthcare professionals had a dedicated and formal referral route to the advice provider, which allowed exchange of patient information) and multi-disciplinary teams (where welfare rights advisors regularly participated in care team activities such as meetings, ward rounds or client appointments). The definition excluded signposting only (where healthcare professionals told patients where they could seek advice, without making a referral), and navigation schemes (where healthcare professionals referred patients to an intermediary rather than to an advice service directly).

Table 3-2: Definition criteria for relevant case studies

	Included	Excluded
Health service characteristics	National Health Service sites, including primary, secondary and tertiary care settings.	Private health facilities
Legal service characteristics	Services providing advice with casework for social welfare legal issues (any area of social welfare law eligible to include)	Service providing information and advocacy only Services providing first-line advice only (without casework support)
Links between services in the partnership	Direct physical or functional links, including co-location, referral mechanisms and multi-disciplinary team working	Signposting only (no coordinated referral) Navigation schemes directing patients to an intermediary (no direct contact between health and legal services)

The outcomes: 'Implementation success'

As defined above in the 'Theoretical framework' section, three implementation outcomes were investigated: 'Collaborative working', 'Sustainability' and 'Impact'. These three outcomes were understood as being independent: partnerships could be successful in any, all or none of the specified ways. Therefore, each outcome was assessed individually rather than aggregated into an overall judgement of 'success'.

Table 3-3 presents positive and negative indicators that were utilised in the analysis to determine service outcomes. Outcomes were assessed qualitatively based on the interview data (see the 'Data analysis' section below).

Table 3-3: Indicators of 'implementation success'

Element	Positive indicators	Negative indicators
Collaborative working	High referral rates Regular communication and coordination of care Familiar working relationships	Low referral rates Little or no communication or coordination of care Absence of working relationships
Sustainability	Years of operation: long-lived Ongoing existence	Years of operation: short-lived Closure
Impact	Reported positive contributions to service efficiency, effectiveness or other quality indicator	Little or no reported contributions to service efficiency, effectiveness or other quality indicator

3.4.4 Case study sampling

Logic of comparison

This study used comparison as a basis for gaining insight into the research question. Comparison enabled explanation of the reasons that implementation was successful in some cases and not others, by identifying factors that determined these differences.

The aims of comparison across the case studies were:

- To identify similarities among successful cases that might explain their success
- To identify differences between successful and unsuccessful cases that might account for their divergence
- To describe the role of the causal factors in determining service outcomes

In order that cases would contribute valuable information to the investigation, the study sample was designed so that services differed on key characteristics:

Context:

> Cases were chosen that differed on various contextual conditions, to ensure a wide range of relevant services were represented. Selecting diverse cases has the purpose of: i) documenting pertinent variation in case characteristics; ii) exploring the role of context within causal pathways; iii) observing patterns that hold true across all cases regardless of the 'noise' of contextual variation, thereby eliminating factors not linked to service outcomes(Berg-Schlosser and De Meur, 2009; Patton, 2015a).

Outcome:

> Cases were chosen that differed on the outcomes of interest, with the goal of exploring what influenced positive or negative outcomes. Comparing positive cases with each other can identify conditions that are 'sufficient' for successful outcomes (these will be present in all successful cases). Including negative cases allows identification of conditions that are 'necessary' for success (these will be absent in the unsuccessful cases).

The case study pool

The pool from which case studies were drawn (the 'universe of cases') was all known health-justice partnerships operating in England in current or recent years. The geographical region was limited to England to maintain consistency in the services' broad operational contexts: laws and policies relating to both health and social welfare vary in the different jurisdictions of the UK, as do population characteristics; together these factors may significantly alter the incentives, pressures and constraints on service delivery in a way that could influence implementation. Currently operating services offered the best opportunity for data collection, however closed services were also important to include as negative cases for the sustainability outcome. Recently closed services were therefore eligible to include, provided evidence on their operation could still be gathered.

Selection criteria

From this pool of cases, partnerships were selected purposefully to vary on key characteristics. *Table 3-4* presents the sampling criteria that were used to guide case selection. Partnerships were selected that were based in different healthcare settings and geographical regions (to ensure diverse contexts) and that differed in their longevity (as an indicator of the sustainability outcome). The collaborative working and impact outcomes could not be determined before undertaking the study, so partnerships were selected with diverse service models to increase the chances of observing variation on these outcomes.

Table 3-4: Purposeful sampling criteria for case study services

Healthcare setting	**Region**	**Service model**	**Longevity**
Primary care Hospitals Mixed settings	Northern England Southern England London	Co-location Referral Care pathway Multi-disciplinary team	Long-lived partnership Newer partnership Ceased partnership

Sampling was not aiming for statistical generalisability (representativeness in terms of the characteristics of health-justice partnerships across England) but rather for analytical generalisability (transferability of findings to cases with similar contextual characteristics)(Yin, 2010). The aim was therefore to generate a diverse sample with variation across the selection characteristics.

The target sample size was ten, which was based on analytical considerations. Firstly, sufficient cases were required which would together embrace each of the sampling criteria in the table. Additionally, the study aimed to use Qualitative Comparative Analysis (QCA) as an analytic method (see the QCA section below). There is no hard rule for sample size using QCA, which was originally developed for small-N research; however, the sample size limits the number of causal conditions that can be assessed in the QCA model(Greckhamer, Misangyi and Fiss, 2013). Benchmarks have been developed to guide the number of conditions that can be analysed reliably according to the number of cases(Marx and Dusa, 2011). A sample size of ten would allow three conditions plus the outcome to be modelled in crisp-set QCA. However, in theory-centred QCA (which is applied in this study) the conditions-to-cases ratio is less important as the model is based on theoretically coherent expectations rather than any possible permutation of conditions(Blatter and Huber, 2017).

3.4.5 Case study recruitment

I identified potential case study services through an existing dataset of survey responses. This dataset contained descriptions of 148 services providing social welfare legal advice in healthcare settings across England and Wales that were operating between October 2017 and March 2018(Beardon and Genn, 2018).

I drew up an initial longlist of potential case study services from the survey data, mapping out the characteristics of each service against the sampling criteria in *Table 3-4*. I then created a shortlist of ten services, aiming to maximise variation and reduce duplication in the sampling characteristics. These services were invited in the first instance. Where an invitation to participate went unanswered or was declined, an alternative service was approached, being chosen to fulfil the desired sample variation.

I sent the invitation email to the service managers of each service, using the contact details obtained through the survey(Beardon and Genn, 2018). The email asked for their expressions of interest and attached a summary of the project. For those who expressed an interest in participating, I arranged a follow-up phone call to discuss in more detail what would be involved. During the phone call, I also checked that the services would have the capacity to participate (be able to provide the requested data and connect the researcher with potential interviewees) and responded to any initial queries about the study. Following the phone call, I sent the managers a more detailed information sheet containing the ethics, data protection and confidentiality details of the study. I asked the service managers to read the information sheet and respond to the email confirming their willingness to participate. This response was saved in writing as a record of consent from the case study service.

3.5 DATA COLLECTION

One-to-one semi-structured interviews were the primary source of data for the study. A qualitative approach was chosen due to the depth and detail it could provide. Qualitative methods can provide rich insight into phenomena of interest, and are therefore useful for research into how things work(Patton, 2015b). This includes studies into systems, organisations, personal and social issues, which require rich descriptive data to understand fully. A qualitative approach was appropriate for this study given its focus on understanding implementation, which takes place in complex and social healthcare environments.

3.5.1 Sample selection

I sought interviews with professionals working in both health and legal services, with the aim of exploring the involvement of each partner organisation, how they worked together and what they valued in the partnership. Interviews were sought from both management and frontline staff in order to understand both strategy and service delivery aspects.

The target sample size was 5 interviews per case study, covering each of the roles listed below:

- Welfare rights advice service manager
- Welfare rights advisor
- Health service manager
- Healthcare professional
- Funder/commissioner

This sample structure aimed to achieve balance and comprehensiveness by capturing a range of views and experiences on each service. It would also keep the volume of data at a reasonable level for analysis while allowing comparison across case studies.

3.5.2 Recruitment and consent

Documents used in the recruitment process are provided in *Appendix 2B*. I recruited interview participants by way of an email invitation. The participant information sheet was attached to the email, providing the study background and details of the interview. The message included the contact details of the researcher and invited recipients to respond if they were happy to participate.

Recruitment of interviewees was done in the first instance through the primary contact for each case study, usually a project manager in the legal service. I asked the primary contact to forward the invitation email to colleagues working in a variety of roles (according to the selection criteria). Individuals responded directly to me if they were interested in participating. Later interviews were also recruited by snowball sampling(Parker, Scott and Geddes, 2019): where it had not been possible to recruit the target participants through the primary contact, I asked interviewees if they could forward the invitation email to relevant contacts of their own. This method was primarily used to reach healthcare professionals who were not in personal contact with management staff of the legal service.

Individuals who responded to the invitation were contacted to arrange an interview date. The participant information sheet and consent form were sent to them prior to the interview to read and consider. A signed copy of the consent form was requested and consent was confirmed verbally at the start of each interview.

3.5.3 Interviews

Topic guides

Development of the topic guides was informed by the literature and theory, as presented in the ‘Theoretical framework’ section. Questions were directed towards understanding how the partnerships operated (the day-to-day service delivery), as well as implementation outcomes (collaborative working activities, sustainability issues and perceived impacts) and the factors that were likely to be influential in determining those outcomes.

I developed a separate topic guide for each staff group to reflect their areas of expertise and differing involvements in the partnership. Initial drafts of the topic guides were refined with feedback from project supervisors to improve the clarity and flow of questions. Early interviews in the first two case studies were also treated as pilots: I requested feedback from participants at the end of the interviews about the structure of the conversation and any topics or questions that were unclear. I also made observations about how readily participants had been able to respond and any questions that had been misunderstood. The topic guides were revised accordingly and are presented in *Appendix 2C*.

Interview format

The interviews followed a semi-structured format, based around a few key questions per topic area. I allowed participants to respond freely and prompted them to elaborate more broadly about their own experiences. The semi-structured format aimed to ensure that consistent data were collected for all the subjects, while also allowing wider discussion of relevant topics.

The interviews were conducted one-to-one. I did most interviews in the first three services face-to-face, but following the start of the Covid-19 pandemic in March 2020, all interviews were conducted remotely. The majority of the remote interviews were done by telephone, with the option of a video meeting where the participants preferred. The interviews were audio recorded and transcribed verbatim.

3.6 DATA ANALYSIS

3.6.1 Purpose

The analysis had a strong exploratory element given the relative novelty of the research. As discussed in the Systematic Scoping Review, few existing studies had examined implementation processes in depth, and none had applied implementation theory. Therefore, the analysis aimed to generate theory as well as test it.

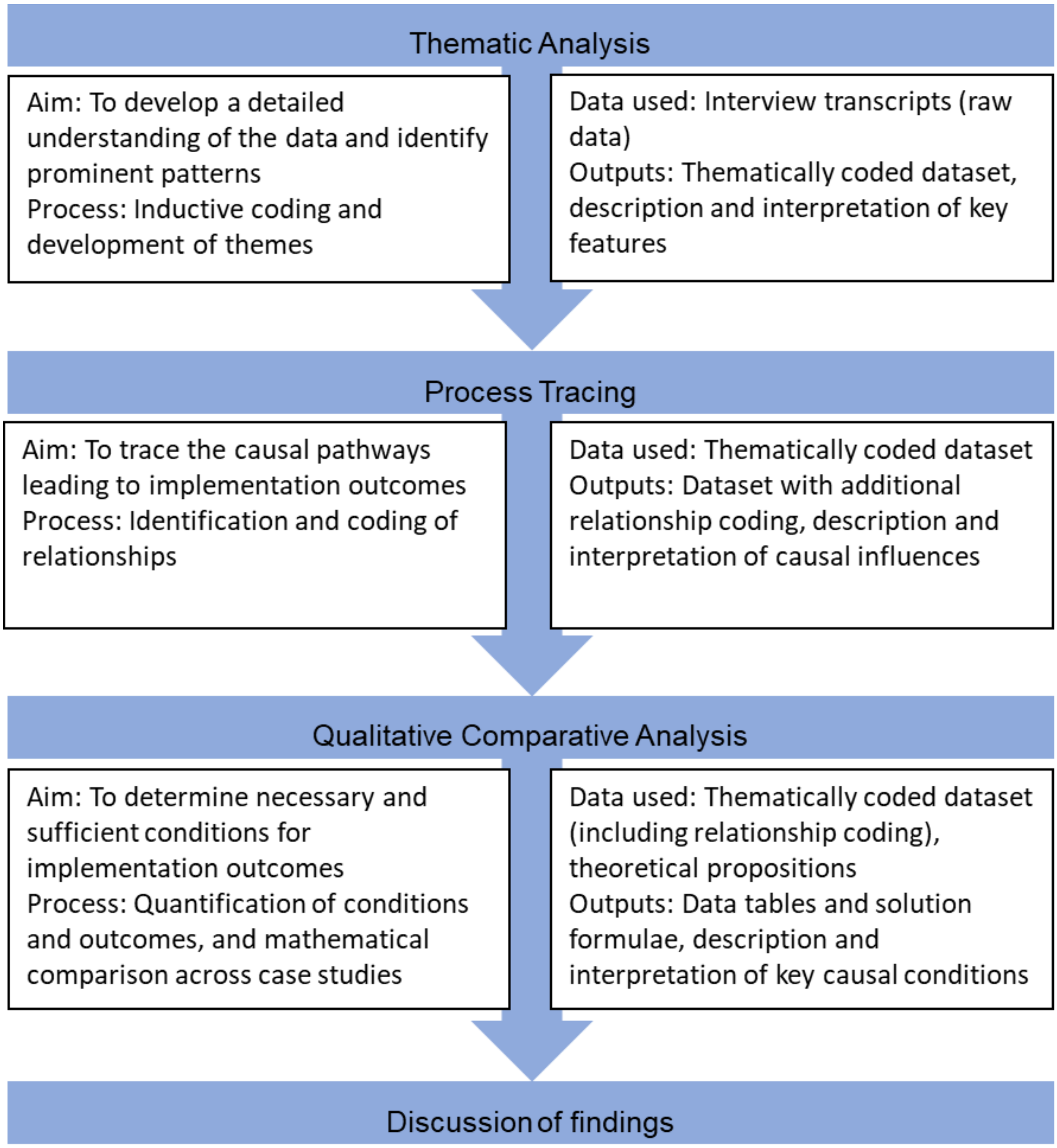
The analysis was undertaken in three successive phases, using different analytic methods:

i) Thematic analysis: a method to identify themes within the dataset
ii) Process Tracing: a method to trace the mechanisms linking causes to effects *within* case studies
iii) Qualitative Comparative Analysis (QCA): a method to identify which conditions are consistently related to outcomes *across* case studies

The stages of analysis are summarised in *Figure 3-2*. The first two methods (Thematic analysis and Process Tracing) were used in a theory-generating way: these were undertaken inductively, without reference to existing theory but based purely on the content of the dataset. The aim was to explore the themes and patterns present in the data in an open way, and capture all the relevant detail before applying a theoretical structure. The final method (The Qualitative Comparative Analysis) was used in a theory-testing way: the theoretical propositions were used to inform which factors to include in the QCA models.

By combining inductive and deductive analysis, I aimed to establish the best explanation for the determinants of implementation success, drawing on both a comprehensive understanding of the data and insights from relevant theory.

Figure 3-2: Summary of analysis stages



Aim: To develop a detailed understanding of the data and identify prominent patterns
Process: Inductive coding and development of themes

Data used: Interview transcripts (raw data)
Outputs: Thematically coded dataset, description and interpretation of key features

Aim: To trace the causal pathways leading to implementation outcomes
Process: Identification and coding of relationships

Data used: Thematically coded dataset
Outputs: Dataset with additional relationship coding, description and interpretation of causal influences

Aim: To determine necessary and sufficient conditions for implementation outcomes
Process: Quantification of conditions and outcomes, and mathematical comparison across case studies

Data used: Thematically coded dataset (including relationship coding), theoretical propositions
Outputs: Data tables and solution formulae, description and interpretation of key causal conditions

3.6.2 Thematic Analysis

I applied Thematic Analysis to the interview transcripts as the first stage in the analysis, to develop an in-depth understanding of the data content. This formed the basis for subsequent analyses, which looked in additional detail at the causal pathways leading to implementation outcomes.

Background to the method

Thematic Analysis is a simple and flexible method of qualitative analysis that is used widely in applied health research. It provides a robust, systematic approach to coding qualitative data and identifying patterns across the dataset in relation to research questions(Braun and Clarke, 2014). The method is independent of particular theories or epistemologies, and is therefore appropriate to use within a wide range of research approaches(Braun and Clarke, 2006).

Braun and Clarke produced the definitive guide to the analysis process(Braun and Clarke, 2006). The first phase involves familiarisation with the data, an active process of reading, note-taking and forming initial insights. Initial codes are then developed, which represent basic elements and features of the data. This process is repeated until the entire dataset is coded. Themes are then developed by searching for patterns of shared meaning in the data and grouping codes at a broader level, under a central organising concept. The technique is creative and iterative, allowing for re-coding and re-grouping of themes as understanding develops.

Analysis procedure

Familiarisation with the data

The process of familiarisation began as interviews were undertaken: I reviewed the transcripts to check their accuracy and made notes on key points, as well as noting reflections (e.g. unusual service features, things that seemed to work particularly well or areas of challenge for the partnership). This served to keep a record of what I knew about each case study and identify information gaps for subsequent interviews.

Once all the interviews were complete, I spent a period of time becoming absorbed in the detail of the dataset as a whole. I read each transcript again at least once and made detailed notes on the content of each interview to become familiar with the story being told. I reviewed interviews within each case study together, to consolidate my understanding of how each partnership functioned and identify factors that seemed important in relation to implementation in each case. Looking across the whole group of case studies, I noted patterns of similarity and difference. This familiarisation stage generated initial insights to inform the analysis and began the process of interpretation.

Generating codes

Using qualitative analysis software (NVivo12), I coded interview transcripts line-by-line to ensure the relevant information was fully captured. In the first instance, I created codes at a fine level of detail, with a new code to represent the meaning of each small section of text. As I went through the data, I coded text together if an appropriate code existed, or created a new code to reflect new information. This process was repeated with 13 transcripts, selecting interviews from across all case studies and types of interviewee (by job role). Through this process I had generated an extensive list of granular codes and could identify patterns of similarity within it. I therefore collapsed codes under new headings that represented their shared meaning. I applied this early coding framework to the remaining transcripts and refined it further as data were added: i) If there was no appropriate code for a section of text, I created a new one; ii) If codes appeared too general and were accumulating a lot of content, I reviewed and split them if appropriate; iii) If new patterns of similarity or difference were identified, I re-combined or merged codes to reflect this. An early version of the coding framework was checked by two members of the supervision team, by applying it to four transcripts; the analysis was then discussed to help develop and refine the coding framework.

Developing themes

The final step was the development of themes, representing shared patterns of meaning in the data. Taking a step back to consider the overall picture, I spent time tabulating information, drawing diagrams, writing about the findings, presenting and discussing them with professionals in the field. This process helped me to identify the main points of significance and where more analysis was needed. I reviewed the codes and grouped them into themes, at the same time re-checking the content to ensure coding had been done consistently throughout the dataset. At this stage, I created a final thematic framework and specified the meaning of each theme (see *Appendix 2D*). This framework arranged the themes under the headings of ‘Context’ (characteristics of the service and its environment), ‘Mechanism’ (factors acting as barriers and facilitators) and ‘Outcome’ (implementation outcomes as specified in the theoretical propositions).

3.6.3 Process Tracing

Process Tracing was undertaken with the thematically coded data as the second stage of analysis. This sought evidence of relationships within the data that demonstrated potential causal links on the pathways leading to implementation outcomes.

Background to the method

Process Tracing is not common in applied health research, but is used widely in the social and political sciences to explore causal processes in case study research. The method seeks to identify causal mechanisms: the processes that lead from a cause (or set of causes) to an effect(Beach, 2017). Studying mechanisms gives us a clearer understanding of how an outcome is produced, and allows us to make stronger causal inferences because each step in the causal pathway is observed(Beach, 2016). Process Tracing examines evidence from individual case studies to understand how causal processes work in real-world cases(Beach, 2017). The analysis involves looking for evidence of causal mechanisms in the data (observations linking causes with their effects), in order to identify how each part of a causal pathway plays out(Beach and Pedersen, 2016b).

Process Tracing can be used for either theory-building or theory-testing purposes(Beach, 2017). This study used the theory-building approach, starting with the empirical data and proposing plausible causal pathways based on analysis of the evidence.

Analysis procedure

I re-analysed the full dataset, examining the content of each code to identify links between themes and determine how one factor was leading to another. I sought evidence that showed chains of events (temporal associations) and factors that were associated together (co-occurring). To identify these links, I examined the text for where interviewees had told stories of how situations had come about or drawn associations between issues they had experienced. I created a new set of codes to represent these relationships and coded the relevant content accordingly. The Process Tracing resulted in a list of relationships linking contextual factors with mechanisms, mechanisms with outcomes, and interactions within and between these codes. I present a narrative account in Chapter 4, describing the observed evidence of relationships and proposing the causal pathways leading to implementation outcomes. In presenting quotations, I tried to select the extracts that were most illustrative of the point being made, were reasonably succinct, and representative of the wider patterns in the data(Lingard, 2019).

3.6.4 Qualitative Comparative Analysis

Qualitative Comparative Analysis (QCA) was undertaken as the final stage of analysis. It built on the previous analytical steps, using both the thematically coded data and the theoretical propositions to go one step further in investigating causal influences. QCA was used to analyse patterns of conditions and outcomes across the case studies, to determine the nature of causal relationships (conditions that were necessary or sufficient for implementation outcomes).

Background to the method

The concept

QCA is a method that was developed in response to the limitations of statistics for assessing causality in complex social settings, and the need for a more systematic approach for generalisation from qualitative findings(Ragin, 1987). Essentially, it involves translating qualitative concepts into numerical scores, which are then compared across the case studies to identify patterns of co-occurring conditions and outcomes. This complements qualitative interpretation by reducing some of the complexity and allowing systematic comparison of key variables(Rihoux and Lobe, 2009).

The approach is based on the logic of set-theory: how factors overlap (combine into 'sets') in relation to observed outcomes(Kane *et al.*, 2014). It asks the question: 'What conditions – alone or in combination with other conditions – are *necessary* or *sufficient* to produce an outcome?' It answers this question by examining how factors cluster into set relationships. If a condition is *necessary*, the outcome cannot occur without it (the condition will always be present alongside the outcome, and will be absent where the outcome does not occur). If a condition is *sufficient*, it leads to the outcome (the outcome will occur wherever the condition is present)(Schneider and Wagemann, 2012).

QCA reveals following characteristics of causal complexity(Wagemann and Schneider, 2015):

- Conjunctural causation: conditions that do not work on their own but do have an effect when combined (single conditions may only display their effects in the presence of other conditions).
- Equifinality: more than one combination of conditions produces the same outcome in difference cases (there may be more than one causal pathway).
- Asymmetry: there are different explanations for the occurrence and non-occurrence of the outcome (a different combination of factors may be important).

QCA has several advantages for use in implementation research(Kane *et al.*, 2014; Hill, Cooper and Parker, 2019). Pathways to implementation 'success' are complex and determined by a host of interacting factors, material and social. QCA can examine the complex causal patterns associated with implementation outcomes, drawing on qualitative insights. Additionally, implementation research is normally based on programmes or services in which case numbers are limited, making statistical comparisons impossible. QCA allows systematic comparison of factors across small to medium case numbers.

QCA integrates well with Process Tracing analysis, because both methods conceptualise causal relationships in terms of set-theory(Beach and Rohlfing, 2018). Combining the two draws on the strengths of each: Process Tracing provides insights into causal mechanisms occurring in individual cases; supplementing this with QCA determines whether those insights extend beyond individual cases to a wider study sample(Beach and Rohlfing, 2018; Rohlfing and Schneider, 2018).

Mathematical basis

QCA is based on Boolean algebra, the algebra of sets and logic. This study uses 'crisp-set' QCA (the original form of the method), which uses binary data(Ragin, 1987). A raw data matrix is constructed, mapping out the presence and absence of conditions and outcome observed in each case study (where 1=presence a factor, 0=absence of a factor). This data table is analysed using software, which performs calculations in two stages(Schneider and Wagemann, 2012):

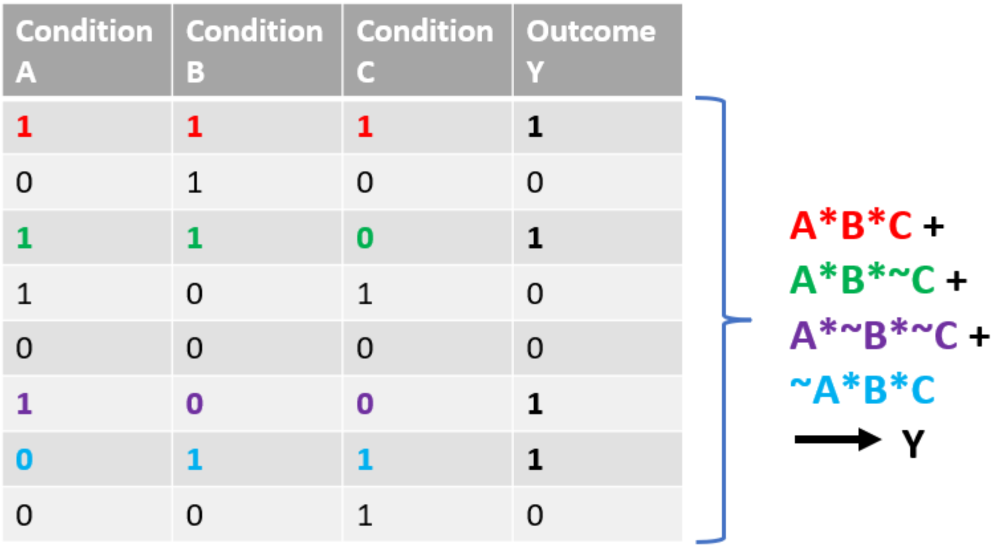
i) Construction of the 'truth table'

Each row in a truth table represents a configuration of outcome and conditions (rather than the raw data from an individual case). The truth table is constructed in three steps:

i) Every logically possible configuration of conditions is listed.
ii) Each case is assigned to the row that corresponds to its values on the conditions.
iii) The outcome value is attributed to each row, determined by the outcome values of the empirical cases that fall into the respective row.

Each row of the resulting truth table represents a configuration of conditions that is *sufficient* for the outcome (observed to occur alongside it) and is known as a 'primitive expression'. The truth table can be represented mathematically as a formula, in which each condition in a primitive expression is combined with Boolean AND, and each primitive expression in the table is combined with Boolean OR. This process is depicted *Figure 3-3*.

Figure 3-3: Example of truth table layout and formula



Condition A	Condition B	Condition C	Outcome Y
1	1	1	1
0	1	0	0
1	1	0	1
1	0	1	0
0	0	0	0
1	0	0	1
0	1	1	1
0	0	1	0

A*B*C +
A*B*~C +
A*~B*~C +
~A*B*C
→ Y

Boolean operators: * = ‘AND’, + = ‘OR’, ~ = ‘NOT’

There may be truth table rows that are not represented by any case studies (the combinations are not observed in the case studies). These are known as ‘logical remainders’, which occur due to the ‘limited diversity’ of reality, and the fact that sampling is unlikely to capture case studies with every possible combination of features(Ragin, 2004). They can be dealt with in different ways in the subsequent analysis (discussed below).

ii) Logical minimisation

There may be many sufficient configurations in a truth table, and the aim is to obtain the most succinct and parsimonious answer. The algebraic equation containing primitive expressions is therefore further analysed using ‘logical minimisation’ to eliminate redundant conditions and produce the simplest mathematical representation. This calculation uses the Quine-McClusky algorithm which applies the rules of Boolean algebra(Schneider and Wagemann, 2012): if two expressions, which are both linked to the outcome, differ in only one condition (the condition is present in one and absent in the other) – then this condition can be considered logically redundant and removed.

This calculation is done in two stages(Ragin, 1987):

i) As many primitive expressions are combined as possible that differ in one condition. The reduced mathematical terms in the equation are called ‘prime implicants’.

ii) The equation is reduced further by comparing prime implicants against primitive expressions. The aim is to obtain the logically minimum number of prime implicants to cover the original primitive expressions.

Logical minimisation can be done in different ways, depending on how logical remainders are used in the calculation(Erasmus University Rotterdam, 2021):

a) Logical remainders can be ignored and the analysis based only on the observed data. This yields the '*complex solution*', which is longer but can be demonstrated by the facts.
b) All logical remainders can be used. This yields the '*parsimonious solution*', which is the simplest mathematical representation, but may involve making theoretically implausible assumptions about how conditions relate to the outcome ('difficult counterfactuals').
c) Theoretically plausible logical remainders can be used. This yields the '*intermediate solution*', which is which is simplified as far as possible based on only easy counterfactuals(Ragin, 2004). The likely direction of effect for each condition is specified when running this calculation.

iii) Determining necessity

The truth table analysis identifies conditions that are sufficient for the outcome. Necessary conditions must be determined in another way: by identifying which (if any) are present whenever the outcome is present, and absent whenever the outcome is absent(Schneider and Wagemann, 2012). This can be done by inspecting the raw data table for single conditions that are shared by all cases with the outcome.

Calibration

Calibration is the process of translating the qualitative to quantitative data, by assigning scores to indicate whether conditions and outcomes are present or absent in each case. This process relies on informed judgement, in which the researcher draws on a deep understanding of each individual case and on knowledge of the relevant theoretical context(Greckhamer *et al.*, 2018). The model can be developed iteratively, moving back and forth between evidence and theory to improve the relevance and fit of the data before undertaking the calculations(Rihoux and Lobe, 2009). When QCA is used in a theory-testing way (as in this study), the formal theory can help determine the conditions to include in the model(Rihoux and Lobe, 2009). The number of conditions should be sufficiently low relative to the number of cases, so that the model is reliable(Marx and Dusa, 2011). To be a good measure, there should also be sufficient reliable data on the conditions for each individual case, as well as variation in the conditions between cases(Basurto and Speer, 2012).

Assessing model validity

The validity of QCA models is assessed through 'consistency' and 'coverage' scores(Greckhamer *et al.*, 2018). Consistency scores capture the proportion of cases exhibiting a configuration that also exhibit the outcome. A high consistency score suggests the model is good at explaining the outcome (there is a strong link between configuration and outcome). Coverage scores capture the proportion of cases that exhibit an outcome that also exhibit the configuration of conditions. A high coverage scores suggests the model is highly relevant in reality (explains the outcome frequently within the sample of case studies).

Analysis procedure

The QCA built on the previous analytical steps, which had identified prominent themes and causal pathways. This prior understanding was important in guiding the development of the QCA models, along with the theoretical propositions based on the General Theory of Implementation. The thematically coded dataset was used as the input.

In carrying out this analysis, I followed guidance on best practices in QCA(Greckhamer *et al.*, 2018).

Calibration of outcome and conditions

Calibration of outcomes:

i) I defined the implementation outcomes of interest, specifying the meaning of each outcome and how it would be measured (in what circumstances a score of 0 or 1 would be assigned).

ii) I assigned scores (0, 1) for each outcome to each case study: reviewing the thematically coded data, I made an assessment of the outcome present in each case study.

Calibration of the conditions to include was an iterative process, in which I reviewed the thematically coded dataset and drew on the theoretical propositions to help develop the model:

iii) Firstly, I reviewed the thematically coded data to map out results from as many themes as I could (both contexts and mechanisms) across the case studies. During this initial exploration, I determined: i) Whether I had enough data to determine the presence or absence of the theme at case level; and ii) Whether the theme varied between cases and could therefore be a meaningful predictor of the outcome. If both were true, the theme was considered for inclusion in the model.

iv) Using a provisional scoring method, I drew up a table showing these initially included themes for each case study.

v) I then reviewed the General Theory of Implementation and arranged the data according to each theoretical domain. Looking at the results for each domain, I judged how they could best be combined into a true and meaningful predictor. This was an iterative process of looking at how themes co-occurred, assessing what could form a representative underlying condition, and reviewing the case study data. I also used the results of the Process Tracing analysis to help develop relevant conditions: this enabled me to choose indicators that were likely to be influential on the causal pathways based on an understanding how different factors interacted.

vi) I specified the meaning of each condition and how it would be measured (in what circumstances a score of 0 or 1 would be assigned).

vii) I assigned scores (0, 1) for each condition to each case study: reviewing the thematically coded data, I made an assessment of the condition present in each case study.

After assigning the scores for outcomes and conditions, I drew up a raw data matrix displaying the scores for each case study. The data matrices are displayed in *Appendix 2E*.

Calculation of truth table and solution formulae

The first step in my analysis was to inspect the data matrix to determine whether any single conditions passed the test for necessity (occurred in every case with the outcome). I then analysed the data matrix using the ‘fsQCA’ software, in the following steps:

i) I constructed the truth table: I set the consistency threshold to 0.85, meaning the algorithm would only assign sufficiency to a configuration where >85% of cases with that configuration had the same outcome. I set the frequency threshold to 1, meaning that all observed combinations were included in the analysis (there was no minimum number of cases with a configuration for it to be included).

ii) I ran the logical minimisation analysis on the truth table, setting the expected direction of effect for each condition. The calculation produced all three solution formulae, which are presented and interpreted.

iii) I ran the steps above twice for each outcome, once for presence of the outcome and once for its absence.

In order to visualise the sufficient condition combinations (truth table rows), I produced Venn diagram illustrations. I also provided a narrative illustration of the results, referring to individual case examples to explain how the QCA solutions were observed to play out in practice.

3.7 ETHICS

3.7.1 Data protection

This study was registered with the UCL Data Protection Office on 4th August 2019 (Ref: Z6364106/2019/08/88).

Handling personal data

The research required the processing of personal data, including:

- Names and contact details of participants
- Signed consent forms
- Interview recordings. These did not illicit personal details, but some included descriptions of individuals’ work activities and personal opinions.

All research data were stored and processed within the UCL Data Safe Haven. The Data Safe Haven has been certified to the ISO27001 information security standard and conforms to NHS Digital's Information Governance Toolkit.

Data were transferred into the UCL Data Safe Haven for storage and processing as soon as possible after collection, and the original copies were destroyed: paper records (e.g. consent forms) were shredded and electronic files (e.g. audio recordings or documents) were deleted from the devices they were collected on.

Interviews were audio recorded using an encrypted voice recorder, and the audio files were named using pseudonymised ID numbers. Recordings were transcribed by the researcher personally or by an approved transcription service, who had signed a confidentiality agreement with UCL. Any personally identifying information was removed from the transcripts.

3.7.2 Ethical approval

The study gained approval from the UCL Research Ethics Committee on 4th October 2019 (Project ID 16061/001).

Informed consent

Recruitment documents (including information sheets and consent forms) are provided in Appendix 2B.

Participation in the research was by informed consent. Managers of the participating case study services were provided with an information sheet about the research, with details of who to contact with questions. They were given an opportunity to discuss the project with the researcher and time to consider participating before providing consent.

Participation in interviews was also by informed consent. Prospective participants were sent an information sheet with the interview invitation. A signed consent form was obtained from each participant and consent was confirmed again at the start of each interview.

Confidentiality

The information collected during the study was treated as strictly confidential. The researcher did not discuss individuals' contributions with anyone outside the research team. No details were shared with anyone outside of the research team that could identify individuals. Precautions were taken to ensure participants would not be identifiable in any ensuing reports or publications: all names or other personally identifying information was removed, as well as information that could identify the service a person worked for. All information was managed securely and in accordance with the General Data Protection Regulation (2016) and the Data Protection Act (2018).

Risks and benefits

There were no direct benefits of taking part in the research and financial incentives were not used. Indirect benefits included that participants would be contributing to research that could lead to increased recognition and value being placed on their work, and may inform future practice within their field. Taking part in the research involved a commitment of some time, to participate in an interview or assist with recruitment; the estimated time commitment was set out in the information sheets.

Other ethical considerations

The research did not involve contact with any vulnerable individuals, as it did not include patients or clients of the health or legal services.

The majority of interview participants were previously unknown to the researcher. However, the study did include three former colleagues. In these cases, the researcher was careful to emphasise the confidential and anonymous nature of the interviews so that participants could contribute openly.

3.7.3 Researcher positionality

As a researcher, my disciplinary background is in public health. I have a commitment to public health values and seek out work that I believe will make a positive contribution to society and further the ambition of health and wellbeing for all. Before beginning my interdisciplinary work with law, I had an interest in health inequalities, which is a pressing issue for public health in the UK today. I was partly drawn to this topic by my own personal commitment to the values of equality and social justice. For two years prior to starting this PhD, I had worked on the topic of health justice partnerships. Not only did I learn to look at health issues through a different lens (that of social justice), I also came to appreciate how powerfully the law could shape the circumstances of people’s lives. I therefore approached this research with the perspective that legal interventions had value for health and that health justice partnerships were a promising approach, particularly for tackling health inequality. My motivation in undertaking the study was to understand how to maximise the effectiveness of these partnerships in practice so that their ambitions could be realised. This standpoint shaped the approach I took in carrying out the research: I actively looked for diverse service models and examples of both success and failure that could be learnt from. My analysis aimed to interrogate the reasons for success or failure and provide actionable insights. Therefore, while my inclination had been to view the partnerships as valuable interventions, my approach to the research was as balanced as possible. Undertaking the research increased my understanding of both the benefits and challenges of delivering health justice partnerships. It has also renewed my appreciation for their positive potential, and the recommendations are aimed at supporting more widespread adoption of this approach.

CHAPTER 4. COMPARATIVE CASE STUDY RESULTS

4.1 INTRODUCTION

This chapter presents the results of the comparative case study. The first section displays the response rates to the recruitment of case studies and interviews. This is followed by a description of the case study partnerships, which presents the service characteristics, approaches to integrating service delivery, administrative processes, governance arrangements, service design issues and experiences during Covid-19.

The main findings are then presented in three sections, according to each implementation outcome investigated:

i) Collaborative working
ii) Sustainability
iii) Impacts

In each section, the results are presented under three headings, according to the analysis undertaken:

i) Outcome description (based on the Thematic Analysis)
ii) Pathways to the outcome (based on the Process Tracing analysis)
iii) Cross-case comparison of the outcome (based on the Qualitative Comparative Analysis)

4.2 RESPONSE RATES

4.2.1 Case study recruitment

Thirteen services were contacted to invite them to participate in the study. Of these:

- 9 consented to participate and provided data
- 1 consented to participate and did not provide data
- 2 did not respond to the invitation
- 1 declined the invitation

The service that provided no data failed to respond to any correspondence following recruitment. The service that declined the invitation did so because the advice project had come to an end due to funding pressures (the advisor had been made redundant) and the manager felt the recent restructure meant there would be few relevant staff members who could participate in interviews.

Table 4-1 displays the recruitment of case studies against the sampling criteria. The sample was diverse in the characteristics of interest: geographical region, healthcare setting, partnership model features and known sustainability outcomes. A map of the geographical coverage and healthcare setting is displayed in *Figure 4-1*.

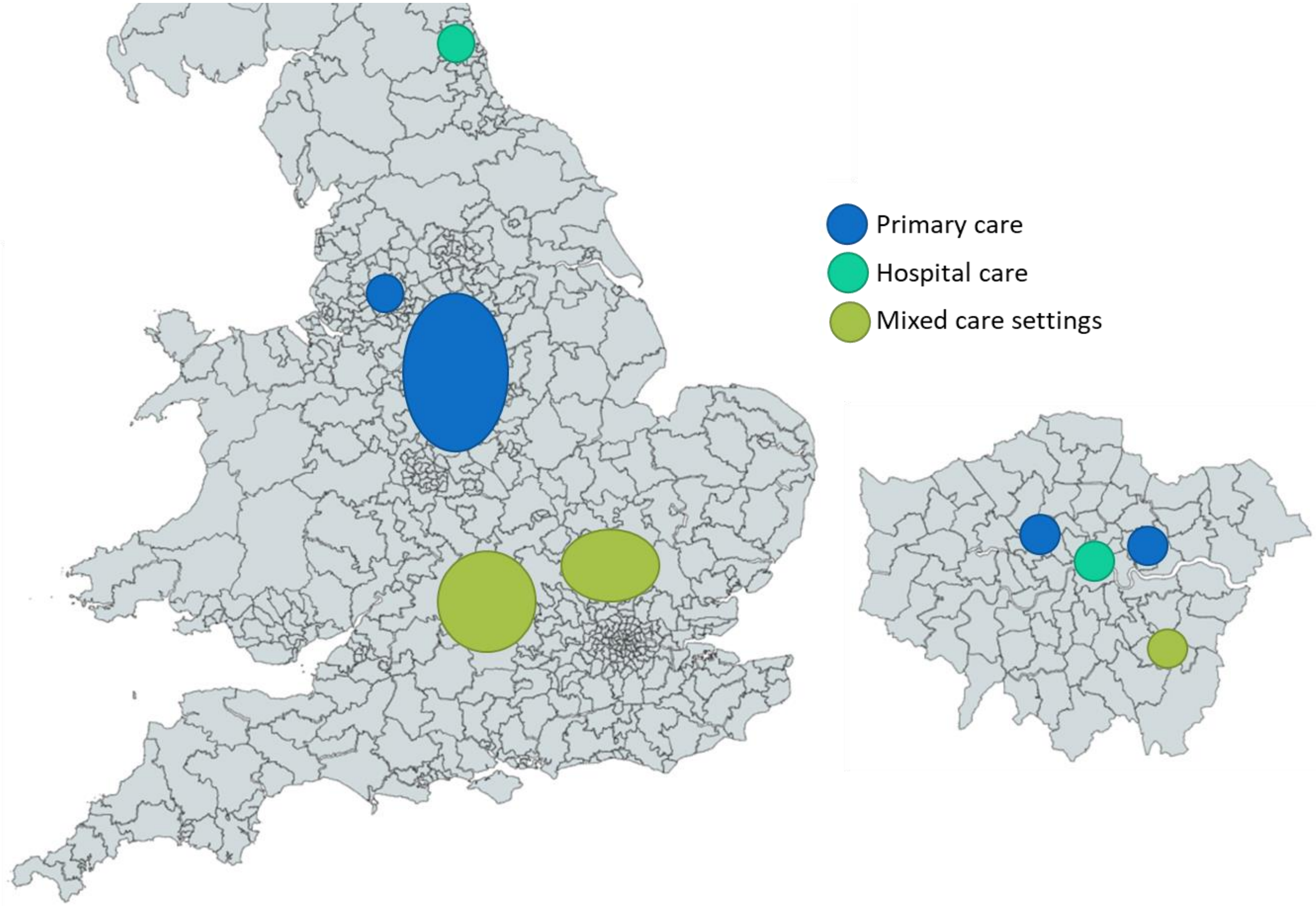
4.2.2 Interview recruitment

A total of 38 interviews across the nine participating case study partnerships were conducted. Interviewees included staff in frontline, management and funding roles, as presented in *Table 4-2*.

Table 4-1: Included case studies by sampling criteria

Case Study	**Geographical region**			**Healthcare setting**			**Partnership model features**				**Sustainability indicator**		
	Northern England	Southern England	London	Primary care	Hospital care	Mixed care settings	Co-location	Referral	Care pathway	Multi-disciplinary team	Long-lived	Newer	Ceased
1	X			X			X	X			X		
2			X	X			X	X					X
3	X			X				X				X	
4			X	X			X	X					X
5			X		X		X	X			X		
6		X				X	X	X	X			X	
7		X				X	X	X	X	X		X	
8	X				X		X	X		X	X		
9		X				X		X				X	

Figure 4-1: Map of geographical location and healthcare setting



** Size of the dots approximately represents the geographical area in which case study sites were located*

Table 4-2: Interviewees by professional role

Case study	Legal service	Health service	Funding organisation	Other	Total
1	1x Welfare rights advice service manager 2x Welfare rights advisors	1x health service manager	1x funder/commissioner		5
2	1x Welfare rights advice service manager 1x Welfare rights advisor		1x funder/commissioner		3
3	1x Welfare rights advice service manager				1
4	2x Welfare rights advice service managers 1x Welfare rights advisor	1x healthcare professional			3
5	1x Welfare rights advice service manager 2x Welfare rights advisors	1x social care manager	1x funder/commissioner		5
6	1x Welfare rights advice service manager 1x Welfare rights advisor	1x health service manager	1x funder/commissioner		4
7	1x Welfare rights advice service manager 1x Welfare rights advisor	1x social care manager	2x funder/commissioners		5
8	1x Welfare rights advisor	2x social care professionals 2x healthcare professionals		1x charity partner	6
9	1x Welfare rights advice service manager 1x Welfare rights advisor		1x funder/commissioner	2x partnership managers	5
Total	19	9	7	3	38

4.3 THE CASE STUDY PARTNERSHIPS

This section provides an overview of the characteristics of participating case study partnerships. The information presented in the results is based on how the partnerships operated during normal times, before the Covid-19 pandemic restrictions. Notes on how things had changed during the pandemic are included at the end of this section under *Partnership experiences during Covid-19*.

4.3.1 Service characteristics

Table 4-3 displays the characteristics of the health and legal services participating in the partnership. Four case studies were linked with GP practices, two were based in hospitals and three covered more than one care setting. Welfare rights advice was largely provided by charities (n=6) but included two local authority services and one law clinic. Advice and assistance was commonly provided in relation to several areas of social welfare law (most commonly welfare benefits, debt and housing), but three services specialised in a single area (welfare benefits). In primary care partnerships, the services were normally open to all local residents; however, in one case access was limited to patients who were registered at the practices where outreach appointments were taking place. In the acute and specialist care settings, the legal services were provided for people with particular health conditions (cancer, HIV, mental health) or demographics (children). Families or carers of the patients could also receive help.

Funding for the projects came from charities (n=2), local authorities (n=2), the NHS (n=1), university (n=1) and multiple or joint streams (n=3). Some had funding that was reviewed and renewed on an annual basis (n=4), others had contracts between 2-4 years. One service receiving higher education funding was not time-limited, due to the service being an integral part of the ongoing student curriculum.

4.3.2 Approaches to integrating service delivery

The main features of the partnerships are summarised in *Table 4-4* and described below.

Co-location

Most of the partnerships provided face-to-face advice appointments on-site in the healthcare setting (n=8). In the single site services (n=3) advisors were present full-time, with allocated rooms or desk space in the GP practice or hospital. The others (n=5) provided regular outreach sessions, rotating between sites to cover a larger region. Two partnerships operated remotely rather than providing on-site appointments. One had placed 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 an inbound call service taking referrals from all local health and social care services as well as patient self-referrals.

Referral sources

In the primary care-based services, most referrals came through self-referral and word-of-mouth. Primary care teams could also signpost or refer, with receptionists being one of the most common sources of signposting and referral. In hospitals and other specialist care settings, most referrals came via the care teams. Staff members that were most actively engaged included social workers, clinical nurse specialists, clinical psychologists, care navigators, hospital discharge teams and information and support centre staff (such as Macmillan cancer centres and Patient Advice and Liaison Services).

Multi-disciplinary and multi-agency approaches

One case study involved a multi-disciplinary team (MDT) that included a welfare rights advisor. The advisor worked closely with the other team members to support patient care, taking part in the regular MDT meetings and receiving referrals from all disciplines. The advisor also provided a care navigation role, supporting patients to access care from within the MDT and local community services.

Two case studies involved multi-agency partnerships that brought together a number of local third sector organisations to work in formal collaboration with the NHS. The charities within these partnerships received referrals from healthcare services, but also referred to each other, facilitating access to the full range of support available within the partnership. One of these partnerships utilised a Single Point of Access (telephone and email address) through which all referrals were triaged by the legal service, ensuring any welfare rights issues were identified and addressed.

4.3.3 Administrative processes for partnership working

The administrative processes for partnership working are summarised in *Table 4-5*.

Referral mechanisms

In primary care, the most common form of referral was verbal signposting: patients would be told about the service and would then organise their own appointment. This required no direct communication between the health and legal services. A common method used across most of the case studies was to have a referral form that was completed and emailed to the legal service. In some places, healthcare staff would also telephone or email the legal service to communicate the referral.

Appointment booking

In four of the case studies (two in primary care and two in hospitals) the advice appointments were booked by the health service administration teams: regular diary slots were available on site and booking was managed by receptionists. In the other case studies, the legal services organised their own appointments.

Integration of IT systems

In most of the case studies, the welfare advisors did not have access to the healthcare information systems. Two partnerships had a shared appointment booking system so that advisors could view and add appointments. In only one case the welfare advisors had full access to the NHS information system and could view the full patient medical records (with patient consent).

Data protection processes

Any exchange of personal information between the services (either written or verbal) was carried out only with patient consent. Several of the services had secure email connections with the NHS, either through an NHS email or a Gov.uk email; this allowed referrals and other communication to take place without additional protections. Where there were no such systems in place, communication was often done via the patient to avoid data protection issues.

4.3.4 Governance arrangements

Contracts

The partnerships were usually formalised through a contract between the funder and provider organisations. Normally this involved two organisations, the advice agency and funding body (a charity, local authority or healthcare organisation). The two multi-agency partnerships had commissioned all the provider services under a single contract. In one case, an NHS organisation acted as the lead contractor, with the third sector organisations subcontracted to deliver services. The other had formed an independent body made up of member charities who worked under a single umbrella to bid for and deliver on the contract. One of the partnerships was not based on a formal agreement.

In this case, a university was both the funder and provider of the legal advice, and the relationship with the health service was based on an informal understanding.

Leadership groups

Several of the partnerships were governed by leadership groups, which varied in size and composition depending on the scale and complexity of the partnership. These usually comprised the senior managers of the participating organisations (both health and legal) and could also include funders and staff representatives. The leadership groups met regularly to discuss operational issues, review performance and make strategic decisions. In the multi-agency partnerships, each member organisation had equal voting rights in the partnership so that decision-making was equally spread.

Table 4-3: Characteristics of participating partnerships

Case study	**Health care setting**	**Welfare rights advice provider**	**Areas of social welfare law advised on**	**Eligible patients**
1	GP practices	Charity	Several areas (Commonly: Welfare benefits, Debt)	All local residents
2	GP practices	Charity	Several areas (Commonly: Welfare benefits, Housing, Debt)	Patients of the practices
3	GP practices	Charity	Several areas (Commonly: Welfare benefits, Housing, Debt)	All local residents
4	GP practice	Law clinic	Several areas (Commonly: Welfare benefits, Housing)	All local residents
5	Paediatric care, tertiary hospital	Charity	Several areas (Commonly: Welfare benefits, Housing)	Families of children receiving care
6	Cancer care, hospitals & hospices	Local authority	Single area (Welfare benefits) + advice on charitable grants & managing health costs	People with cancer and their families/carers
7	Adult mental health care, hospital & community	Charity	Single area (Welfare benefits)	People with mental health issues
8	HIV care, hospital service	Local Authority	Single area (Welfare benefits)	People with HIV and their families/carers
9	All local health services	Charity	Several areas (Commonly: Housing, Welfare benefits, Employment, Debt)	All local residents

Table 4-4: Approaches to linking service delivery

Case study	Co-location	Referral sources	Multi-disciplinary and multi-agency approaches
1	Outreach appointments on rotation	Self-referral, primary care teams (including receptionists)	Not applicable
2	Outreach appointments on rotation	Self-referral, primary care teams (including receptionists)	Not applicable
3	On-site free-phones, advice delivered remotely	Self-referral, primary care teams (including receptionists)	Not applicable
4	Full time on-site presence and appointments	Self-referral, primary care teams (including receptionists)	Not applicable
5	Full time on-site presence and appointments	Hospital care teams (especially social work & Patient Advice & Liaison Service), self-referral	Not applicable
6	Outreach appointments on rotation	Hospital and hospice care teams (especially Clinical Nurse Specialists, hospital Information & Support Centres), self-referral	Not applicable
7	Outreach appointments on rotation	Mental health care teams (especially hospital social work, community Adult Mental Health Teams), third sector	Multi-agency partnership: five mental health charities working in partnership with the NHS to support mental health care.
8	Full time on-site presence and appointments	Hospital multidisciplinary team (including medical consultants, specialist nurses and social workers, clinical psychologists, third sector partner)	Multi-disciplinary team: Welfare rights advisor employed as care team member.
9	Telephone advice line, advice delivered remotely	Local health and social care services (especially care navigators, hospital discharge teams), third sector, self-referral	Multi-agency partnership: independent third sector enterprise formed of five local charities, commissioned to support health and social care.

Table 4-5: Administrative processes for partnership working

	Referral mechanisms (other than self-referral)	**Appointment booking**	**Integration of IT systems**	**Data protection processes for secure information exchange**
1	Verbal signposting (patients told about the service by care teams)	Appointments booked by GP reception	None	Patient consent Information exchanged via the patient
2	Verbal signposting (patients told about the service by care teams)	Appointments booked by GP reception	Access to GP appointment booking system	Patient consent Information exchanged via the patient
3	Verbal signposting (patients told about the service by care teams) Referral form submitted by email or online referral platform	Appointments organised by legal service	None	Patient consent Secure email system via NHSmail GDPR-compliant online referral platform
4	Verbal signposting (patients told about the service by care teams) Referral form submitted by email Referrals made by telephone	Appointments organised by legal service	None	Patient consent Information exchanged via the patient
5	Appointments requested for patients by hospital staff	Appointments booked by hospital social work reception	Shared appointments calendar Access to summary patient records	Patient consent Secure email system via NHSmail
6	Verbal signposting (patients told about the service by care teams) Referral form submitted by email or on paper Referrals made by telephone	Appointments booked by hospital information support centre	None	Patient consent Secure email connection via Gov.uk
7	Referrals submitted by email or communicated in person	Appointments organised by legal service	Full access to patient care notes	Patient consent Secure email system via NHSmail
8	Referral form submitted by email or on paper	Appointments organised by legal service	None	Patient consent Secure email connection via Gov.uk
9	Referral form submitted by email	Appointments organised by legal service	None	Patient consent Secure email system via NHSmail

4.3.5 Service design issues

Access

Achieving full coverage of a population was a particular challenge in primary care, where the number of healthcare sites to be covered was large. One well-resourced partnership was able to provide physical outreach to almost all GP surgeries across the county. Here, where there was no space within a surgery (only three sites), patients registered at neighbouring surgeries were allowed to book in to ensure full coverage. Other partnerships operating physically in primary care did not have such wide reach. In one case, physical outreach was limited to less than a quarter of surgeries and was not made available to patients registered at other practices; this excluded most of the patient population and created inequity in access.

Two partnerships had addressed the issue of coverage by delivering services remotely, enabling a wider reach with the available staffing capacity. One had physically placed telephones in GP practices, providing patients with a free direct line to advisors; primary care teams across the city could also refer through a secure NHS email address. The other was fully remote and was open to referrals from all health and social care services across the borough (including primary and secondary care).

In acute care and specialist care settings, there were a smaller number of sites to cover and patients attended from across a wider region. Equity in access was therefore less of an issue in the partnership design. Advice teams were either based at a single site or covering several sites on rotation. Referrals were still received remotely on a continuous basis and face-to-face advice appointments were available within the allocated on-site sessions.

While remote delivery increased the geographical reach of the service, it may have been less accessible for particular patients: interviewees thought there could be certain groups that were less willing or able to access remote services, including the elderly, those with hearing or visual impairments, mental health conditions or English as a second language. The importance of face-to-face advice in certain circumstances was highlighted by this study participant:

> *"When you think of people with severe mental illness, communication can be a real issue, engagement can be a real issue and actually saying "well here's a phone number, phone them" [the advice service]; they won't." [Case study 7, Social care manager]*

Demand and capacity

The demand for welfare rights advice was often very high and some of the legal services had significant waiting lists (up to six weeks in the busiest cases). Some had limited staff capacity to meet the referral demand and others lacked capacity for specialist areas of advice (such as housing and immigration) or for specialist types of assistance (such as tribunal representation). In order to contain demand, services had tried to focus on the groups of people that were most in need; for example, by working with particular services or departments where welfare rights issues were common (e.g. mental health, hospital social work) and minimising publicity to other areas.

> *"We don't do a phenomenal amount of publicity in the general world… the team need to focus on those people who need us most." [Case study 7, Welfare rights advice service manager]*

Some of the legal services had boosted their capacity by bringing in volunteers or building connections with other local services with greater resource or specialism. Capacity to meet patient needs was also improved through 'secondary consultation', (see also Outcome 1: Collaborative working below) which was common in the partnerships in acute care settings: advisors worked with healthcare professionals to improve their knowledge of the welfare system and answer general questions, so that they could pass on information to patients with simpler enquiries.

> *"We don't send every single welfare benefit query to [the legal service], you know a lot of the Family Support Officers as we call them are up to speed on what people are entitled to, so it's helpful if [the legal service] can keep updating us so we can then give out the basic sort of information without referring to them, because sometimes there can be long waiting lists." [Case study 5, Social care manager]*

Efficiency

While demand was generally high, some of the primary care-based services experienced difficulty generating sufficient referrals through the GP practices to fill their on-site sessions and attendance could be low at times. With pre-booked pop-up appointments, there were sometimes issues with clients not turning up or only needing brief assistance that did not require the full appointment time. These efficiency issues had been a driving force behind the development of remote delivery models, which enabled more efficient use of staff time, reduced waiting times for the service and increased client throughput.

> *"It just meant we were able to help so many more people… and in terms of a commissioning model, we're giving much more, much*

> *better value for money than we would by putting a person in a few GP practices." [Case study 3, Welfare rights advice service manager]*

4.3.6 Partnership experiences during Covid-19

During the Covid-19 pandemic restrictions, the face-to-face advice services changed to remote delivery, although two of the hospital-based service maintained a reduced on-site presence. Advice and assistance was provided by telephone, email and video calls. None of the services ceased to operate and were open for referrals and appointments. However, many experienced a large drop in demand. This was thought to be partly because the pandemic response measures (such as suspension of housing evictions and debt recovery) had relieved individuals of the immediate pressures of welfare problems. With face-to-face healthcare appointments being reduced or suspended in some places, the usual route in through co-location had also stopped. Referrals were still coming in by email in some places, particularly from health services that continued to operate with less disruption (such as hospices and care navigation services). Multi-disciplinary team meetings had continued regularly but were happening remotely.

Advisors were concerned that the shift to remote service provision might lead to certain groups of people being missed, such as those without access to mobile phones and the internet. They also felt face-to-face delivery was preferable for certain patients (notably those with mental health issues) because it was easier to build rapport, read body language and get a better understanding of the person, and therefore was important for high quality service provision to these groups.

The welfare advice workload had increased again following the lifting of pandemic response measures in summer 2020, and several participants were concerned about a potential wave of welfare issues coming in the near future due to the impacts of the pandemic on income and livelihoods.

4.4 OUTCOME 1: COLLABORATIVE WORKING

This section focusses on collaborative working in the case study partnerships, which is the first implementation outcome investigated in the study. As defined in the methodology chapter, collaborative working refers to 'active participation of frontline staff from both organisations in the shared activities of the partnership, whereby patients are proactively referred, and the staff teams communicate and coordinate care in consultation with each other'.

The results are presented in three sections:

i) Description of collaborative working
ii) Pathways to collaborative working
iii) Cross-case comparison of collaborative working

4.4.1 Description of collaborative working

Table 4-6 summarises how staff in the health and advice teams were working together in the partnerships. The passage below describes the patterns of variation within and between case studies.

Table 4-6: Activities of collaborative working

Activity	**What was involved**
Identification of need	Picking up on the need for welfare advice (by healthcare professionals) and picking up on the need for health care (by Welfare rights advisors)
Making referrals	Connecting patients to the welfare advice service through referrals and signposting. Connecting patients back to health/social care if needed.
Exchange of medical information	Exchanging medical information to support welfare applications, including patient records and supporting letters.
Joint input into case work	Contributing jointly to an individual's case, including liaising about the situation, discussing appropriate responses and coordinating input.
Secondary consultation	Providing technical information and strategic advice to members of staff, helping them understand welfare situations how to respond, and equipping them with information to pass on to patients.
Feedback on outcomes	Communicating the progress and outcomes of welfare cases back to referring health and social care professionals.

Identification of need

Proactive identification of welfare need was occurring in three ways: i) by hospital social workers, who were routinely doing social assessments with patients and helping with welfare issues to a basic level; ii) by Macmillan cancer services (Clinical Nurse Specialists and Information and Support Centre staff) who were doing Holistic Needs Assessments using a concerns checklist as part of the package of care offered; iii) though multi-disciplinary team working, where patient needs were discussed in team meetings and social issues would be raised in conversation. Otherwise, needs were being identified opportunistically: healthcare professionals might be asked for help directly during consultations (for example, with benefits forms or housing applications) or become aware of welfare issues that were impacting on health, as illustrated in the quotation below.

> *"When GPs did speak to us, it was 'cause they'd got concerns that perhaps patients weren't saying what an issue was. The GP was noticing that they weren't feeding themselves, or there were underlying issues that they weren't disclosing that were perhaps impacting on their mental health." [Case study 1, Welfare rights advice service manager]*

A wide range of healthcare staff were involved in identifying needs, in addition to medical teams; this included administrative staff, counsellors and psychologists, social workers, information and support centre staff. Sometimes these professionals were engaged to a greater extent than clinical teams. Suggested reasons for this included that they were more attuned to welfare issues, were asked about them more frequently by patients, had more time to spend with people and had a better knowledge of the legal service. Interviewees felt that patients could be reluctant to discuss welfare issues with clinical teams due to embarrassment or not wanting to waste time; also that clinical teams lacked confidence to raise welfare issues with patients, might worry it would upset people or may not recognise when welfare assistance was needed.

> *"Patients don't always talk about their financial worries with their clinical team because they don't want to bother them or they are embarrassed or it hasn't been raised, you know lots of issues like that, but they might talk about them in the information centre." [Case study 6, Funder/commissioner]*

Identification of health need was also occurring in the partnerships: advisors would sometimes identify unmet need for healthcare during the course of their welfare assessments and could support and encourage patients to engage with the care that they needed.

> *“[The welfare rights officer] will see the patient and do a really good thorough assessment with the patient, and she’s very psychologically-minded and very good at noticing and picking up on any psychological issues like depression, anxiety, trauma… and then she might refer that patient to us.” [Case study 8, Healthcare professional]*

Making referrals

Health and social care professionals would make referrals to the legal service when welfare needs were identified. While in some case studies the legal service was highly utilised, several of the partnerships experienced challenges achieving sufficient and consistent referrals from healthcare teams. Within the case studies, levels of referrals also seemed to vary significantly between professional groups and between individual staff members. Across the board, doctors appeared less engaged in making referrals and patients would mostly come through other routes (see also ‘Referral sources’ above).

> *“Very wide range in referrals from GPs, health visitors I would’ve thought would be great, no they’re not you know… midwives were better. Practice nurses not very often, counsellors could refer. So there was a kind of mixed response from primary care.” [Case study 1, Funder/commissioner]*

> *“I think there was a mix. Some were very keen, others had managed to miss it or avoid the whole thing or didn’t have much understanding for it, some were very active in referring people and some weren’t. It really varied.” [Case study 4, Welfare rights advisor]*

Exchange of medical information

Medical evidence was often needed to support the more complex welfare cases and could be requested from health services with patient consent. In most case studies there was no shared information system and seemed to be no uniform approach to information exchange. Straightforward information like patient summaries could often be obtained from the patient themselves or from the health service reception. Where greater medical input was required, advisors would sometimes communicate directly with clinical teams to source the necessary supporting information. Another method was to ask patients to source information from their medical teams themselves.

There was variation in how forthcoming health services (and individual health professionals) were with this information. Many were willing to provide it and worked closely with the legal service to coordinate this. However, others preferred not to and could act obstructively, for example by refusing to provide evidence or charging fees.

> *“For a few patients there was a dialogue between the advisors and the doctors to kind of get bits of medical evidence that were needed … but the extent to which it was happening I think kind of varied from GP to GP.” [Case study 4, Welfare rights advice service manager]*

> *“Some GPs are very good, “yes I will do”, you know, “just draft me a letter and I’ll adapt it accordingly”. Other GPs may say “Yes I will do a letter if the patient asks me directly and there will be a fee for that”. Some GPs charge, some don’t. Others will say “It’s our practice policy not to provide those letters”.” [Case study 1, Welfare rights advisor]*

Two of the case studies had some limited access to the healthcare information system (e.g. being able to see patient summaries) and could therefore source some supporting information directly. In one case, the legal service had full access to the information systems, which meant the advisors were fully equipped with the necessary information and could also update the health records with progress on the legal casework to keep the care teams informed.

Joint input into casework

In the primary care-based partnerships, healthcare professionals and welfare rights advisors worked separately in relation to the case work, however co-working was much more common in the acute and specialist settings. Sometimes this could take the form of meeting the client together for shared discussions, through joint clinics, ward rounds, home visits or other meetings. Staff would also liaise with each other to convey information on needs, discuss appropriate responses, contribute to support plans and coordinate their input at different stages, as well as providing feedback and progress updates. Where this co-working took place, it had a clear role in facilitating the work of both healthcare and welfare rights professionals and progressing individuals’ cases.

> *“We might decide a bit of joint working is needed, so we might see that patient together, to be thinking about how welfare issues or debt might be impacting on psychological wellbeing, and have a joint discussion with the patient about what areas [the welfare rights officer] might work on and what areas Psychology might work on.” [Case study 8, Healthcare professional]*

> *“We will work alongside [the legal service], we won’t necessarily refer in and close the case, we will manage the other elements to it and we will work, so we will liaise with the clinicians on behalf of [the legal service] to get clinic letters or to get supporting letters for DLA.” [Case study 5, Social care manager]*

Secondary consultation

Where members of health and advice teams were in regular contact, they often supported each other with professional advice. Rather than relating to individual cases, this was technical and strategic advice to support their practice. Largely it involved welfare rights advisors helping healthcare professionals; for example, to understand welfare systems and processes, how to respond in certain situations, or what input was required of them regarding the welfare issue. It also worked in the opposite direction, with healthcare professionals helping advisors to understand the impact of health conditions on someone's capabilities. Often these consultations took place during on-the-spot interactions while working together on site, however colleagues also provided information updates during regular meetings. The knowledge enabled staff to respond better to individuals' needs, as well as pass on general advice and support to patients.

> *"(The Clinical Nurse Specialists) will pop their head round the door if they need anything, or ask for benefits advice, not for themselves, but for their clients. If they're unsure about something, they'll just run something past us." [Case study 6, Welfare rights advisor]*

> *"That's happened at every MDT meeting as well, you know, general queries, changes of benefits, things that might affect our patients, that's part of the role… just giving them some insight into potentially what could be affecting presentation of their patients." [Case study 8, Welfare rights advisor]*

Feedback on outcomes

In the case studies where health and advice teams worked closely together on individual cases (see 'Joint input into casework' above), feedback was provided as a routine and natural part of co-working. In other case studies this did not normally occur. The reason given was the confidential nature of the welfare rights advice, meaning the work would not be communicated with anyone unless the client specifically asked advisors to do so. Some advisors also felt there was no need to provide this feedback and that clients could communicate it to their care teams themselves if they wished. Others had approached this issue by providing anonymous feedback and case vignettes to illustrate the types of work being done and outcomes achieved.

> *"Individually we wouldn't (provide feedback to GPs) because we'd need a client's permission, we've got confidentiality stuff, and I suppose we just think the client can go and tell them." [Case study 2, Welfare rights advisor]*

> *"People who come to us for advice really put a lot of faith in a confidential service, and as a result unless you specifically ask us to*

> *tell your GP something, or we have specific consent, but again we wouldn't really seek out that consent unless we felt it was really necessary." [Case study 3, Welfare rights advice service manager]*

4.4.2 Pathways to collaborative working

This section explores the causal pathways leading to engagement in collaborative working activities. Evidence is presented in two sections:

i) Mechanisms influencing collaborative working
ii) Contextual factors influencing identified mechanisms

Mechanisms influencing collaborative working

Figure 4-2 shows the mechanisms leading to engagement in collaborative working activities, as identified using the Process Tracing method. These mechanisms interacted to some extent with each other, and the identified interactions and feedback loops are depicted in

Figure 4-3. The mechanisms, and relationships between them, are described in the passage below.

Mechanism theme: Willingness

The 'willingness' theme describes staff attitudes towards the partnership and their preparedness to participate in collaborative working.

Sentiment towards partnership

Sentiments towards the partnerships seemed predominantly positive in all the case studies, with most team members being happy to work together. Staff with favourable views on the partnership accepted the advisors into their teams, were active in referring patients and helpful in providing information and supporting evidence. They were also proactive in facilitating the practical aspects of the partnership and promoting it to patients and colleagues. However, there were also individuals who were negative towards the partnership and could be obstructive; for example, by refusing to host the advice service or engage in making referrals and providing supporting evidence. Some also levied financial charges for room space or medical reports. The diversity of sentiments towards working in partnership is illustrated by the quotations below.

Figure 4-2: Mechanisms leading to collaborative working outcomes

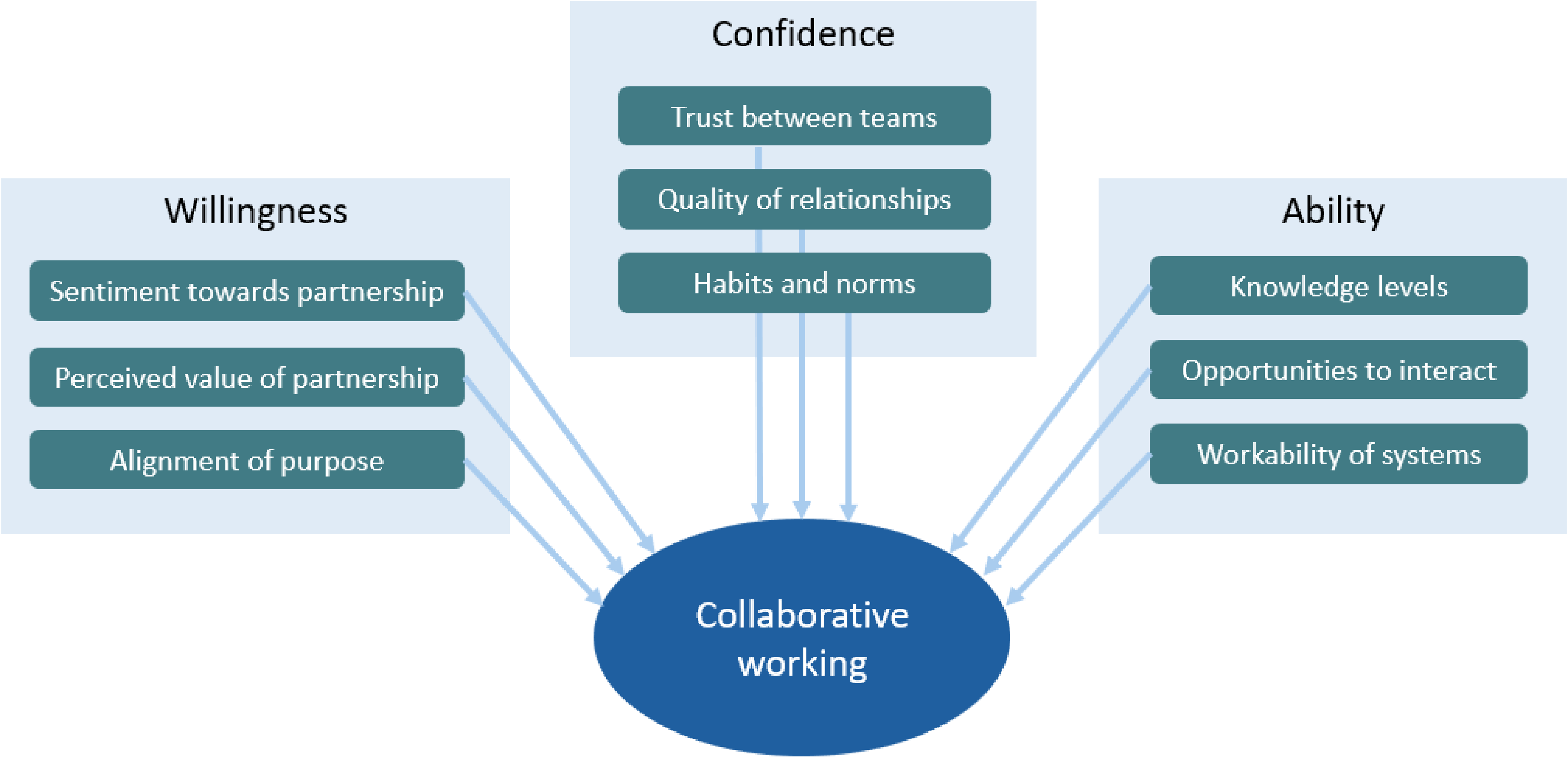
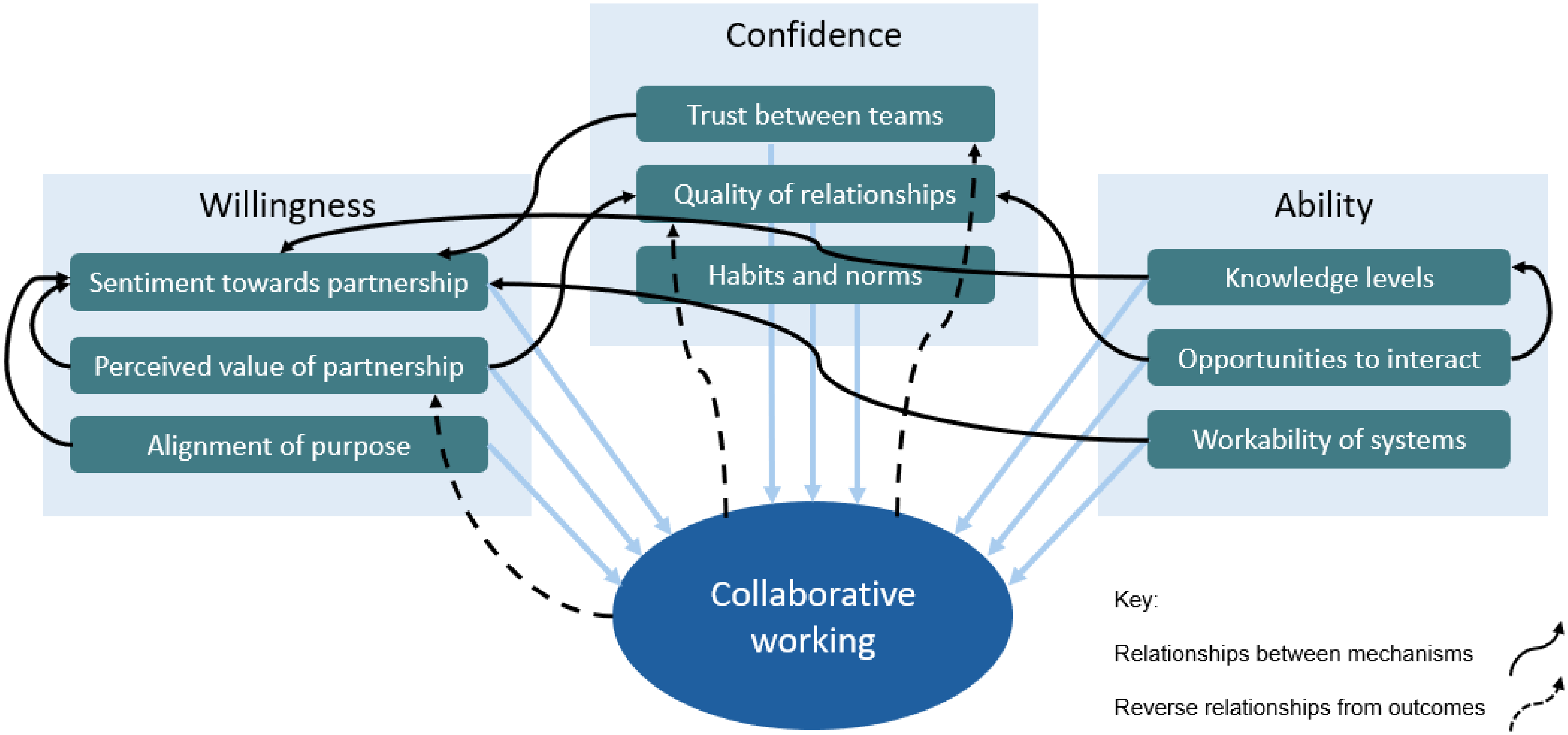


Figure 4-3: Interactions among mechanisms on the pathways to collaboration



> *“From day one, I was involved in the steering group. It’s good to get involved at the beginning, and as I say, you’re their voice and you feel keen and everything to make it succeed.” [Case study 6, Health service manager]*

> *“The Adult Mental Health Team in a town called (Name) has always perceived (the legal service) to be meddling amateurs, and that has a long history… it’s been very slow to turn that around.” [Case study 7, Welfare rights advice service manager]*

Several of the other mechanisms interacted with ‘*Sentiment towards partnership*’, highlighting the diverse factors which influenced people’s positivity towards the partnership, and thereby engagement with it. These included ‘*Perceived value of partnership*’, ‘*Alignment with purpose*’, ‘*Trust between teams*’, ‘*Knowledge levels*’ and ‘*Workability of systems*’. The influence of these factors is discussed in their respective sections below.

Perceived value of the partnership

Members of staff who valued the partnership engaged well in collaborative working because of the benefits that they saw for themselves and their patients. Interviewees valued the partnership when they observed high levels of need for welfare assistance among patients, recognised the importance of non-medical interventions to support health, and believed that collaboration could achieve better outcomes for individuals. Partnerships with legal services were also valued for the quality and professionalism of their assistance for patients, and the support they provided for health and social care professionals. The quotation below illustrates how a positive perception of the value of team working can facilitate engagement:

> *“They’re part of the inpatient team and they’re seen as an integral part of the team and they are invited to and do attend the inpatient social work team meeting which is held every Monday. I mean, they can’t always do that but they are actively encouraged, because they are people who might have ideas and experience… we are all working together for the benefit of that person.” [Case study 7, Social care manager]*

Conversely, professionals who did not value the partnership would not engage with it. Various reasons were identified to do with attitudes among healthcare professionals: some did not recognise a need for welfare support among patients or appreciate interdisciplinary approaches to care; others felt that collaborative working might negatively affect their own work, including their relationships with patients or administrative workloads. The quotation below exemplifies how a lack of appreciation for collaborative working can inhibit engagement:

> *"There are certain consultants who know you're there, know what you do, never refer… The one I'm talking about never goes to Multi-Disciplinary Team [meetings]… Doesn't necessarily value the worth of MDT because he's very medically model focussed." [Case study 8, Welfare rights advisor]*

'*Perceived value of partnership*' positively influenced '*Sentiment towards partnership*': when staff saw benefits for patients/clients and for themselves, this contributed to them feeling the partnership was worthwhile and therefore being positive about working with the partner organisation, as illustrated by the quotation below:

> *'I've been here a very long time and there's been different facilitators from Citizens Advice Bureau coming to us, but they've all been good, you know? I think they're very knowledgeable, I think they've got quite high levels of expertise and I think the feedback we get is all very good.' [Case study 1, Health service manager]*

A feedback loop was also identified, in which engagement in collaborative working positively influenced '*Perceived value of partnership*'. Through exposure and opportunities to work together, healthcare professionals witnessed for themselves the high-quality of the advice service and the positive impacts for patients. This led them engaging repeatedly going forward because they had seen the positive track record:

> *'If for instance in the hospital somebody felt very vulnerable, they would come down with a member of staff, and the staff member would be sitting there with me as well. And then they may think 'oh right, this has proved really beneficial for this patient, I must remember to refer another patient another time'… because they get to know me and see what could be available'. [Case study 9, Welfare rights advisor]*

Alignment of purpose

There was variation among both health and welfare rights advisors in how they felt collaborative working aligned with their core role and purpose. This influenced their willingness to participate and their levels of engagement. Among advice teams, some saw close links with healthcare professionals as the key to reaching and helping their client groups, while others felt that close working was not necessary for them to carry out their roles effectively. A minority questioned the need for those links at all. These diverse views are illustrated by the quotations below:

> *"Working with healthcare professionals is, I believe, the best way to help work with the client, and that's what we're about." [Case study 7, Welfare rights advice service manager]*

> *"It does work like that as and when needed. I can speak to a GP and they can speak to me, but I don't think it's really needed any more than what we've got already." [Case study 1, Welfare rights advisor]*

> *"The lawyers who were there were there to help clients. Yes it's an added bonus that we can help GPs, but that's not the main focus." [Case study 4, Welfare rights advice service manager]*

Among healthcare teams, there was variation in the extent to which individuals felt responsible to address non-medical issues among patients. While some saw this as an essential and acceptable part of their role, others felt it was outside their remit and were reluctant to engage in associated activities. These perspectives seemed to vary from person to person, but some teams showed a sense of collective responsibility which facilitated good levels of engagement with the partnership.

> *"All the ward staff know, the nurses and other health professionals, all know how to refer somebody to (the legal service) and, so we see it as not just a social work task but it's everybody's business that if you see somebody needs something, we will make efforts to support you to access it." [Case study 7, Social care manager]*

> *"I'm sure, as doctors, we all have different orientations towards social problems… I think the temptation would be to not have finely-tuned antennae to pick up the social problems because they are complex to deal with." [Case study 4, Healthcare professional]*

Interviewees identified a clash of cultural values which had inhibited collaborative working in some cases. Certain healthcare professionals had been reluctant to work with the legal service because of negative conceptions of the welfare system or would not cooperate on patient cases because they felt uncomfortable supporting welfare claims.

> *"I had one practice who said "We are philosophically opposed to this intervention", because they thought it was developing a benefit culture and dependency." [Case study 1, Funder/commissioner]*

'*Alignment with purpose*' had an influence on '*Sentiment towards partnership*'. When professionals felt that collaboration was an important part of their role and contributed towards their own aims, this led to positive sentiments about the partnership. Conversely, if they felt uncomfortable collaborating, or that it was outside their remit, this could lead to more negative sentiments about the arrangement. This relationship is illustrated by the quotations below:

> *‘We’re doing the same job just from a different angle, so we’re all there to help the service users, so therefore it’s good to work together… there isn’t anyone I’ve met that you don’t find some sort of common ground with’. [Case study 7, Welfare rights advisor]*

> *‘GPs who are more traditional, and think that essentially you come to a doctor because you need medicine… they don’t necessarily see. It’s not that it’s the Citizens Advice service, I think the social prescribing thing as a whole they are just a bit sceptical about’. [Case study 3, Welfare rights advice service manager]*

Mechanism theme: Confidence

The ‘confidence’ theme describes staff members’ certainty in their own actions and faith in the actions of others.

Trust between teams

Having trust in the legal service was important for healthcare professionals to feel confident making referrals, communicating and sharing medical evidence with advice teams: they needed to know the service was competent, legitimate and providing an effective intervention. Levels of trust were therefore an important determinant of engagement in collaborative working, as illustrated by the following quotation:

> *“I think also it’s building up trust as well with the GPs, that they realise actually you’re in there and what you’re doing makes sense and is making a difference to those patients, and so you need to be trusted as much as other professionals.” [Case study 9, Partnership manager]*

Trust could be a challenge particularly in the early stages of partnerships when the arrangement felt new or temporary and before the teams had experience of working together. Often trust built up over time as colleagues witnessed the professionalism of the service, saw the positive outcomes for patients and became known to each other. The following quotation illustrates how the confidence of healthcare colleagues was inspired by witnessing welfare advisors dealing competently with suicidal behaviour in mental health patients:

> *“Those who use us most frequently and most regularly are the ones who have seen us in action and know that we’re not afraid to ask the difficult questions… and (have seen) how we deal with the responses as well.” [Case study 7, Welfare rights advice service manager]*

‘*Trust between teams*’ positively influenced ‘*Sentiment towards partnership*’. When healthcare professionals trusted welfare rights advisors as colleagues and insiders, they were welcomed into the health setting. Conversely, a lack of trust in the legal services had contributed to negative perceptions among healthcare professionals. Reasons for this included believing that the initiative would be short-lived (due to previous experience of project turnover) or feeling protective over patients and unsure that the advice service would provide a positive and supportive experience for patients. This relationship is illustrated by the quotations below:

> *'They know us, they know the work that we've done, you know it's a proven service over the years. They can see the benefits for the patients I think, so they always want to work with us'. [Case study 1, Welfare rights advisor]*
>
> *'I don't know if there's an element in people's minds… there's not much point because these services come and go, and they might not be here in six months' time so I won't make too much effort'. [Case study 4, Healthcare professional]*

There was a relationship in the reverse direction, whereby engagement in collaborative working increased the trust between teams. By seeing the welfare rights advisors in action, speaking to them about situations and getting to know them as people, healthcare professionals came to trust their competence, knowing that they could manage difficult situations, would pick up on patient needs and provide a high-quality service. The quotation below illustrates the high levels of trust that had built up through close collaborative working in one case:

> *'It's always really straightforward to communicate with the Welfare Rights Officer, and she is always very responsive, and you know from a psychology point of view, she is really picking up on the needs of this demographic and that's what we're totally reassured about'. [Case study 8, Healthcare professional]*

Quality of relationships

The level of familiarity between health and welfare teams varied between the case studies: while some teams knew each other well and had regular personal contact during daily activities, others were much less familiar with each other. Nonetheless, the advisors were generally made welcome in the healthcare environment and relationships between teams were largely positive in all the case studies.

Good working relationships facilitated collaborative working in several ways. In some places the advisors were accepted as members of the healthcare teams, and as such were included in team meetings and other communications. Colleagues who were accommodating and helpful would assist with the practicalities of partnership working (for example, helping to coordinate appointments and arrange access to appropriate room space) and would aid any necessary exchange of personal information to support the welfare casework. Warm relationships also facilitated good communication between the teams, making it possible to discuss patients' needs and coordinate responses. The importance of relationships to effective collaborative working is illustrated by the following quotations:

> *"Very, very easy now we've got it streamlined to be honest with you, very much so, and because we know them by name, they know us… I think because we've got a really good working relationship, you know, it's working with your colleagues so it's easy." [Case study 6, Health service manager]*
>
> *"I would speak to a couple of the GPs about issues I were dealing with, and I'd feel I could approach them sometimes for a medical opinion on an issue that I'd seen, and seeing whether something needed to be done further or what advice they could give to support an application." [Case study 1, Welfare rights advice service manager]*

Despite the mostly positive relationships between teams, many of the partnerships had also experienced a more negative reception from certain individuals. These people could be obstructive by refusing to engage with the partnership personally or promoting it in an unfavourable light to patients and colleagues.

There was a relationship in the reverse direction, whereby engagement in collaborative working helped to develop positive relationships. By crossing paths, interacting and communicating regularly, the teams got to know each other and sometimes the relationships were very close and collegiate. Where there was less opportunity to interact and work together, relationships were harder to build. This association is illustrated by the quotations below:

> *'The advisors are talking to the nurses and the hospice staff all the time really… particularly the ones that are referring very regularly, yes they would know them very well'. [Case study 6, Welfare rights advice service manager]*
>
> *'When I was there, I was largely in the room seeing clients and so it would be just at the beginning I might say hi to the practice manager and to the reception obviously… but otherwise there wasn't extra space to build those relationships I think'. [Case study 2, Welfare rights advisor]*

Habits and norms

Regular engagement in collaborative working happened once it had become a routine, natural and automatic part of everyday activities. One of the challenges in generating referrals to the legal service was that healthcare professionals were not used to referring to this type of service, their training and experience being to work with other medical services. It was therefore not at the forefront of their minds while interacting with patients and could be difficult to remember and act on in a short space of time. With limited previous experience, they could also be uncertain if referrals were appropriate or how to go about providing supporting evidence where that was required, as well as unsure how to raise and discuss welfare issues with patients. Over time as experience developed, staff would get into the habit of engaging and it would become more automatic. Also, as they witnessed colleagues engaging, the behaviours would catch on and become part of team practice. The quotations below illustrate some of the challenges experienced by new members of staff and new partnerships, before habits and norms had developed:

> *"Towards the end of my time there, there were some newer GPs that came in and I think some of those were much more nervous about things like providing evidence actually, and it's probably just because they perhaps weren't used to it in the same way." [Case study 2, Welfare rights advisor]*

> *"I think, you know we're just… we're not used to referring to this kind of service. It's a very new service. We're not trained to refer to it… You're talking about quite a significant kind of behavioural change, and indeed maybe even a cultural change, in getting people to refer to a new service." [Case study 4, Healthcare professional]*

Mechanism theme: Ability

The 'ability' theme describes staff members' possession of the means and skills to participate in collaborative working.

Knowledge levels

Awareness of the legal service among healthcare teams varied between services, departments/teams, and individuals. Generating and maintaining awareness could be a significant challenge in the partnerships where there was little in the way of regular interaction between teams and visibility of the service was low. Low levels of awareness led to low levels of referrals because the staff did not know of the service's existence or would easily forget. Maintaining visibility through regular face-to-face contact, promotional activities and reminders helped to address this issue. Awareness was much less of a problem in places where the health and advice teams routinely interacted in person during their daily work. The importance of awareness in facilitating engagement is illustrated by the quotations below:

> *"Having people in the hospitals and hospice settings, besides actually seeing people face-to-face there, it also helps to, it's a constant reminder to the nurses and the information centre staff that we're*

> *there, so the referrals are coming in all the time." [Case study 6, Welfare rights advice service manager]*

> *"There's only so many things GPs can hold in their heads at one time. And that's, I think that's the point, it's about just who spoke to them last, so it is kind of the requirement to be just a constant noise and not let them forget." [Case study 3, Welfare rights advice service manager]*

Other aspects of knowledge were also important, including an understanding of what the legal service offered: what sorts of issues could be referred, what type of assistance was provided, who would benefit from a referral and in what ways. When the purpose and the details of the partnership were understood, people could engage with it more effectively. A related issue was the ability to recognise legal needs: welfare issues were beyond the normal realms of knowledge for many healthcare professionals, making it difficult to identify when a referral was needed. Similarly, some healthcare professionals did not understand what was required of them in sharing medical evidence to support welfare casework, particularly when they had little experience of doing so. The ways that knowledge limitations could affect ability to work collaboratively are illustrated by the quotations below:

> *"It's just that it's not on my consciousness. Do I see many people…? I think, you know, because I don't know what I don't know, so I don't know when people have got a legal problem." [Case study 4, Healthcare professional]*

> *"Quite often it's much harder to get medical evidence, particularly when you're going to GPs, whereas the Clinical Nurse Specialists know exactly what's required… there are certain types of evidence that they're consistently asked for, so they know what they have to do because they do it so often." [Case study 6, Welfare rights advice service manager]*

'*Knowledge levels*' could have an influence on '*Sentiment towards partnership*'. When healthcare professionals had a good understanding of the purpose of the partnership and the activities of the legal service, this generated positive feelings about it. The quotation below illustrates how being involved in regular meetings together increased understanding and appreciation for the work of the partnership:

> *'It is really good, I meet with them three-monthly and we go through the service development and how we can make that better… it just gives a nice bigger picture and also makes you very, very keen on the work they're doing, you get an understanding of the sort of passion they're putting in, to do well.' [Case study 6, Health service manager]*

Where levels of understanding were low, healthcare professionals would sometimes act in a negative or obstructive way because they did not appreciate the role or benefits of the partnership. This included being reluctant to engage with the legal service, trying to evict it or charge rent to operate in the health setting. The quotation below illustrates how increasing understanding helped overcome resistance to the partnership:

> *‘Once we’d got past those teething issues of people just being a bit uncertain about what kind of support we were really going to offer… people were a little bit sceptical at first, but I think those have come round to it quite a lot and it’s been quite positive overall.’ [Case study 3, Welfare rights advice service manager]*

Opportunities to interact

The levels of interaction during daily work varied significantly between the partnerships. In the primary care-based case studies the advisors would regularly see the administrative staff, with whom they worked to organise appointments and obtain medical records. However, there was much less cross-over with the medical teams because they worked in separate offices and had few if any formal meetings together. The remotely-delivered services also had little opportunity for personal interaction between health and advice teams, although one had initiated remote team meetings which healthcare staff would sometimes join. The teams in acute care had more in the way of opportunities to interact through shared workspaces (offices and other facilities), as well as more commonly holding joint care team meetings and joint clinics.

Face-to-face interaction facilitated collaborative working by enabling communication between teams. Shared spaces and joint meetings provided opportunities for colleagues to come together and talk, discuss issues, ask questions and learn from each other. It also facilitated joint working on individual cases, through liaising about situations and sourcing supporting evidence. The opportunities that interaction presented are illustrated by the quotations below:

> *“Social work department, we are actively liaising with them all day every day. So we are in and out of the 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’”[Case study 5, Welfare rights advisor]*

> *“With the physical presence of the advisors there, you know, they were able to go around, talk to nurses, they could speak to, if they need evidence, medical evidence, they pick it up when they’re there. It just makes things a lot easier.” [Case study 6, Welfare rights advice service manager]*

‘*Opportunities to interact*’ had a positive influence on ‘*Knowledge levels*’, through increasing awareness of the partnership. When the advisors were physically present in the health setting, healthcare professionals would see them around during their daily activities, which served as a constant reminder about the partnership. It was more challenging to maintain awareness when the physical environment separated the teams. The quotations below illustrate the challenge of maintaining visibility and awareness, and how one service had begun using remote team meetings to combat this during Covid:

> *‘We were put on a corridor at the back of the surgery and I just don’t think that’s where it should have been… it depends of space and facilities, but I think the more visible you can be the better.’ [Case study 4, Welfare rights advisor]*

> *‘We’ve been reaching out and we’ve had quite a few healthcare professionals come into the Zoom meeting. That’s been really beneficial… they can tell us about their service, our staff can ask questions and vice versa, so that’s been a really good way of doing it.’ [Case study 9, Welfare rights advice service manager]*

‘*Opportunities to interact*’ also positively influenced ‘*Quality of relationships*’, because it enabled staff to get to know each other. The quotations below illustrate how the ease and regularity of interactions determined whether relationships were built between teams:

> *‘We can just drop in, they are literally across the corridor… they use our kitchen and they are in and out of our duty room as well, so… yeah, there’s a good relationship between us and Citizens Advice Bureau’. [Case study 5, Social care manager]*

> *‘I don’t see GPs that often, occasionally I might, so I don’t have that close a relationship with them. It’s more with the admin staff and practice managers, I would say.’ [Case study 1, Welfare rights advisor]*

Workability of systems

Having the time to engage in collaborative working was raised as an issue, mostly in the context of healthcare professionals who may have little time to spend with patients (therefore reduced ability to identify welfare issues), to communicate with advice teams or build personal relationships. Welfare rights advisors also mentioned having limited time to organise and attend meetings or engage in promoting their work. However, despite the teams clearly being busy in all the case studies, collaborative working was taking place to a high degree in some and staff were working closely together despite high workloads. This is illustrated by the quotation below:

> *"I can recall (the advisors) being in the office… you could hear them leaving messages for someone to call them back and they would, invariably be called back very quickly, which always, I thought, was really good given the pressures on the staff." [Case study 6, Welfare rights advice service manager]*

Where there was lack of engagement, some interviewees felt it was rather an issue of priorities and that partnership working was not high on the list: time could be created if the personal willingness was there. Engagement also increased as healthcare professionals become used to new systems, and collaborative ways of working became habitual rather than something extra. The following quotations illustrate the importance of personal will and priorities over time constraints:

> *"The reality is that this centre is a very busy centre, people constantly moving, everybody over-running. It's quite difficult to build those personal connections I guess, unless you're really interested. As I say, I tend to go and search out people and talk to them personally because I think it's a really interesting idea and I'm keen to support it." [Case study 4, Healthcare professional]*
>
> *"It is frustrating when people just don't even bother to come back to you… So, I suppose the challenge is the will, and also I think I would say time, but in a way I think that's a bit of an excuse. I think that like with anything, if you want something to happen you will make the time." [Case study 9, Welfare rights advisor]*

Systems needed to be as easy to use as possible to facilitate engagement from healthcare teams. They found it helpful to have information about the service readily at hand (for themselves and to give patients), and to have simple ways of providing input such as letter templates that could be filled and returned quickly. Some people disliked filling in referral forms and preferred to signpost or refer by email for simplicity. However, referral forms need not be complex and had often been adopted without difficulty; they also provided important information for the welfare case work and for service evaluation. In primary care, where community initiatives were numerous and constantly changing, some GPs had a preference for working with care navigators which avoided the need to know about individual services. Systems utilising self-referral (at least in part) were felt to be more realistic in primary care to by-pass the need for GP input.

Certain administrative approvals needed to be in place to enable colleagues from separate organisations to work together. Information governance was an important one, enabling secure exchange of information and access to IT systems (where such arrangements existed). Working on hospital premises also required honorary contracts or other forms of permission. While the administration could be challenging to set up, these systems enabled colleagues to interact, communicate and work together seamlessly. Conversely, when proper administrative processes had not been established, this could inhibit even simple functions including making referrals and booking appointments. The quotation below illustrates the importance of connected systems for effective co-working, as well as the challenges in establishing them:

> *"(The legal service) are thinking of getting an NHS emails address, which is fine, but you have like an audit to just get one email address. It cuts people off a little bit even though we're talking to all these people every day. I understand the security implications, of course I do, but that shows you the level of difficulty in connecting systems." [Case study 9, Welfare rights advice service manager]*

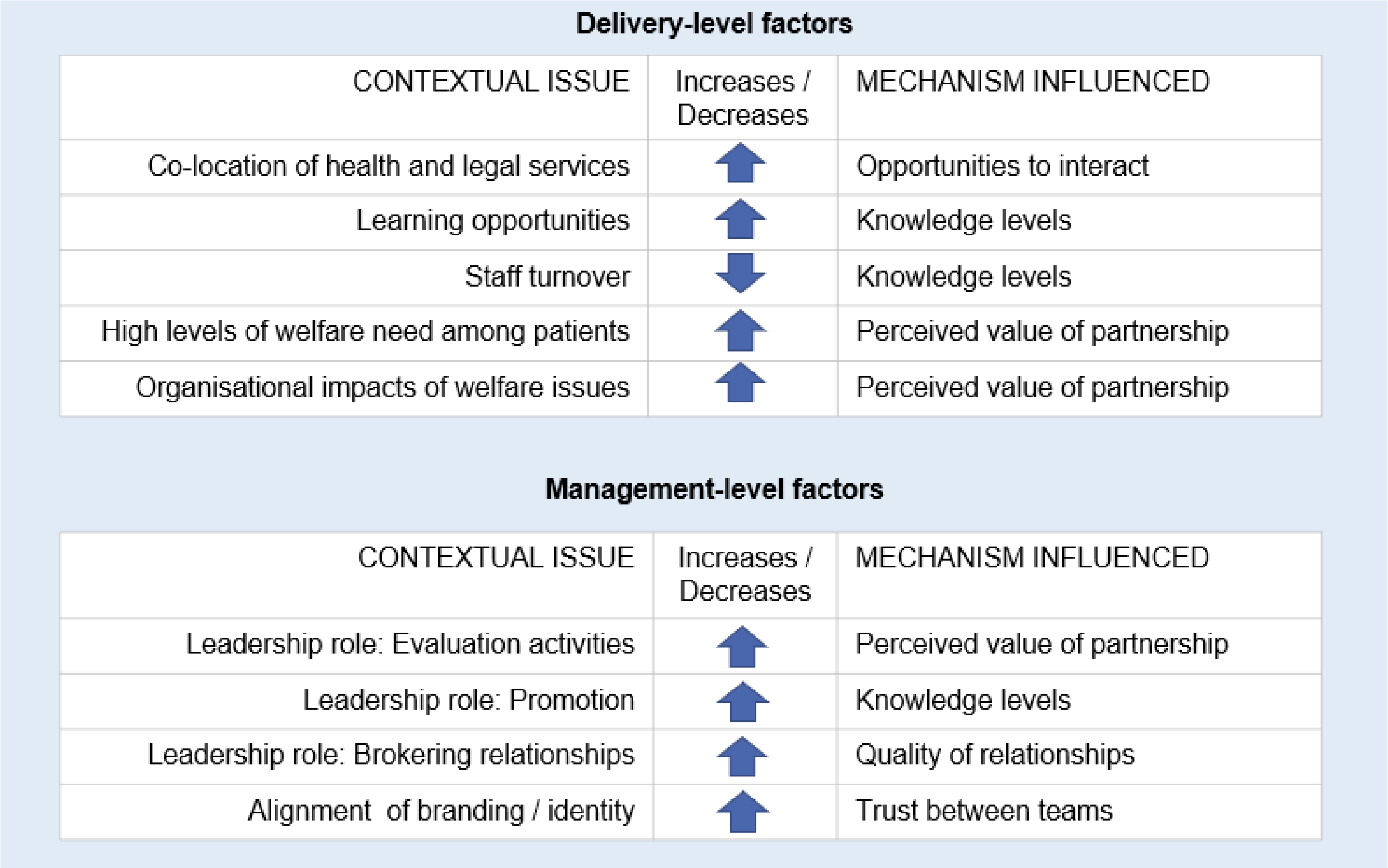
'*Workability of systems*' had an influence on '*Sentiment towards partnership*'. There was a concern among some healthcare teams that partnership working would increase demands on their time, which led to some hesitancy and reluctance. They were keen to minimise their workload and therefore preferred systems that were as quick and easy as possible. This relationship is illustrated by the quotations below:

> *'The [GP] I'm talking about, I'm not sure he was negative about the service but he didn't say anything positive… he was more, saw it as a bureaucratic problem for himself'. [Case study 2, Welfare rights advice service manager]*
>
> *'There's a lot going on, isn't there? So, if we can send a letter up via admin… an addressed letter that they can bounce back quite quickly, I think they prefer that kind of relationship.' [Case study 1, Welfare rights advisor]*

Contextual factors influencing identified mechanisms

The Process Tracing analysis identified aspects of the wider context that influenced the identified pathways, both positively and negatively. These relationships are shown in *Figure 4-4* and explained further in the passage below.

Figure 4-4: Contextual factors influencing identified mechanisms



Delivery-level factors

CONTEXTUAL ISSUE	Increases / Decreases	MECHANISM INFLUENCED
Co-location of health and legal services	↑	Opportunities to interact
Learning opportunities	↑	Knowledge levels
Staff turnover	↓	Knowledge levels
High levels of welfare need among patients	↑	Perceived value of partnership
Organisational impacts of welfare issues	↑	Perceived value of partnership

Management-level factors

CONTEXTUAL ISSUE	Increases / Decreases	MECHANISM INFLUENCED
Leadership role: Evaluation activities	↑	Perceived value of partnership
Leadership role: Promotion	↑	Knowledge levels
Leadership role: Brokering relationships	↑	Quality of relationships
Alignment of branding / identity	↑	Trust between teams

Context theme: Delivery-level factors

Co-location of health and legal services

As outlined under 'Approaches to integrating service delivery', the advice services were often delivered on-site in the health setting. This physical presence provided regular opportunities for face-to-face interaction between healthcare staff and advisors. In turn, this raised awareness of the legal service, increased personal familiarity and facilitated communication between staff teams. However, despite co-location, levels of interaction were relatively low in some care settings (notably primary care), due to physical separation during daily work and lack of regular attendance of advisors at practice meetings. The remotely-delivered services lacked the opportunities for interaction that co-location provided.

Learning opportunities

Most of the legal services were providing regular learning opportunities for the healthcare teams to increase their knowledge and encourage engagement with the partnership. This was most often done by advisors or managers attending team meetings and presenting information about the work of the legal service, as well as providing updates on welfare system changes. Some partnerships also offered induction meetings for new staff members and allowed them to sit in on advice sessions. These learning opportunities raised colleagues' awareness of the legal service and increased understanding of what it did, why it was there, how it helped patients and how they could engage with it. Due to high staff turnover in some services, regular learning opportunities were important to maintain awareness and understanding among health teams.

Staff turnover

Interviewees in a range of settings raised the issue of rapid staff turnover and high use of locum staff. Where staff frequently came and went, it was difficult to build up and maintain an awareness and understanding of the partnership among health teams. Several of the legal services were carrying out regular promotional activities, which helped to increase the visibility of the service and maintain staff engagement over time.

High levels of welfare need among patients

High levels of welfare need among local patients was one reason that members of staff valued the partnerships. Certain patient groups had high rates of welfare problems, often arising from their health condition or contributing to it. In other settings, rates of poverty had risen considerably and become increasingly apparent to health professionals. Seeing the widespread and significant impacts on individuals' health, they valued the partnership for the support it provided to the patients and the contribution it made to their own caring roles. The high levels of welfare need in health settings were also important to welfare rights advisors, who wished to reach those in most urgent need of their support.

Organisational impacts of welfare issues

High prevalence of welfare rights issues among patients was contributing to workload and stress levels for some care teams. Confused and anxious patients often sought assistance from them to make welfare claims (such as filling out forms and setting up online accounts), which not only reduced the time they could spend providing care but also caused anxiety because they did not have the knowledge to help effectively. Welfare issues were also causing delays in care, delays in hospital discharge and repeated hospital admissions, which was reducing the effectiveness of care and creating financial expense. The legal services were valued by staff members for their role in addressing these issues, both supporting care teams and improving service efficiency.

Context theme: Management-level factors

Evaluation activities (leadership role)

Most of the legal services were evaluating their work, with the aim of demonstrating its value to their health service partners. They collected information to show the activities of the legal service, the characteristics of clients, and the personal welfare outcomes achieved through the intervention. Welfare rights advice service managers were often very active in communicating this information with health service staff, producing monthly or quarterly reports for distribution. Sometimes this was tailored to each individual GP practice or other local setting, so they could see the outcomes for their own patients. This work helped to raise the profile of the service locally and build an appreciation of the work, because colleagues could see the impacts being achieved.

Promotion (leadership role)

Regular promotional activities were important to maintain awareness among healthcare teams and remind them to engage with the partnership. The busy working environments of health services meant it was important to keep up the information level. This was being done by welfare rights professionals attending meetings and events in person to showcase their work, including team trainings, conferences and away days. They also created regular email news bulletins for the health services and advertised through posters and leaflets on site. Using existing professional forums and communication networks was an effective way to get the message out. These activities helped to keep up the partnership profile, build understanding of welfare issues and provide the information people needed to engage in collaborative working.

Brokering relationships (leadership role)

In some of the case studies, people within the health organisation (often in leadership or management roles) had played a critical role in facilitating relationships between the partnership services. At the start, they had helped initiate the relationship by negotiating about practical arrangements, building connections between the right people and ensuring colleagues were invited to all the relevant meetings. They had also helped to overcome significant hurdles, mediating when there was resistance to the partnership (such as health professionals being reluctant to work with the advice teams, or practice managers trying to charge or evict the service from their practice). Often these people also acted as champions for the service, putting the word out, pushing for the partnership and encouraging engagement within frontline teams.

Alignment of branding / service identity

Three of the partnerships were branded under a healthcare brand (in one instance a renowned health charity, in the others a formal NHS-charity partnership). Staff in the legal services reported that having health branding had engendered the trust of health care colleagues by giving them an internal identity, which meant they were seen as genuine and legitimate partners rather than outsiders. One legal service had experienced a complete transformation due to being formally included in a health partnership: health teams that had previously distrusted and rejected them subsequently welcomed them in as professional colleagues.

4.4.3 Cross-case comparison of collaborative working

This section presents the results of the Qualitative Comparative Analysis, examining the patterns of causal conditions in relation to the collaborative working outcome.

Calibration of outcome and conditions

Table 4-7 displays how the inductive themes (generated in the preceding analyses) map against the domains of the implementation theory (GTI). It also presents the way in which these themes were consolidated into a single condition, to facilitate comparison of the key determinants across the case studies. This consolidation process was guided by the theoretical propositions and aimed to generate a summary score representing each theoretical domain. Assignment of the score was based on analysis of the empirical data:

scores for each inductive theme were mapped out across each case study to determine what was known before making an assessment on the summary score.

Table 4-8 shows how the conditions and outcome were defined and scored.

Table 4-7: Selection of conditions using theoretical domains

Theoretical domain	**Inductive themes**	**Consolidation to single condition**	**Rationale for consolidation**
“Capability”	Opportunities to interact Workability of systems	“Communication opportunities”	Represents the ability of teams to interact and communicate, determined both by physical and administrative barriers / facilitators.
“Capacity”	Knowledge levels Habits and norms Trust between teams Quality of relationships	“Leadership facilitation”	These inductive themes vary within case studies (by individuals, sites and teams). Therefore a proxy measure is used, representing the leadership activities that facilitate these mechanisms (as determined in the Process Tracing analysis).
“Potential”	Sentiment towards partnership Perceived value of partnership Alignment with purpose	“Collective commitment”	Represents willingness to engage among healthcare teams. Because sentiments vary between individuals, this refers to an inclusive team culture and an embracing of the partnership at team level.

Table 4-8: Definition and scoring of outcome and conditions

Factor		**Meaning**	**Measurement**
Outcome	Collaborative working	The extent to which health and legal teams communicate and work together during their daily activities.	"Close" = Includes joint working on cases, discussion of needs, coordination of input. "Not close" = Mostly limited to occasional referrals.
Conditions	Communication opportunities	The extent to which health and legal teams were able to interact in person, communicate and share information without physical or administrative barriers.	"High" = Regular personal interaction and communication during daily work. "Not high" = Limited personal interaction and communication during daily work.
	Leadership facilitation	How actively managers were facilitating joint working between the services, including through awareness-raising activities (training, evaluation and promotion) and provision of formal support (relationship brokering and alignment of branding).	"Highly active" = Regular awareness-raising activities, including with presence formal support. "Not highly active" = Occasional awareness-raising activities, minimal or no formal support.
	Collective commitment	The extent to which healthcare teams had adopted and embraced the partnership, perceiving it as an important and integral part of their work.	"High" = High level of team buy-in and engagement, little resistance "Not high" = Varies from person to person, certain level of ambivalence or resistance

QCA results

Necessary conditions for close collaborative working

‘Communication opportunities’ and ‘Collective commitment’ were both ‘high’ in all cases where collaborative working was close, and ‘not high’ in all cases where collaborative working was not close. These were therefore determined to be necessary conditions.

Sufficient conditions for close collaborative working

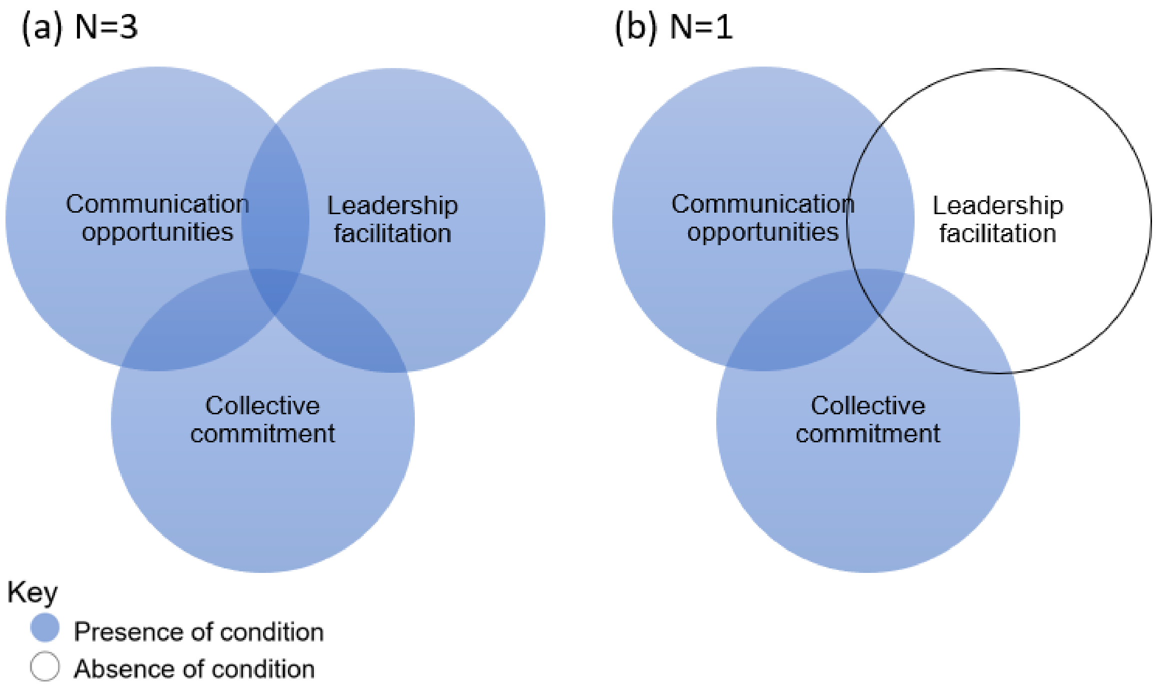
The truth table is displayed in *Table 4-9*, showing the combinations of conditions observed in relation to the outcome. The table rows represent sufficient condition combinations.

Table 4-9: Truth table for collaborative working

Outcome	**Conditions**			**Number of cases**
Close collaborative working	**Communication opportunities**	**Leadership facilitation**	**Collective commitment**	
1	1	1	1	3
1	1	0	1	1
0	0	0	0	3
0	0	1	0	2

Figure 4-5 presents the combinations of conditions that were sufficient for collaborative working to be close.

Figure 4-5: Sufficient condition combinations for collaborative working being close



Complex and intermediate solution:

*Communication opportunities * Collective commitment ⇒ Collaborative working is close*

Key: * means AND

Solution term	Raw coverage	Unique coverage	Consistency
Communication opportunities * Collective commitment	1	1	1

This solution predicts that when communication opportunities are high AND collective commitment is high, this is sufficient for collaborative working to be close. The solution has high validity: 100% consistency shows that all the cases with this configuration of conditions displayed the outcome; 100% coverage shows the solution applied to all the cases in the sample.

Illustration of the solution using case examples:

Three cases had the combination of high opportunities for communication, high levels of collective commitment and high levels of leadership facilitation. These were all based in secondary care, including hospitals, hospices and mental health services. The teams could easily communicate because they functioned as interdisciplinary teams (holding regular team meetings, joint clinics or ward rounds) or worked within the same physical spaces (offices, wards and patient information centres). Healthcare professionals regularly made referrals and communicated with the legal service as a matter of course, both through formal channels and in corridor conversations. Partnership working had become part of the team culture in these places and positive sentiments seemed widespread within healthcare teams, who understood the value of the partnerships and took it upon themselves to engage proactively. Leaders were also actively engaged in facilitating the partnerships on the ground, through regular promotional activities and learning opportunities to raise awareness (such as through talks, trainings, publicity on site and in the media, and advocacy/championing roles). Two of the partnerships were also formally included under a healthcare brand, giving them a recognised internal identity and facilitating trust between teams. The remaining case had a lower score for leadership facilitation. This partnership was very longstanding, and while intervention from management had been more active in the early years, the partnership had become embedded to the extent this was no longer required to facilitate team engagement.

Parsimonious solution:

Communication opportunities + Collective commitment ⇒ Close collaborative working

Key: + means OR

Solution term	Raw coverage	Unique coverage	Consistency
Communication opportunities	1	0	1
Collective commitment	1	0	1

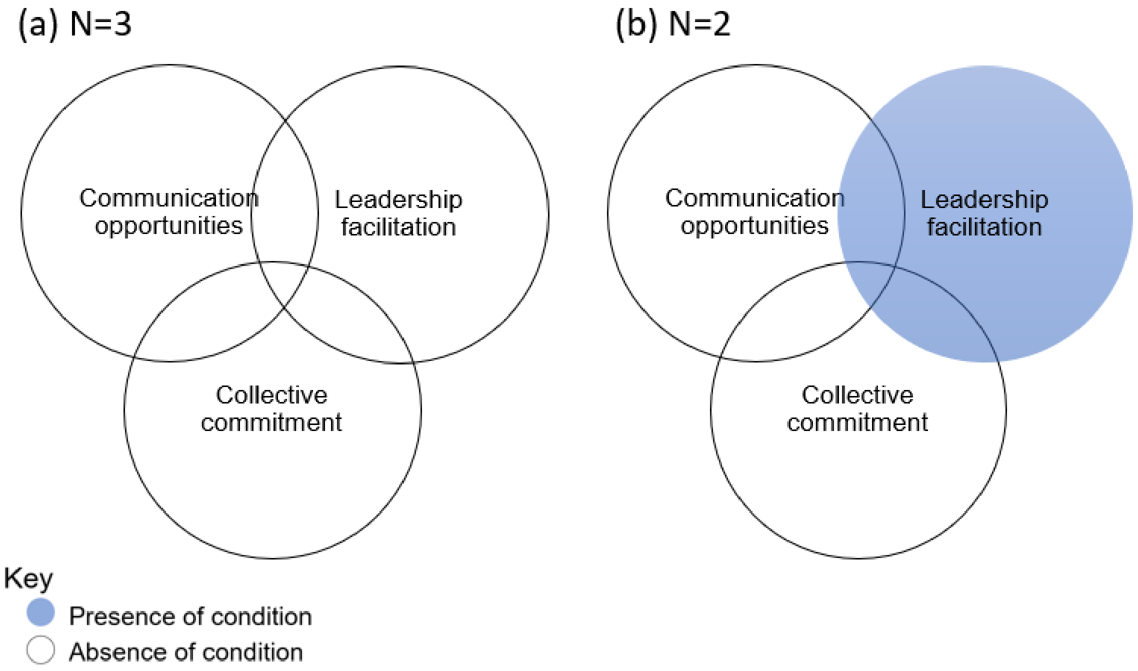
This model predicts that when either communication opportunities are high OR collective commitment is high, this is sufficient for collaborative working to be close. The solution has lower validity than the complex/intermediate solution: unique coverage of 0% shows that individually, neither condition alone explained the outcome when observed in reality.

Illustration of the solution using case examples:

The predictions made by the parsimonious solution were not observed and cannot be verified using the existing data. Both communication opportunities and collective commitment were determined to be necessary conditions, so the outcome is unlikely to occur in the absence of either one.

Figure 4-6. presents the combinations of conditions that were sufficient for collaborative working to not be close.

Figure 4-6: Sufficient condition combinations for collaborative working not being close



Complex and intermediate solution:

*~Communication opportunities * ~Collective commitment ⇒ Collaborative working is not close*

Key: * means AND, ~ means NOT

Solution term	Raw coverage	Unique coverage	Consistency
~Communication opportunities * ~Collective commitment	1	1	1

This solution predicts that when opportunities to communicate are not high AND collective commitment is not high, this is sufficient for collaborative working to not be close. The solution has high validity: 100% consistency shows that all the cases with this configuration of conditions displayed the outcome; 100% coverage shows the solution applied to all the cases in the sample.

Illustration of the solution using case examples:

Three cases had low opportunities for communication, low levels of collective commitment and low levels of leadership facilitation. These were all based in primary care. Despite delivering advice sessions on site in the GP practices, advisors and GPs had limited opportunities to communicate because their workspaces were separate and joint meetings occurred rarely if ever. There were few personal interactions during daily work that would enable spontaneous conversation, and sometimes barriers due to information security / confidentiality concerns (where necessary systems had not been established). The services operated largely independently rather than as a collective team. Sentiments varied between individual GPs in each setting, with some being highly supportive and engaged while others were ambivalent or could behave negatively towards the partnership. Facilitation of partnership working by leaders was not strong or regular, although there were occasional promotional activities (such as putting up posters/flyers, writing newsletters and attending annual meetings) and, more rarely, offering trainings or inductions for new staff. The remaining two cases had higher scores for leadership facilitation. These were both remote (telephone-based) services whose managers were highly engaged with the local health services; for example, producing monthly tailored reports for every practice, checking in personally with every practice manager and promoting their services through local forums and networks. However, not being physically based on site, the health and advice teams had little personal contact and therefore opportunities to communicate, and as above the sentiments towards the partnerships were variable among healthcare professionals.

Parsimonious solution:

~Communication opportunities + ~Collective commitment ⇒ Collaborative working is not close

Solution term	Raw coverage	Unique coverage	Consistency
~Communication opportunities	1	0	1
~Collective commitment	1	0	1

This model predicts that when either opportunities to communicate are not high OR collective commitment is not high, this is sufficient for collaborative working to not be close. The solution has lower validity than the complex/intermediate solution: unique coverage of 0% shows that individually, neither condition alone explained the outcome when observed in reality.

Illustration of the solution using case examples:

The predictions made by the parsimonious solution were not observed and cannot be verified using the existing data. However, because both communication opportunities and collective commitment were determined to be necessary conditions, it is conceivable that the absence of either one could lead to working practices not being close.

4.5 OUTCOME 2: SUSTAINABILITY

This section focusses on sustainability of the case study partnerships, which is the second implementation outcome investigated in the study. As defined in the methodology chapter, sustainability refers to 'the longevity of the connection between partner organisations, and the ongoing continuity of the partnership over time'.

The results are presented in three sections:

i) Description of sustainability
ii) Pathways to sustainability
iii) Cross-case comparison of sustainability

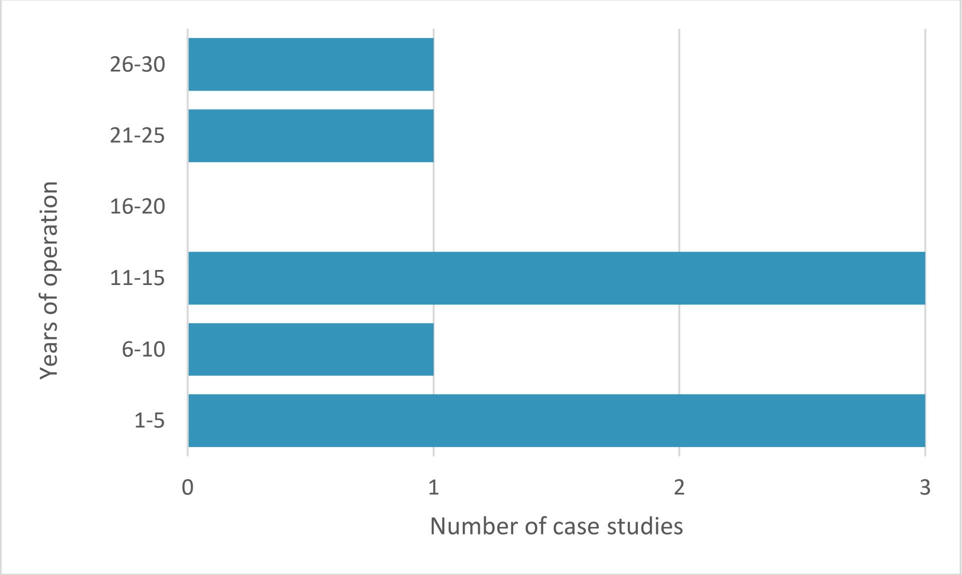
4.5.1 Description of sustainability

Two main indicators were used to investigate sustainability of the partnerships: i) longevity (the number of years they had been operating) and ii) continuity (whether they had continued to operate over time). These indicators provided a picture of the partnerships' trajectories over time.

Longevity

The lifetimes of the case studies ranged from less than five years to almost thirty, as depicted in *Figure 4-7*. This was counted as the total length of time from the year of initiation up to the year of study (2020) or the year of partnership closure (for discontinued projects). While some partnerships had operated in a similar way throughout their lifespans, others had experienced frequent change: growth or contraction in scale and changes in the way the partnerships operated. These shifts were often seen in response to changing organisational context such as NHS re-structures, new policies or funding initiatives, and changes in staffing and capacity of the legal service.

Figure 4-7: Years of operation of the case study partnerships



Continuity

Seven of the case study partnerships were ongoing at the time of data collection, one of which was discontinued shortly afterwards. Two of the case studies had already ended at the time of data collection.

Among the case studies that were ongoing, several had experienced cuts or other setbacks that had reduced or limited their activities at certain points (although not ended them fully) and survival over time was in spite of these challenges. For example, legal services had had to stop operating at some healthcare sites, reduce their staffing capacity, or restrict eligibility due to limited resources. This is illustrated by the quotations below. In two of the case study regions there had been previous attempts at similar partnerships, which had not gone on to survive.

> *"We do cover all of the GP surgeries in our area. I think there's one exception, because of the restrictions they've got in terms of space and the increasing demand for the surgery, we had to stop that one last year." [Case study 1, Welfare rights advice service manager]*

> *"(The welfare rights officer) would love to support everybody, but because of restrictions in her post she's only allowed to support people who live in certain areas. That's been a real challenge, and I can only imagine that that's gonna be restricted further and further." [Case study 8, Healthcare professional]*

Typology of partnership trajectories

Using the longevity and continuity indicators, the case study partnerships can be characterised according to the fourfold typology shown in *Table 4-10*. This describes the trajectories of the partnerships. The types are clarified further below.

Table 4-10: Typology of sustainability outcomes

		Continuity	
		Ongoing	**Ended**
Longevity	> Decade	"Long runners" (N=3)	"Late casualties" (N=2)
	< Decade	"Successful starters" (N=3)	"Early enders" (N=1)

- "Long runners". Longstanding partnerships that had continued to operate over time, often with periods of instability.
- "Late casualties". Longstanding partnerships that had experienced cuts or other setbacks that had caused operations to end.
- "Successful starters". More recent partnerships that were currently operating and well-resourced for the near-mid future.
- "Early enders". More recent partnerships that had started as pilots but not continued to a more permanent arrangement.

4.5.2 Pathways to sustainability

This section explores the causal pathways leading to sustainability. The continuity indicator is used as the outcome: the analysis explores factors influencing whether partnerships had continued or come to an end. Evidence is presented in two sections:

i) Mechanisms influencing partnership continuity
ii) Contextual factors influencing identified mechanisms

Mechanisms influencing partnership continuity

Figure 4-8 shows the mechanisms leading to continuity, as identified using the Process Tracing method. These mechanisms interacted to some extent with each other, and the identified interactions and feedback loops are depicted in *Figure 4-9*. The mechanisms, and relationships between them, are described in the passage below.

Figure 4-8: Mechanisms leading to partnership continuity

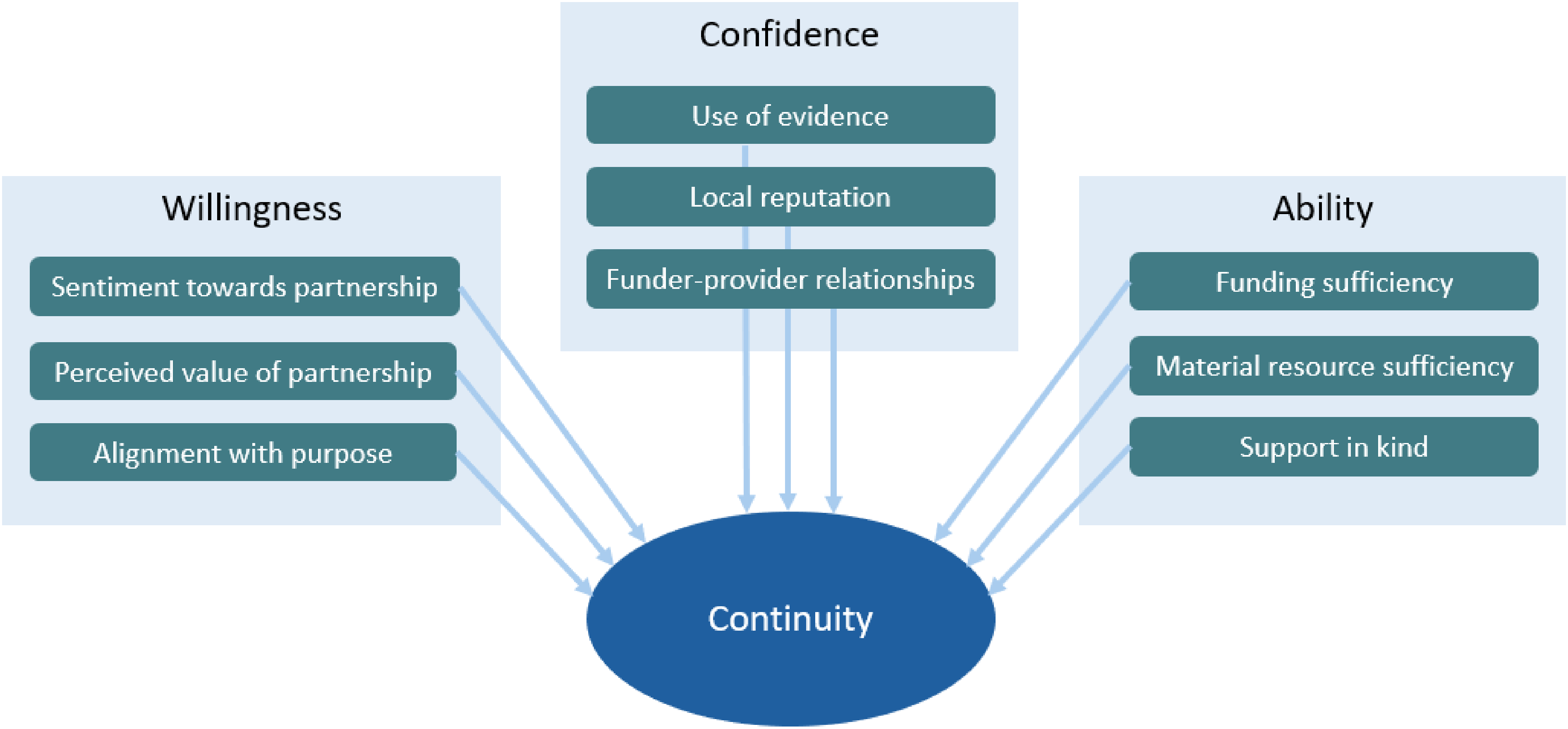
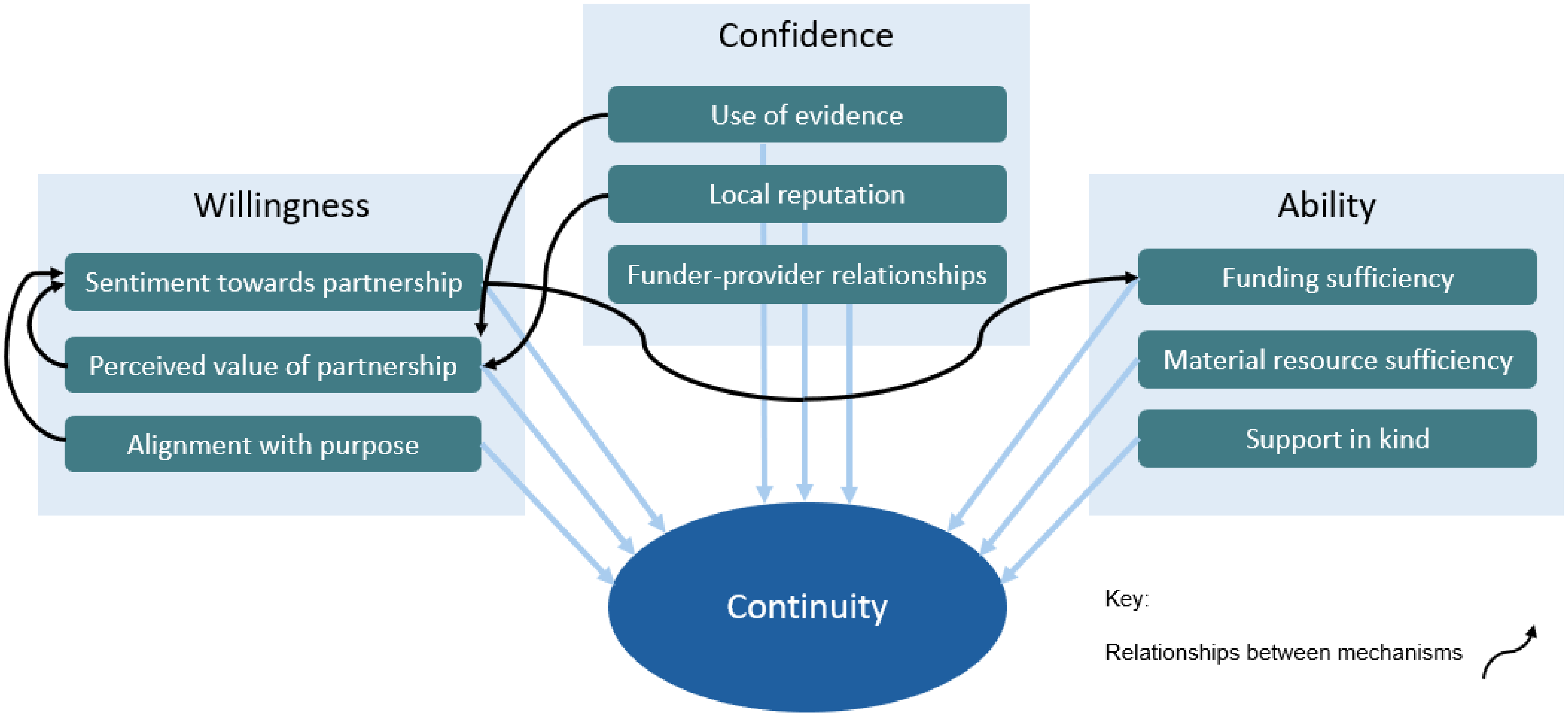


Figure 4-9: Interactions among mechanisms on the pathways to continuity



Mechanism theme: Willingness

The ‘willingness’ theme describes funders' and managers' attitudes towards partnership and preparedness to support and fund the initiative.

Sentiment towards partnership

The views of funders and senior leaders towards the partnerships varied in their positivity. Interviewees in these roles were largely very supportive and regarded the projects as important initiatives tackling wider determinants of health and providing vital assistance for patients. Supportive leaders had often been the driving force in establishing the partnerships, reaching out to local organisations and working to design, implement and develop the services. Positive sentiments towards the partnerships were linked to professional orientation (whether social factors were considered to play an important role in health), as well as personal interests and connections. Of note, key leaders in a number of the case studies had personal or family backgrounds in social welfare and had developed supportive views though this previous experience.

> *“I think we’re very lucky that our main commissioner has a background in advice services… he used to be an advisor, so he really gets it and he understands how much of a difference that advice can make to people’s health.” [Case study 3, Welfare rights advice service manager]*

‘*Sentiment towards partnership*’ was clearly linked to ‘*Continuity*’. The support of people in senior positions had served to steer the partnerships through organisational change and protect their resources when they were threatened. During their lifetimes, the longstanding partnerships had often faced attempted funding cuts and it was only the intervention of supportive senior leaders that had prevented closure. In some cases, continuity of the partnerships seemed relatively precarious from one funding cycle to the next, and high levels of commitment and ongoing support were needed to keep them going. The following quotations illustrate how strategic level support had enabled partnerships on the brink of closure to continue:

> *“That was the closest we’ve ever come to having it stopped completely. And because the Director of Public Health, and it just shows you how tenuous it all is, partly because his mother had been a volunteer in Citizens Advice, he managed to persuade the chief exec to keep it going.” [Case study 1, Funder/commissioner]*

> *“I think everyone felt that it was a really important service that they were providing for the hospital, and we felt it should carry on, even though (the council) had withdrawn their funding, so at that point the*

> *charity picked up the cost of (the service)." [Case study 5, Funder/commissioner]*

Views of funders and senior leaders were not always positive, and this had contributed to closure and downscaling of partnerships. Unsupportive views originated for a wide variety of reasons. Where budgets were being cut, funders had felt the service was unaffordable, or unjustifiable within their means and core funding remit. Arguments were also made that the service was not needed, was not delivering to high standards or good value and did not align well with other local service provision or important goals. These issues are explored in further detail in the themes below. However, service closures were not always due to a lack of support at strategic level but caused by extreme financial pressures that prevented any flexibility with the budgets. This situation is illustrated by the quotation below, in which a longstanding partnership had recently come to an end:

> *'If money were no object I think [our Consultant Head of Department] wouldn't hesitate, because he does value and does want to keep this post going, certainly for every benefit that he gets from it. But his hands are tied financially, everything's going in the Covid response.' [Case study 8, Welfare rights advisor]*

Where sentiments towards the partnerships were not wholly positive, they could nevertheless be open to influence. For example, one funder who had decommissioned a project was open to interdisciplinary approaches and the possibility of such a partnership, if the service design and resourcing were approached differently:

> *'Moving forwards, I think the way the NHS is structured now, there is probably a greater argument for a service like advice services being located in GP practices. But I guess there's still the case that it's difficult to justify that being NHS funded, and I guess it's more about how do councils, the voluntary sector and the NHS work in effective partnership and look at benefits in kind.' [Case study 2, Funder/commissioner]*

Perceived value of partnership

Strategic leaders were supportive when they felt the partnerships were providing something valuable for their local regions or services. Some valued the role of non-medical interventions for public health, or recognised high levels of welfare need among patients that were having negative impacts on wellbeing. They also valued the high quality of legal services and significant welfare outcomes being achieved, the support they provided for healthcare teams and the value of collaborative working for patient care. These perspectives are illustrated by the quotations below.

> *"I think overall we feel, as a charity, that this is one area that we should be investing in, because it makes such a direct and tangible difference to the patients and families." [Case study 5, Funder/commissioner]*

> *"We now have (the legal service)… in the inpatient social work team. That creates a much more holistic approach for people's care and support. It means there's cross organisational learning. I think it's been a real success story." [Case study 7, Partnership manager]*

However, funders' views on the value of the partnerships were not all positive. One participant felt there was no need to provide the service in-house given the ready availability of council-funded advice services in the local area and that the partnership therefore duplicated provision. Issues around poor service design were also raised in one case study, where access to the legal service was limited and inequitable in its reach; this had contributed to unfavourable views on its worth.

Views on affordability and value for money were also mixed: one funder felt the income gains for residents were worth the investment since they would contribute to local economic development, and that compared with clinical mental health services the advice service was cheap. Others felt the interventions were expensive to provide over and above their essential outgoings on medical services, particularly when their budgets for investment were being cut by central government or impacted by the pandemic. These differing perspectives are illustrated by the quotations below:

> *"To see a psychiatrist… 20 minutes, that cost £230 at the time. Whereas I'm saying, ok for £187 what you get is an advisor helping this individual until all their problems are sorted. And we know for example that debt causes mental health problems, so if you can prevent it, you're saving a lot of money down the line." [Case study 1, Funder/commissioner]*

> *"Compared to some of the other interventions it was quite expensive, and it was that time where the CCG had to make substantial savings. And it's never nice having to decommission any service, but yeah the financial position was quite dire." [Case study 2, Funder/commissioner]*

There was a prominent link between '*Perceived value of partnership*' and '*Sentiment towards partnership*'. Decision-makers were supportive towards the service when they felt it was meeting a significant need and delivering high quality outcomes. Conversely, unsupportive views stemmed from feeling the partnership was not an important priority or was not achieving relevant outcomes. This relationship is illustrated by the quotations below:

> *‘Bringing together that many experts in their own voluntary sector field is such a benefit to the [local] residents and I can’t speak highly enough of the [outreach in the] hospital discharge services, they’re absolutely not only necessary but so well-received by the hospital discharge team’. [Case study 9, Funder/commissioner]*

> *‘We were quite lucky in [the locality] that there is a wealth of services already available for people to be signposted to, so there wasn’t a need at that time to commission any services’. [Case study 2, Funder/commissioner]*

Alignment with purpose

Funders’ sentiments were closely related to whether they felt the partnership was serving a purpose that aligned with their goals as funding organisations. Health-justice partnerships clearly fitted with goals around addressing social determinants of health, taking a holistic approach to care that considered social factors, and supporting patient experience by providing services that responded to expressed needs. This alignment of ethos contributed to the ongoing support of funders and continuity of the partnerships over time, as illustrated by the quotation below:

> *“We’ve grown services and we focussed on what patients tell us are the needs, so we are patient-led, and obviously that has remained top, one of the things at the top of the pile is financial worries. And so I’d say that’s probably why, historically… (the legal service) has been long standing.” [Case study 6, Funder/commissioner]*

Where alignment with funder goals was unclear, this contributed to unfavourable views on the partnership and discontinuation of the project. One health service-funded partnership had been established without clear goals in the contract, and following management changes in both the health and legal services, the purpose of the partnership was no longer clear to leaders on either side. The commissioner was seeking health-related goals and outcomes that were neither specified in the contract nor evidenced in service evaluation, and ease of access to advice was not a sufficient justification for health service investment. This had contributed to the decision to decommissioning the partnership.

> *“There wasn’t very many Key Performance Indicators, and wasn’t very many outcomes attached to the contract. So, when it came to reviewing it, it was quite difficult to find sufficient evidence to say ‘These are the benefits that the service is providing’”. [Case study 2, Funder/commissioner]*

Alignment with policies and political values also determined funding support for the partnerships. Council-funded projects were subject to the leanings of the party in power and judged against how they delivered on local political priorities, such as anti-poverty action or supporting personal independence. Funders in the health service and integrated care were concerned with addressing local and national health priorities and valued projects that contributed towards these aims, such as health promotion and prevention. Policy shifts could be disruptive to existing partnerships. For example, the introduction of social prescribing had led to the decommissioning of one of the partnerships, where the new social prescribing model focussed on navigation to existing externally funded services and replaced the in-house health-justice partnership model. A second partnership was under review by commissioners to consider how the existing model would interact with the new social prescribing scheme:

> *“They have been quite clear that they feel like it probably won’t be commissioned in its current state anyway. I think because there are so many social prescribing things happening, they need to understand where we fit within what’s already happening… it’s not to say that they won’t continue to support the project, but they’re just keen to sort of say ‘Actually, in this form, it may not be feasible to continue’” [Case study 3, Welfare rights advice service manager]*

Funders’ perceived responsibility to fund the service had a strong influence on sentiments towards the partnership and whether they provided ongoing funding support. In four of the partnerships, funders seemed content with their funding role because of the value they placed on collaborative working for health; three of these were jointly funded through integrated local budgets. The remaining partnerships were supported through single funding streams, and although the value of the work was appreciated, issues were raised by all funder types in relation to responsibility to support it. These doubts were heightened in the face of cuts to income, which had recently affected several of the funders. One health service funder felt it was difficult to justify spending healthcare budget on legal services, which had contributed to a decommissioning decision. A local authority had cut back another service, restricting it only to patients who paid council tax locally, followed by a complete cut the following year because they could not justify outgoings on specialist roles for health services. Charity funders, who were continuing to fund, nevertheless questioned their responsibility to do so, feeling they were picking up the bill where others should be contributing: they recognised that this was not standard work for either the health service or local authorities, and were supporting the projects due to a clear need among patients and a gap in public service provision. This is illustrated by the quotation below:

> *“I wouldn’t say there have been any obstacles in terms of do we or don’t we have the resource. It’s more just that philosophical question*

> *about should or shouldn't we be funding, you know… are we essentially sort of subsidising governmental, or… you know, should somebody else be supporting this." [Case study 5, Funder/commissioner]*

Mechanism theme: Confidence

The 'confidence' theme describes sources of information and evidence contributing to decision-making in relation to the partnership.

Use of evidence

Evaluating the service was important to demonstrate the positive impacts of the intervention and make the case for ongoing investment in the partnership. Continuity of the longstanding partnerships was partly attributed to a strong focus on evaluation and demonstrating the impacts of the work, which had impressed the funders and contributed to their ongoing support.

> *"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 has been in it." [Case study 1, Funder/commissioner]*

For some funders, evidence was central to the decision-making process (notably for health funding that was allocated on an appraisal of options), while for others it played more of a contributory / confirming role. This included local authority funding where political priorities held greater sway than evidence of effectiveness, and charity funders who responded directly to the needs and wishes of patients. Evaluating according to funder goals was important to demonstrate how the project was meeting expectations and contributing to strategic priorities, as illustrated by the quotations below:

> *"Money talks, if you can show that you saved staff time, freed them up, which we struggled to do but we did, that's a really good outcome… it's about putting yourself in the shoes [of decision-makers], you know, why would the NHS want us, you know, you're gonna have to show something that they're gonna value." [Case study 5, Welfare rights advice service manager]*

> *"We've got leadership that is keen to try and compare and contrast, so we know we're getting the best value for money, so again we can go back to our donors and say, 'We are getting the highest return on what we are doing with your money'." [Case study 6, Funder/commissioner]*

Where evidence was lacking in relation to outcomes that were important to funders, this contributed to unfavourable impressions of the service and to discontinuation of projects.

This was exemplified in one case study, where communication between the funders and providers had broken down and the goals were not clear to service managers, leading to the evaluation not meeting funding expectations.

> *"When it was originally commissioned, there wasn't a clear expectation of what that service was going to achieve, but with a health focus. And I think over time expectations had changed and that hadn't been communicated effectively enough with the service so that they could then change their data collection." [Case study 2, Funder/commissioner]*

Funders' expectations of the evidence also differed. Some were well satisfied with relatively simple evaluations measuring process and outcome data (for example, showing reach of target client groups, provision of legal assistance and rates of welfare outcomes), which were sufficient to demonstrate a relevant and positive influence. Others expected evidence on wider impacts, for example in relation to health improvement, disease prevention and reduced care utilisation. These outcomes were more challenging for services to evidence, although a number were making efforts to do so; others were drawing on the rationale and academic evidence to help with making this case.

Local reputation

Some of the partnerships were very well known locally and even nationally. In these partnerships the service leaders were very active in promoting their work within their immediate health settings, to local health authorities and funders, and more widely in national forums. This raised awareness of the work and its positive impacts, as well as generating a reputation of excellence for the partnership which encouraged support at strategic level.

> *"I've spoken at loads of conferences about it, word's got around, people have contacted me… it's found it's way into lots of reports as an example of good practice, so yeah, I've made sure that the people who've invested in it, the commissioners, get appropriate recognition for it." [Case study 1, Funder/commissioner]*

Others were not known locally, within the local health authorities or even within the health services they were connected with. This meant the work being done was not recognised and appreciated, making them more vulnerable to being discontinued as illustrated by the quotation below:

> *"When there was a need to make significant financial cuts, again I think because it didn't have that high a profile because people weren't aware of what outcomes it was achieving, that in part made it*

> *more susceptible to losing funding." [Case study 2, Funder/commissioner]*

However, high levels of recognition were not sufficient to guarantee continuation of projects. One case study was known nationally as a centre of excellence for HIV care and highly prominent in the local setting, but was nevertheless de-funded following significant budget cuts required at the local council which provided the service.

> *"And then (the All Party Parliamentary Group report) says how intrinsically linked we are within the service, and then it goes on to say how it's pretty much gold standard around the country what we offer in (the city), and what we did offer then, before the cut." [Case study 8, Welfare rights advisor]*

Funder-provider relationships

Several of the partnerships were well linked in at management level, with funders and providers working closely together to design, implement, review and develop the services. Relationships seemed strong and supportive, and the managers worked together with trust and openness. Welfare rights advice service managers were in regular contact with their funders, providing frequent progress reports and attending meetings with project steering groups. The managers worked together to review performance data, address any service delivery issues and discuss potential improvements, as well as planning promotional activities. These relationships ensured that the partnerships were delivering according to funder expectations, and that service achievements were known and understood by the funders. This contributed to their ongoing support.

> *"It's a very supportive commissioning relationships that we have with (the funders), so they are helping us to sort of look at, how do we deliver and how do we develop the service so that it has kind of added value, that might mean it gets commissioned in a different way." [Case study 3, Welfare rights advice service manager]*
>
> *"The importance of things like that steering group is you have people who will sit down and approve your funding bid, or would know the people who will do that, and that's why it's important to have some kind of connection with people at a strategic level. People who understand what you're doing." [Case study 5, Welfare rights advice service manager]*

Absence of relationships at strategic level created the conditions under which partnerships were discontinued. Goals and expectations were not communicated so that services could deliver accordingly and demonstrate relevant outcomes. Neither were problems with service delivery, meaning that partnerships were not developed and improved. This absence of relationship contributed to a mutual lack of understanding between funders and providers, less than adequate service delivery and poor impressions of the quality and value of the partnership among funders. A service manager describes this lack of communication in the run-up to a funding cut:

> *"I don't remember it ever being said… 'if you don't meet this target we are not going to fund you to do it', so it was more that the information was being provided, I suppose proactively in the natural course of explaining what we did… Then when the funding did go, equally there was almost no discussion." [Case study 2, Welfare rights advice service manager]*

Mechanism theme: Ability

The 'ability' theme describes the resources available to funders and managers to make service delivery possible.

Funding sufficiency

The availability of funds to support service delivery was a significant issue for some of the partnerships. Longstanding partnerships had expanded and contracted in scale over the years in response to funding availability, that came and went with economic circumstances and policy changes. In previous years when public health investment was higher, large-scale health-justice partnership initiatives had been developed. However, the central government spending cuts since 2010 had affected both health service and local authority funders, and continuing requirements to reduce spending had been a primary consideration in the closure of partnerships that had ended. The Covid-19 pandemic had compounded these financial pressures, reducing the income for some funders and adding to the costs of others. Most of the partnerships were therefore operating on relatively minimal funds and with little guarantee of future stability. The quotation below illustrates the continuous fighting for resources that had been experienced by longstanding partnerships.

> *"My experience over 25 years has been, it will continue to be a battle. The two key battles were philosophically in the early days, I think, hopefully, to a large extent, that battle's now won… I think the big challenge now is gonna be money, because money's gonna be even shorter than it was before." [Case study 1, Funder/commissioner]*

In some cases, projects had been protected from closure by senior leaders in funding organisations, who had fought their corner because they valued the partnerships highly and prioritised their survival: funders had protected project budgets in the face of income reductions, pulled back on funding for other services, or negotiated re-allocation of planned spending.

> *"What we have done is made a massive commitment across the country… to extend the welfare benefit services with funding. Which is a big thing. I guess it shows you the strength of feeling that we are committed to welfare rights advice, and also in the current climate I think there's a recognition that it is going to be really important for people." [Case study 6, Funder/commissioner]*

However, this had not been possible in circumstances where the funding organisation was in severe financial difficulty, despite funders being supportive of the partnerships. One service had been limited in its capacity due to financial constraints, even though the funder wanted to expand it. Another had had been cut completely despite being a longstanding, nationally recognised and locally valued service: successive years of local authority income cuts had meant the single part-time welfare rights role could no-longer be supported, nor picked up by the health service due to the additional costs of Covid recovery.

> *"The Welfare Rights Unit as a whole has had a 40 per cent reduction generally, and obviously every time we have a reduction, we have to look at the criteria for the service again. So, whilst we support the most vulnerable in (the city), obviously it's squeezed and squeezed and squeezed every time." [Case study 8, Welfare rights advisor]*

Material resource sufficiency

In addition to funding, material resources such as physical space and sufficient staffing capacity were needed to keep the projects going. While most of the partnerships were managing to operate with the room space available (which was often quite restricted), others had had to stop working on site in health settings due to insufficient space. Sometimes space issues could be circumvented by being flexible with the timing of schedules or using whatever space was available at short notice. However, it was more of a challenge in very small GP practices and where the space requirements of the legal service were greater, for example in one university-run case study that undertook research and teaching alongside the advice provision.

> *"So we do cover all of the GP surgeries in our area. I think there's one exception, because of the restrictions they've got in terms of space and the increasing demand for the GP surgery, I think we had to stop that one last year." [Case study 1, Welfare rights advice service manager]*

In one of the partnerships, insufficient staffing capacity in the legal service had led to the closure of a specialist advice outreach at a mental health hospital. This was provided alongside the main activities of the partnership, but could not be sustained alongside the expansion of other work in the legal service.

> *“That was the reason why we felt we couldn’t do (the hospital) surgeries at the same time, because it’s just too busy to do both really… The contract is funded for two full-time caseworkers, and at the time the other caseworker had left so I was pretty much doing it alone as well. So, it was definitely a case of managing the capacity really.” [Case study 9, Welfare rights advisor]*

Support in kind

Most of the health services were contributing to the resourcing of partnerships by providing forms of non-financial support to the legal services. This included providing rooms and desk space without charge, as well as administrative support (managing appointment bookings), equipment (such as computers and laptops to access shared information systems) and training resources. This support assisted the legal services enormously with their day-to-day operations as well as reducing overhead costs.

> *“We piggybacked onto an existing admin structure here, because we have no funding for admin, so they kindly book out appointments and handle the phone calls.” [Case study 5, Welfare rights advice service manager]*

However, not all the health services did provide such support, and those co-located in GP practices had sometimes come up against attempts to charge rent or prevent access to equipment. One service had been unable to continue operating in the primary care setting due to the prohibitively high rents that were being demanded:

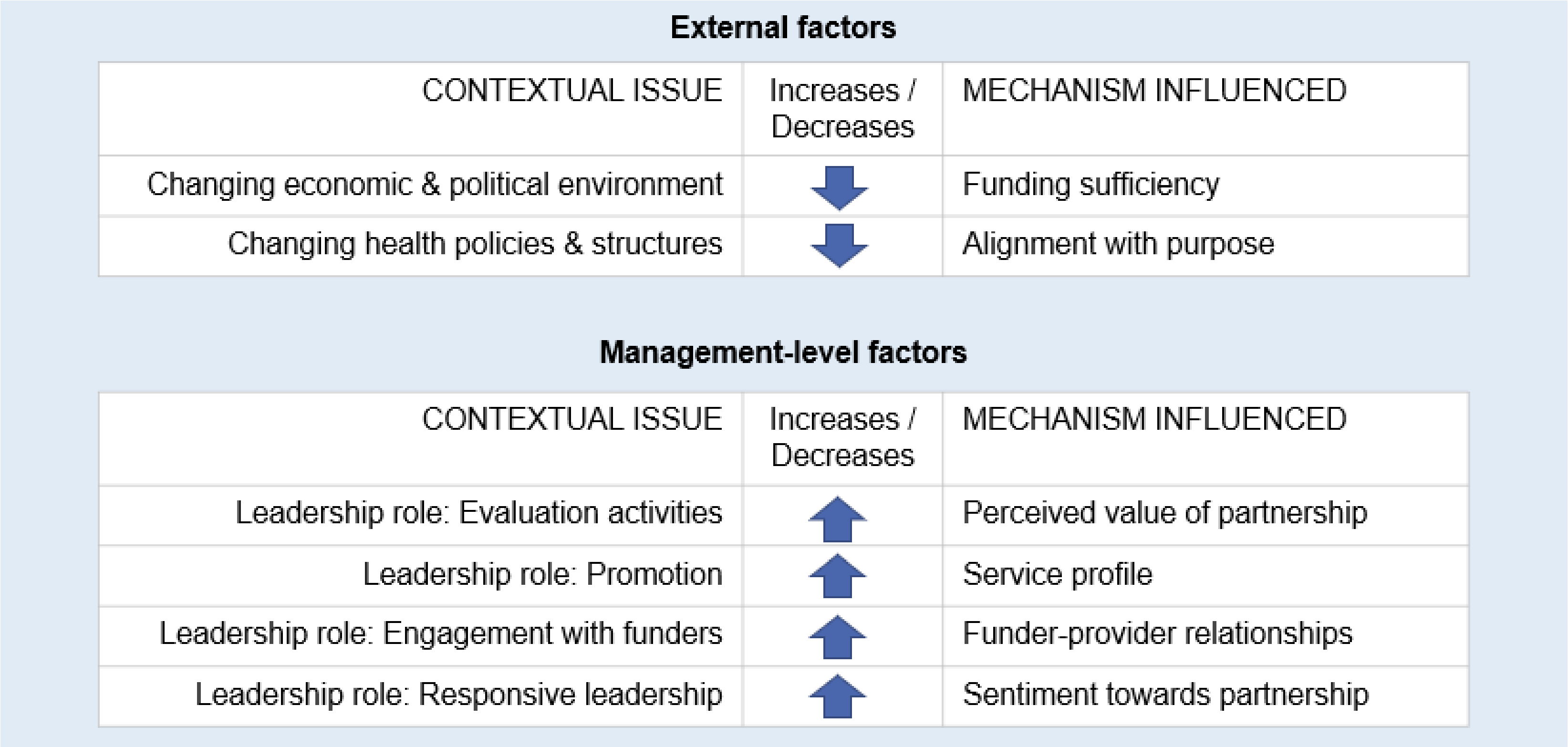
> *“Ultimately we weren’t able to secure the necessary space in the health service to be able to continue operating. Because we weren’t able to afford the rates that they wanted to charge us.” [Case study 4, Welfare rights advice service manager]*

Contextual factors influencing identified mechanisms

The Process Tracing analysis identified aspects of the wider context that influenced the identified pathways. These relationships are shown in *Figure 4-10* and explained further in the passage below.

All of the identified factors were leadership roles, which highlights the importance of service managers (and people in other positions of leadership) in creating the conditions for sustainability.

Figure 4-10: Contextual factors influencing identified mechanisms



External factors

CONTEXTUAL ISSUE	Increases / Decreases	MECHANISM INFLUENCED
Changing economic & political environment	⬇	Funding sufficiency
Changing health policies & structures	⬇	Alignment with purpose

Management-level factors

CONTEXTUAL ISSUE	Increases / Decreases	MECHANISM INFLUENCED
Leadership role: Evaluation activities	⬆	Perceived value of partnership
Leadership role: Promotion	⬆	Service profile
Leadership role: Engagement with funders	⬆	Funder-provider relationships
Leadership role: Responsive leadership	⬆	Sentiment towards partnership

Context theme: External factors

Changing economic & political environment

Over the years, the longstanding partnerships had experienced significant economic and political changes that had affected the stability and availability of funds for their services. At times in the past when national investment in public health initiatives was high, this had enabled expansion and roll-out of partnerships due to the additional funding that was made available. In the last decade, the trends had been in a downward direction. Local authorities were affected by annual cuts to their budgets (including public health) and health services were attempting to make efficiency savings in the face of growing financial problems. The Covid-19 emergency had compounded these issues, affecting the incomes of all funder types and necessitating a shift in spending towards pandemic recovery. These money shortages were putting increasing pressure on funders and forcing them to re-evaluate their spending in the light of current priorities. In contrast, partnerships supported by wealthier funders and those in more affluent regions had not experienced these pressures to the same extent.

Changing health service policies & structures

Changes in health service policies and structures had affected the stability of partnerships, influencing the position that welfare rights advice services held within the context of other local activity. This could be in a positive way; for example, new initiatives to facilitate collaboration between the NHS and third sector organisations had enabled partnerships to develop and gain greater levels of support and local recognition. However, other shifts had been more destabilising. One partnership was brought close to termination by an NHS restructure, in which new leadership had tried to remove the partnership in pursuit of financial savings. The introduction of social prescribing had also caused some instability: one partnership was closed because the new social prescribing model did not include welfare rights advice, and another was about to be remodelled to fit in better with local social prescribing activity. The imminent move towards Integrated Care Systems was felt to strengthen the case for collaborative working, but also to come with uncertainties for existing partnerships as the systems were designed and introduced.

Context theme: Management-level factors

Evaluation activities (leadership role)

Evaluating the partnership well was necessary to demonstrate its impacts to funders and other strategic leaders, and thereby generate and maintain their support. Welfare rights advice service managers were often driving this activity, collecting data and producing regular reports for their funders. Some were keenly aware of the need to evaluate in accordance with funder expectations and were tailoring the evidence collection towards their goals and priorities as far as possible. In some cases, evaluation and performance monitoring were being done in close collaboration with the funders as part of the funding or commissioning cycle: funders and service managers would meet to discuss expectations, set goals and review performance in an ongoing way. This helped ensure the funders received the evidence they wished for and were satisfied with what was being achieved. Funders did not value the partnership when they felt insufficient (or less relevant) evidence was being provided on its impacts.

Promotion (leadership role)

Several of the case studies had gained a high level of local and national recognition through the efforts of their leaders in promoting the work. This promotional activity was being done by passionate members of staff in various roles, including welfare rights advice service managers, welfare rights advisors and people in strategic leadership roles. They were engaged in speaking at conferences, presenting at parliamentary committees, submitting evidence for national reports, and campaigning in a wider public forum. This had gained positive press for the local providers and raised awareness of the importance and impacts of the partnerships. Where little was being done to promote the work, colleagues and local strategic leaders were not aware of the service and its achievements and were therefore less convinced of its value.

Engagement with funders (leadership role)

Several of the partnerships clearly had strong and positive relationships with their funders, who they worked with closely on a regular basis. Funders and service managers had worked together to design the partnerships in the early stages and would meet on an ongoing basis to develop and improve the service delivery. They held regular operational meetings to review performance, discuss progress and make plans. This engagement led to trusting and open relationships between the organisations. Notably one partnership lacked any kind of relationship with their funders and little effort was made by either organisation to communicate or make personal contact. Expectations were not discussed, performance was not reviewed and the relationship between organisations were not maintained, which subsequently affected the quality of service and its long-term survival.

Responsive leadership (leadership role)

Responsiveness and flexibility from the services on the ground had impressed those at strategic level, demonstrating their relevance and adaptability to changing needs and situations. Service managers were responsive to requests from commissioners, keen to develop and improve their own services and open to change when necessary. This was valued both for improving day-to-day service delivery and in response to larger scale events. For example, services had reacted by providing tailored support to patients in response to the Covid-19 pandemic and the impacts of Brexit on access to healthcare. In contrast, one partnership had problems with accessibility for patients, but these were never addressed despite managers being aware of the issues; this had contributed to less positive views on the quality of the service.

4.5.3 Cross-case comparison of sustainability

This section presents the results of the Qualitative Comparative Analysis, examining the patterns of causal conditions in relation to the continuity outcome.

Calibration of outcome and conditions

Table 4-11 shows how the inductive themes (generated in the preceding analyses) map against the domains of the implementation theory (GTI). It also presents the way in which these themes were consolidated into a single condition, to facilitate comparison of the key determinants across the case studies. This consolidation process was guided by the theoretical propositions and aimed to generate a summary score representing each theoretical domain. Assignment of the score was based on analysis of the empirical data: scores for each inductive theme were mapped out across each case study to determine what was known before making an assessment on the summary score. *Table 4-12* shows how the conditions and outcome were defined and scored.

Table 4-11: Selection of conditions using theoretical domains

Theoretical domain	**Inductive themes**	**Consolidation to single condition**	**Rationale for consolidation**
“Capability”	Leadership activities (evaluation, promotion and engagement with funders)	“Proactive leadership”	Represents the leadership activities that facilitated strategic-level relationships, awareness and support for the partnership (as determined in the Process Tracing analysis).
“Capacity”	Funding sufficiency Material resource sufficiency Support in kind	“Resource sufficiency”	Represents the sufficiency of material resources that enable service delivery.
“Potential”	Sentiment towards partnership Perceived value of partnership Alignment with purpose	“Strategic commitment”	Represents the willingness among strategic leaders to support the partnership.

Table 4-12: Definition and scoring of outcome and conditions

Factor		**Meaning**	**Measurement**
Outcome	Continuity	Whether the project was ongoing or had been discontinued at the time of study.	"Ongoing" = currently in operation "Not ongoing" = currently not in operation
Conditions	Proactive leadership	How actively leaders were engaged in advancing their service through evaluation, promotion and engagement with funders and strategic leaders.	"Highly active" = High levels of effort and passion, regular ongoing communication and engagement. "Not highly active" = Low levels of effort and passion, little communication and engagement.
	Resource sufficiency	Whether funding was under pressure from external events (income cuts) or internal changes (service reorganisations /policy shifts).	"Sufficient" = apparent ability to afford service "Not sufficient" = apparent difficulty in affording service

	Strategic commitment	The extent to which strategic leaders valued the partnership and were willing to provide resources towards it.	"High" = High level of support and commitment "Not high" = Low level of support and commitment

QCA results

Necessary conditions for ongoing partnerships

‘Resource sufficiency’ was ‘sufficient’ in all partnerships that were ongoing, and ‘not sufficient’ in all partnerships that were discontinued. This was therefore determined to be a necessary condition.

Sufficient conditions for ongoing partnerships

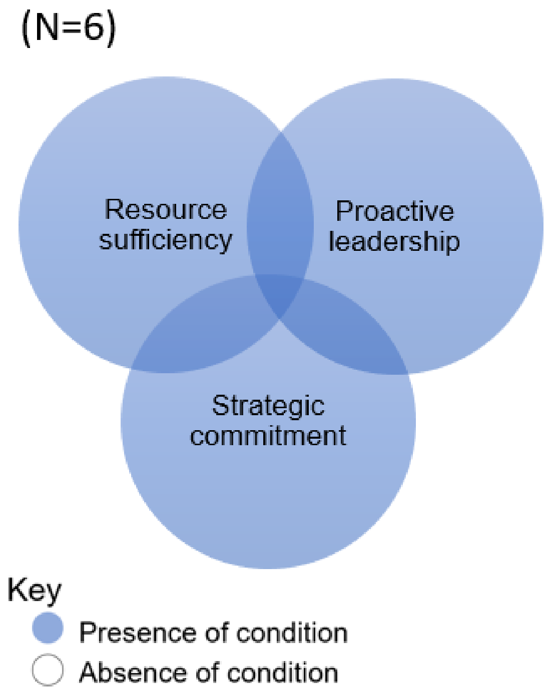
The truth table is displayed in *Table 4-13*, showing the combination of conditions observed in relation to the outcome. The table rows represent sufficient condition combinations.

Table 4-13: Truth table for partnerships being ongoing

Outcome	**Conditions**			**Number of cases**
Partnership ongoing	**Proactive leadership**	**Resource sufficiency**	**Strategic commitment**	
1	1	1	1	6
0	0	0	0	1
0	1	0	0	1
0	1	0	1	1

Figure 4-11 presents the combinations of conditions that are sufficient for partnerships to be ongoing.

Figure 4-11: Sufficient condition combinations for partnerships being ongoing



Complex and intermediate solution:

*Resource sufficiency * Proactive leadership * Strategic commitment ⇒ Partnership is ongoing*

Key: * means AND

Solution term	Raw coverage	Unique coverage	Consistency
Resource sufficiency * Proactive leadership * Strategic commitment	1	1	1

This model predicts that when resources are sufficient AND proactive leadership is highly active AND strategic commitment is high, this is sufficient for the partnerships to be ongoing. The solution has high validity: 100% consistency shows that all the cases with this configuration of conditions displayed the outcome; 100% coverage shows the solution applied to all the cases in the sample.

Illustration of solution using case examples:

Six cases were ongoing at the time of study, all of which had sufficient resources, proactive leadership and high levels of strategic commitment. These included partnerships in both primary and secondary care. While funding cycles were short-term in some cases, funding had been allocated regularly over a long period of time and did not appear to be under immediate threat because the financial position of funders was relatively stable. Some of these partnerships had experienced cuts in the past but had recovered and seemed on a stable footing. The managers of these partnerships were highly aware of the importance of engaging with their funders and people with influence at strategic level to ensure the long-term viability of their service. They were therefore actively evaluating and promoting their work, as well as reviewing and developing the service to improve quality and meet expectations. There was also a clear and strong commitment at strategic level, with funders that valued the work of the partnership and believed in its positive contribution to their goals.

Parsimonious solution:

Resource sufficiency ⇒ Partnership is ongoing

Solution term	Raw coverage	Unique coverage	Consistency
Resource sufficiency	1	1	1

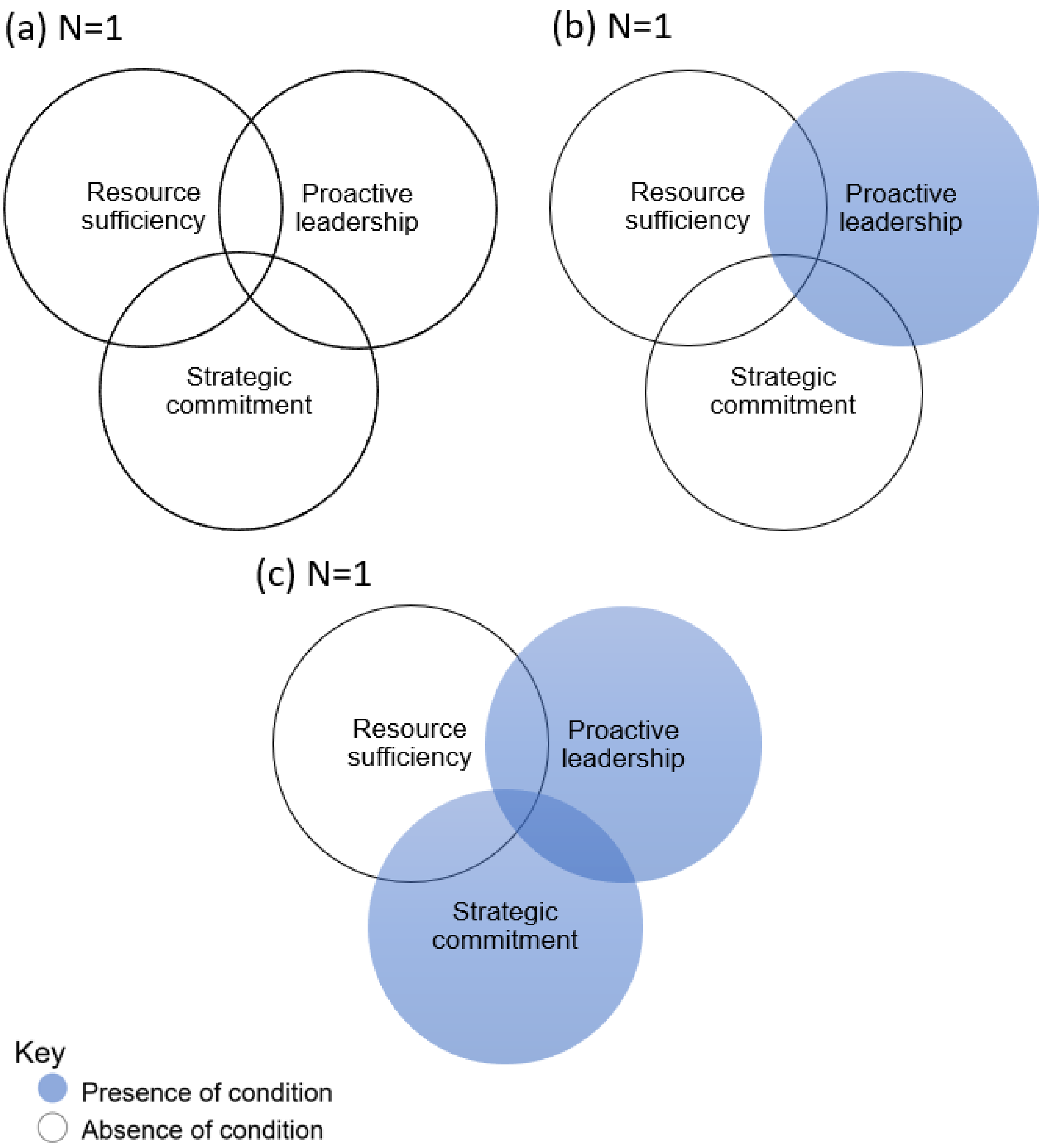
This model predicts that when resources are sufficient, this alone is sufficient for the partnerships to be ongoing. The solution has high validity: 100% consistency shows that all the cases with this configuration of conditions displayed the outcome; 100% coverage shows the solution applied to all the cases in the sample.

Illustration of solution using case examples:

The prediction made by the parsimonious solution was not observed and cannot be verified using the existing data. Resource sufficiency was the only necessary condition identified, and it is plausible that partnerships could continue in the absence of proactive leadership and strategic commitment as long as resources were maintained. However, the Process Tracing results showed that these factors can have a strong influence on whether resources are allocated.

Figure 4-12 presents the combinations of conditions that are sufficient for partnerships to be not ongoing.

Figure 4-12: Sufficient condition combinations for partnerships being not ongoing



Complex solution:

*~Resource sufficiency * ~Strategic commitment + ~Resource sufficiency * Proactive leadership ⇒ Partnership is not ongoing*

Key: ~ means NOT, * means AND, + means OR

Solution term	Raw coverage	Unique coverage	Consistency
~Resource sufficiency * ~Strategic commitment	0.67	0.33	1
~Resource sufficiency * Proactive leadership	0.67	0.33	1

This model predicts that when either resources are not sufficient AND strategic commitment is not high OR resources are not sufficient AND proactive leadership is highly active, this is sufficient for discontinuation of partnerships. The coverage scores for this solution are relatively low, showing the predictions only partially explain the outcome when observed in reality. The second solution term does not make intuitive sense because proactive leadership should have a positive influence.

Intermediate and parsimonious solution:

~ Resource sufficiency ⇒ Partnership is not ongoing

Key: ~ means NOT

Solution term	Raw coverage	Unique coverage	Consistency
~ Resource sufficiency	1	1	1

This model predicts that when resources were not sufficient, this alone is sufficient for discontinuation of partnerships. The solution has high validity: 100% consistency shows that all the cases with this configuration of conditions displayed the outcome; 100% coverage shows the solution applied to all the cases in the sample.

Illustration of results using case examples:

Each case had a different combination of conditions; however, resources were under strain in all the discontinued partnerships. In two publicly funded cases, the funders needed to find financial savings due to income cuts and increasing demand on their services. In the other, the resource issue had arisen because of high and rising rent being charged to provide the legal service on site in the health setting. These financial pressures had been a central in the decisions to discontinue the partnerships and had sometimes overridden the best efforts of the leadership. For example, one partnership had been established bottom-up on the aspirations and goodwill of the service leaders but was undermined by those at strategic level refusing to provide the support in kind (rent-free space) that would have enabled the continuation of the project. Another was brought to an end due to the sheer severity of the financial situation, despite leaders who were highly engaged in evaluation and promotion locally, and a funder who valued the partnership. The final example involved a funder with a poor impression of the quality and value of the partnership, together with (and partly due to) service leaders who were disengaged from activity at strategic level and doing little to evaluate or promote their work.

4.6 OUTCOME 3: PARTNERSHIP IMPACTS

This section focusses on impacts of the case study partnerships, which is the third implementation outcome investigated in the study. As defined in the methodology chapter, impact refers to 'the difference that the partnership makes for patients, staff and organisations, focussing on outcomes attributable to the connections between health and legal organisations'.

The results are presented in three sections:

i) Description of impacts
ii) Pathways to impacts
iii) Cross-case comparison of impacts

4.6.1 Description of impacts

Figure 4-13 displays the reported impacts of the partnerships for patients, staff and organisations.

Figure 4-13: Reported partnership impacts

Impacts for patients	Impacts for staff	Impacts for organisations
• Improved access to legal assistance • Improved socio-economic circumstances • Improved health and wellbeing • Improved patient experience	• Enabled care teams to focus on core role • Facilitated access to information for legal casework • Improved knowledge of individual needs • Increased subject expertise	• Provided a resource to meet non-medical needs of patients • Facilitated hospital discharge

Impacts for patients

Improved access to legal assistance

The connection with healthcare facilitated access to legal assistance for people who may not otherwise have done so. The healthcare setting was sometimes the only accessible location; for example, in acute care (such as hospitals and hospices) where patients could not physically leave to seek assistance, and in rural communities where the GP-based legal services were the only local source of advice. Healthcare-based legal services provided swift and convenient access for patients, avoiding the need to navigate external advice agencies that could be scarce or have long waiting times. The health setting was also somewhere trusted and familiar, where people could access help discreetly for sensitive issues.

> *"If someone isn't very well or they are in a real state of stress and it's urgent, they can just come upstairs, they don't have to go and find another clinic or wait for Citizens Advice to open and then queue and then wait for the appointment for a week, it can almost be immediate." [Case study 4, Welfare rights advisor]*

Through the link with healthcare, legal services were able to reach people at a time of need, when poor health was creating urgent requirements for welfare support. This issue was particularly pronounced in acute care settings, where patients were coping with sudden and serious diagnoses, or the severe illness of a child or family member. At such a time, they were less able to manage their affairs or cope with the bureaucracy of the welfare system when their energy was drained, and they were under emotional strain.

> *"When you're coming into the hospital and you're quite disorientated, a lot of the families have got all sorts of other issues going on as well… having those services available is a safety net and provides an important support that can make all the difference at that time." [Case study 5, Funder/commissioner]*

The healthcare-based legal services also offered access to expert advice for patients. By working with particular patient groups, the advisors developed specialisms in the issues affecting people, including those with serious and complex illnesses. They built up a greater understanding of the effects of illness on people's lives and were able to offer the best possible assistance in the circumstances. This also helped patients because they had less to explain and justify, particularly where the health conditions were rare or stigmatised, which could be a barrier to people seeking assistance from external welfare advice services.

> *"It means we have some experience of dealing with the type of issues that often come up and they are likely to face… It's just really being on hand to offer slightly more tailored support than a general office on the high street would." [Case study 5, Welfare rights advisor]*

> *"Often you're the only person that knows about their diagnosis apart from the doctors they see, and so you're the only person that they can be free with, and not have to worry about what they're saying, or how they're saying it, or how it's being interpreted." [Case study 8, Welfare rights advisor]*

Improved socio-economic circumstances

An outcome reported consistently across the case studies was the significant difference made to social and economic circumstances. This was largely in relation to financial gains, which could be very considerable for individuals accessing the service. In one of the larger-scale services, this amounted to several millions of pounds in income gain at the area level each year. The legal assistance was highly successful in generating income for patients by helping them to access their benefits entitlements, overturn benefits withdrawals, prevent and managing debts. This had helped to lift people from poverty, stabilise their personal circumstances and cope with the additional financial costs of illness. The legal assistance had also dealt with housing issues, preventing homelessness and allowing people to move from harmful living environments.

> *"It was producing amazing outcomes… you know, millions of pounds for people who otherwise wouldn't have had access to that money, preventing evictions, domestic abuse… we saw the whole raft of it." [Case study 1, Funder/commissioner]*

> *"I had a dad this week… said it had made a tremendous difference to him because he got not just the benefit but the backdated benefit, and this man had been living in absolute poverty for it must be at least a year and a half. A huge difference, huge impact it has on the patients." [Case study 5, Social care manager]*

Improved health and wellbeing

The patients accessing the legal services were often in a poor state of mental health due to the welfare issues they were experiencing. Welfare benefits and debt problems were consuming people with anxiety and panic, to the point where there had been suicides, attempted suicides and other mental health crises among the patient groups. The legal assistance was a critical intervention, supporting mental health by addressing the source of anxiety and stabilising people's circumstances. Care teams reported seeing reductions in stress and anxiety, improved ability to cope and to look after themselves.

> *"If she can help, in her expert welfare rights role, it just makes our job a little bit easier, because if that's sort of nipped in the bud and that's managed, people calm down, they become less distressed, they're then able to look after themselves, and adhere to their medication and not engage in risky behaviours, so it has a big impact on somebody's ability to just function in the world." [Case study 8, Healthcare professional]*

Even where the mental health situations were less acute, the intervention was supportive to mental wellbeing. Resolving the welfare issues removed a significant burden from people and reduced their anxiety levels. It also made their circumstances more manageable, allowing them to move forward with their lives and continue their daily activities. Having the support of the welfare rights advisors was in itself beneficial to mental health: their listening ear and practical guidance improved people's state of mind by providing much-needed reassurance and a plan of action to address their problems.

> *"It's a big issue with the debt side of things that people come to us and they're at their wits end because they don't know what to do. Very often clients will say, even after the first appointment, when they know they're able to get some support, they will say it's a weight off their shoulders. Yeah, it's a cliched thing but that's literally what they say to us. That they feel, because they've been able to open up, because they know that there's support there and that there is a way out… it's there for them and they've benefitted immediately from it." [Case study 1, Welfare rights advice service manager]*

For some patients, engaging with the legal service had been a gateway to other forms of support including necessary health and social care. People would sometimes go to the advice workers rather than medical teams because they were approachable and offered practical support. In the course of working with clients, advisors would become aware of health issues that people had not sought help with. Having developed trust with the client, advisors could then encourage them to speak to their GP or other care team. This had helped overcome anxiety or distrust of services and engage with the necessary support, as illustrated below in the case of receiving psychological therapy:

> *"I think it's often a way into Psychology, because often people would reject a referral to Psychology. But to get them into welfare first, get those basic needs met, get them safe a secure financially, or get things moving in the welfare system. They're then a bit more open to addressing some of the psychological issues." [Case study 8, Healthcare professional]*

Improved patient experience

The staff members interviewed reported very positive feedback from patients about their experiences of the partnership, largely relating to the ease of access to the legal service and the quality of support it provided. Patients valued having the support readily available at a difficult time, when many were anxious, confused and disorientated. They were grateful for the dedicated service and the expert advisors that understood their needs and could help them navigate the challenges of the welfare system. Some relied heavily on this support and the security it provided; the extent of this became clear in services that had experienced cuts to the legal services, as illustrated by the quotation below:

> *"When it first stopped, we were kind of inundated with calls from the hospital to say 'where do we go?' The patients just didn't know where to turn when they needed support." [Case study 9, Welfare rights advisor]*

> *"For the people that (the welfare rights officer) used to support but now can't support, they have been very distressed about that, and we've had to sort of pick up the pieces of that, 'cause you know, to be offered something and then to have that security blanket taken away, it's very threatening." [Case study 8, Healthcare professional]*

Integration of the services (through co-location or referral pathways) provided a smooth experience for patients. They could access assistance quickly and easily and all in one place, while being in hospital or at the same time as attending healthcare appointments. They appreciated this convenience and not having to leave their place of care to seek additional help. It was also a place they felt safe to be open and where they could receive welfare support in a confidential and anonymous way.

> *"I think the co-location element is important for patients. You know, patients are really delighted when you say we've got this service and it's in the next room or it's one floor up – patients really like that and so I think it's really important for them." [Case study 4, Healthcare professional]*

Where care pathways were integrated, this provided a seamless service for patients that provided continuous support, helping patients in their transition from hospital back to the community.

Impacts for staff

Enabled care teams to focus on core role

Patients in all the health settings (primary and secondary care) would present to their care teams with welfare issues that were worrying them or affecting their health, or had arisen from their illness. Prior to the partnerships being established, health and social care professionals were trying to assist patients themselves by filling in applications for benefits, grants, and other welfare support. This was not only extremely time-consuming and took them away from helping other patients, but was something they could not do well or with confidence because they did not have the legal knowledge and expertise. It was therefore both burdensome and stressful to them, as illustrated by this participant:

> *"The other thing I find is, they've come in with these huge forms for Attendance Allowance and Personal Independence Payment, "Can you fill this in with me?". And I don't feel expert enough that if I get the wording wrong, I'm worried they'll get rejected… and the page can take about two hours to fill in the form and by that time we've lost*

> *a lot of other patients who are wanting other questions, really." [Case study 6, Health service manager]*

The partnership with the legal service was a valuable resource for care teams, providing a dedicated and immediately accessible service they could refer people to when welfare issues arose. This took some of their administrative workload away and meant they had one less thing to worry about, knowing the patients would be supported to get the welfare issues addressed. It also meant they had more time to spend on their caring roles and could therefore provide a better service to patients.

> *"Previously they would either wait for the social worker to come on and the social worker would do the benefits bit, or it would be the nurses themselves and they would fill the forms out… So, they are finding that there is a little bit more time, and that's the biggest thing they enjoy and that they value, is that it frees them up from having to do stuff they didn't like, weren't skilled at, and were never sure whether they were doing it correctly or not." [Case study 7, Welfare rights advice service manager]*

These benefits were also evidenced in partnerships where the legal service had been cut back or lost completely, removing the support that staff had previously had. In these circumstances, healthcare professionals reported increasing numbers of patients coming to ask for welfare assistance and not knowing how to respond or provide the right advice. It resulted in increasing administrative workload and reduced time to care, as well as feeling more pressured (due to the lack of support) and worrying that patients were not getting the help they needed.

> *"For a colleague of mine, I know that's meant that she's holding a lot more risk, and she's trying to communicate with people herself, and it's just, she's not as good at it obviously, 'cause she doesn't have the information and the knowledge, so it's sort of taking her away from her core role." [Case study 8, Healthcare professional]*

One interviewee in primary care challenged the idea that the partnership would save time for health professionals, if the alternative was to ignore patients' welfare issues or tell them to seek advice elsewhere. This highlights the diverse approaches of health professionals in relation to managing patients' non-medical needs, which will affect the extent to which they utilise and benefit from partner legal services.

> *"I don't know about less to do… you know, if the alternative was I ignored the legal problem then it gives me more to do. If I'm desperately looking for a solution and your clinic comes to mind, then it is extremely helpful. I think it's probably too early to say that, as a consequence, they are making fewer appointments to see me." (Case study 4, Healthcare professional)*

Facilitated access to information for legal casework

The relationship between the services made it significantly easier for welfare rights advisors to obtain medical information when that was needed for the legal case work. This meant the legal intervention could be much more effective because it was supported by the necessary evidence, which was a huge benefit to the legal services in helping their clients effectively.

> *"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." [Case study 6, Welfare rights advisor]*

One of the legal services had full access to the healthcare IT system, and two others had read-only access; this allowed them to view patients' records and obtain the information they needed directly. In the other partnerships, information was obtained through communication with the health service, which was made significantly quicker and easier because the welfare rights advisors were known internally and able to communicate directly with staff members. The financial charges that are often levied by GPs for medical reports were also waived for the legal services they had relationships with.

> *"A lot of the types of cases, the welfare benefits of housing, will require medical evidence to prove the case, and sometimes that includes a letter from the doctor. And obviously us being able to directly contact the GP, them knowing who we were (because either they'd referred the patient directly to us or they'd heard about the service and it was in the same building) we were getting very fast responses and they wouldn't charge us for the work they were doing because we were obviously helping their patients." [Case study 4, Welfare rights advice service manager]*

Improved knowledge of individual needs

Through communication and collaborative working, both health and advice teams gained a better understanding of people's needs and situations, which helped inform the care they provided. Information was transferred to the advisors on referral forms, through conversations in person and through access to care records, meaning they knew more about the scenario and understood the patient's health situation. They could therefore approach their discussions with patients better informed about potential welfare entitlements, and more prepared to discuss sensitive issues such as end of life planning. This pooling of knowledge was particularly necessary where health conditions were rare or complex, and where patients had mental health or communication difficulties affecting their ability to convey accurate information to the advisors. The quotation below illustrates how this collaboration facilitated the advisors in doing the welfare casework effectively:

> *"There's a lot of rare conditions… you are never going to be able to understand the distinctions between all the different metabolic conditions, so (the advisors) would ask us to go and talk to the clinical nurse specialist it tends to be, to get more accurate information about what does this condition actually mean in terms of functionality." [Case study 5, Social care manager]*

In some of the partnerships, advisors were actively feeding back on progress and outcomes of the welfare rights cases. This meant that care teams knew what assistance had been provided and were aware of issues that may be impacting on health or causing anxiety, meaning their interactions with patients were better informed.

> *Being able to access the client's records means that our workers go in equipped with full information. Then… once they've seen the client, they update that on the care notes. So immediately they've been seen, anybody else who's working with them, within the Adult Mental Health Teams, is able to see what we've done, where we're at, so their conversations with their clients are more informed. [Case study 7, Welfare rights advice service manager]*

One participant explained how this feedback on the welfare situations could be helpful to care teams in informing how they manage the treatment of individuals:

> *"It's really good to know they're still waiting for an outcome and we can help them manage that feeling of being out of control and help them manage worry. And then if they get a positive outcome , it's really good to know that so we can help them plan for the future. And if it's a negative outcome it's really good to know that to then monitor the risk with them, and to think about what do we need to help them to put into place and manage that." [Case study 8, Healthcare professional]*

Increased subject expertise

By working in health settings, the advisors developed specialisms in health-related welfare issues and became experienced in the kinds of situations affecting patient groups. They developed detailed knowledge of health conditions, treatments and side effects and could therefore offer more expert and tailored support for patients. The care teams also gained knowledge in relation to welfare rights: the advisors would very often be informing them about welfare issues, explaining the laws around benefit entitlement and keeping them up-to-speed with continuous changes in the welfare system. This meant the care teams were more knowledgeable about the support available to individuals, could pass on the basic information to patients and could identify when a referral to the legal service might be needed. Some care team members had learnt a lot through the collaboration and felt it made them better practitioners because they could provide better advice and assistance for their patients.

> *"It's increased my knowledge and understanding, because it's not my area of expertise, and as well as that the law can change rapidly, particularly around the pandemic, COVID-19 and about the changes and what people are entitled to… So (the welfare rights officer) keeps up-to-date with all that information and knowledge, and shares that with us." [Case study 8, Social care professional]*

Impacts for organisations

Resource to manage non-medical needs

Partnerships with legal services enabled healthcare teams to address social welfare issues that presented frequently among patients and were affecting them negatively. These issues were outside their field of expertise and could not be addressed without additional help. The care teams appreciated having somewhere to direct people to, to ensure that patients received the necessary assistance and to resolve underlying issues that were having a negative impact on health. It also made their own work easier as they no longer had to deal with complex and time-consuming welfare problems, but could pass them on to the experts in one easy referral.

> *"One GP said to me, he was like "It's completely transformed the way that I deliver a consultation with a patient now, because essentially I know I've got 10 minutes. I spend 10 minutes saying, "Talk to me about all of the things I can fix, talk to me about your medical issues". And then I just point them outside and say "Go and use that Citizens Advice phone to basically fix everything else"." [Case study 3, Welfare rights advice service manager]*

Care teams appreciated having the legal service close at hand and accessible via a direct internal referral, which saved them having to hunt for support elsewhere and navigate services they did not know. This impact was obvious where partnerships had been discontinued and healthcare staff had not known how to support people or where to go for help:

> *"We only have a limited amount of knowledge, so how do we get them organised? It was a greater workload for us, and also not feeling sometimes we knew how to take it right through all the way, so kind of passing it back to the stressed relative of whatever to sort. So it definitely felt very lost, not connected, people probably didn't get*

> *half the benefits they should've got." [Case study 6, Health service manager]*

Care teams also valued the expertise of the welfare rights advisors, which helped them deal with complex issues like housing problems and benefits appeals. It was useful to have someone on hand for specialist advice, who could provide knowledgeable input and on-the-spot information to help patients. Some had also found that patients could engage better and get the best from their care when the welfare issues had been addressed.

> *"It's a support to us that we know if we've got a really strange situation, you know maybe with an unusual condition, or an unusual financial arrangement of the family, or also immigration issues, we can go and get that specialist advice from people who are right next door to us." [Case study 5, Social care manager]*

Facilitates hospital discharge

One of the outcomes mentioned by staff in acute care settings was that the legal services facilitated the discharge of people in hospital. Discharge could be delayed if patients' benefits were not in place or housing issues were unresolved, which was costly for health services and detrimental to personal recovery. The legal service played an important role by intervening early and speeding up people's access to welfare support. This facilitated quicker patient discharge, alongside the inputs from medical and social care teams.

> *"At one stage, we had 17 beds available which was unheard of, and that was a combination of (the legal service) being involved and really good links with housing partners." [Case study 7, Social care manager]*

4.6.2 Pathways to impacts

The passage below explores how the impacts described above were arrived at, identifying features of the partnerships that influenced these outcomes. Determinants of impact included aspects of the service design (context) and how collaborative working was taking place (mechanisms), as well as other impacts being achieved which had knock-on effects.

Figure 4-14 displays the determinants of impacts for patients and *Figure 4-15* displays the determinants of impacts for staff. These pathways are described in more detail below.

Figure 4-14: Factors leading to impacts for patients

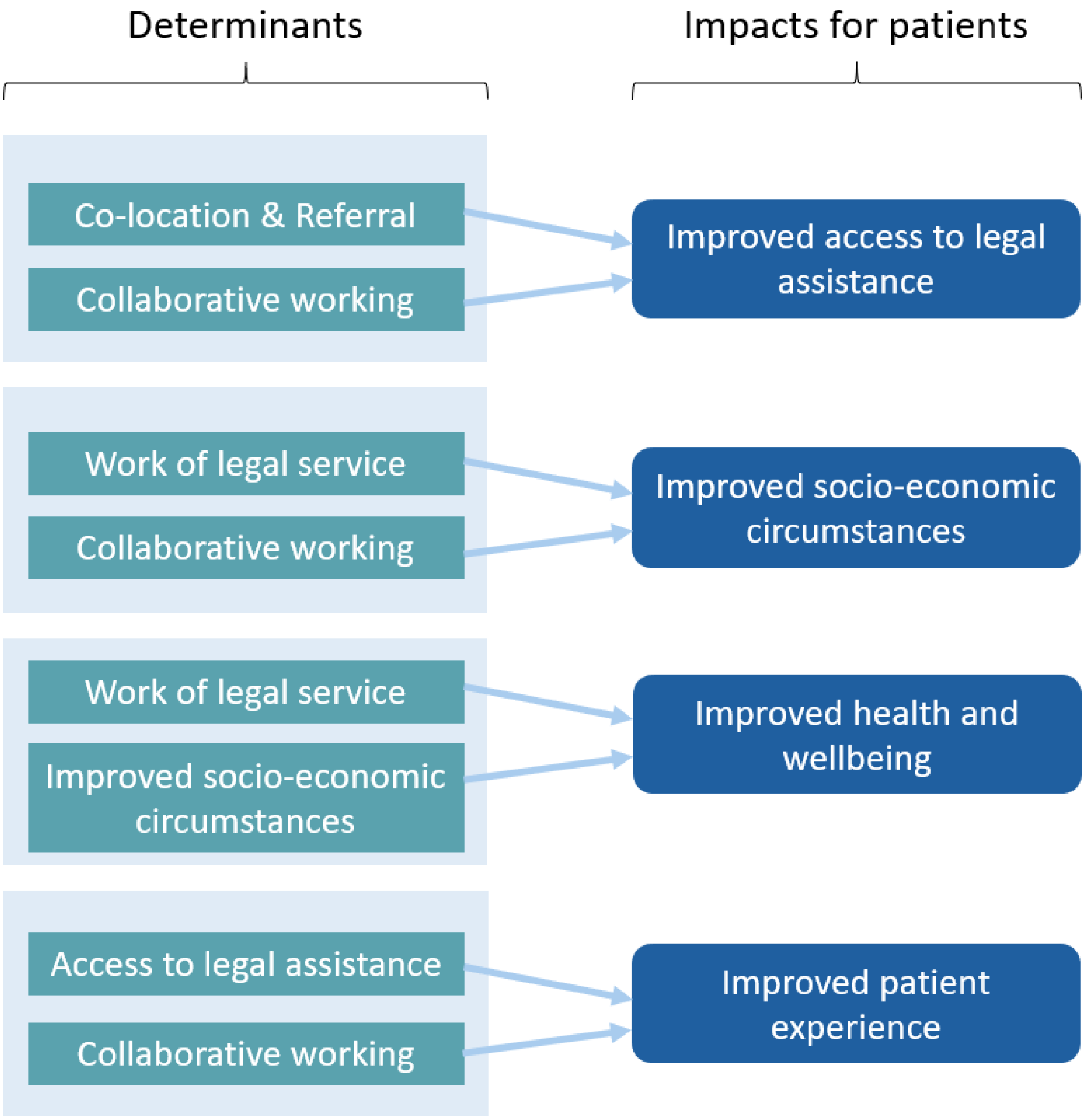
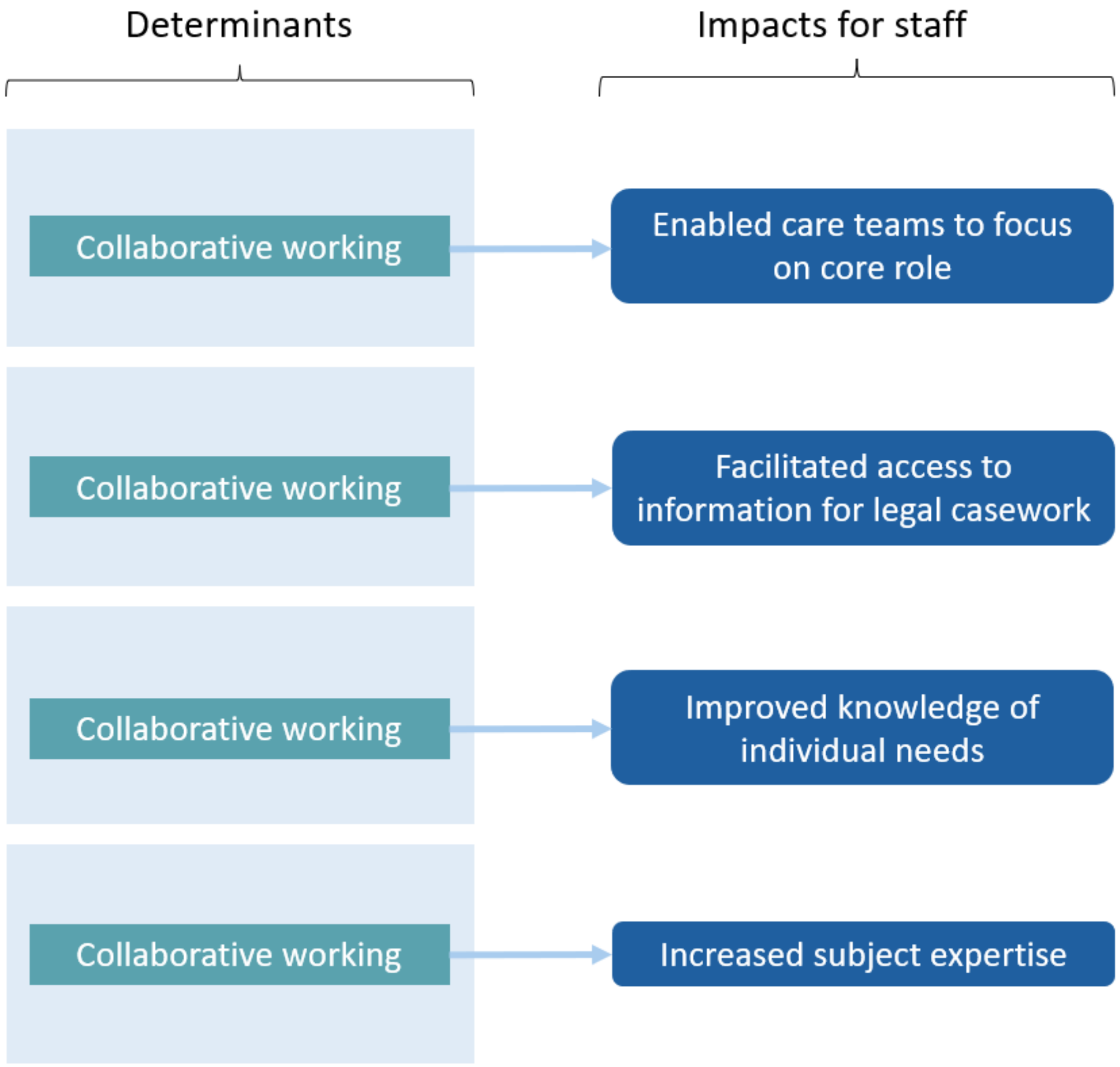


Figure 4-15: Factors leading to impacts for staff



Impacts for patients

Improved access to legal assistance

The connections between the services (co-location and referral links) facilitated access to legal assistance for patients. Being physically present in the healthcare setting meant people would see the legal service when they were attending appointments and could access it unprompted. Others were told about the service by care teams and either signposted or referred directly. Some teams were engaged in proactive identification of needs, meaning that welfare issues were identified more consistently and referred at an early stage.

Improved socio-economic circumstances

The legal assistance was successful in achieving significant improvements in financial circumstances, living conditions and other socio-economic outcomes for patients. Collaborative working strengthened this outcome: through exchange of medical evidence, consultation and discussion between teams, and joint input into the casework, the welfare rights advisors were equipped with the knowledge and information they needed to provide the most effective assistance. This strengthened the legal case and increased the chances of successful outcomes.

Improved health and wellbeing

Receiving assistance for welfare problems and being supported by welfare rights advisors provided immediate relief and reassurance for people. It addressed issues that were causing significant mental distress and led to reduced anxiety. Improvements in financial position and living circumstances also improved mental wellbeing and quality of life.

Improved patient experience

Patients were glad and grateful to have the legal assistance available to them at a time of need and without having to seek help from external services. They appreciated the convenient access and expert advice. Collaborative working strengthened this outcome: coordination between teams ensured that patients received help seamlessly as part of their care, and that staff members were fully informed about their needs.

Impacts for staff

Enabled care teams to focus on core role

Having a partnership with the legal service provided a resource for healthcare professionals to address the welfare issues of patients, meaning they did not have to spend time on it themselves and could focus on patient care. In order to benefit from this, healthcare professionals needed to connect patients with the service by making referrals to the advice teams.

Facilitated access to information for legal casework

Having a relationship with the health services meant that welfare rights advisors could access medical evidence much more easily. This relied on communication with healthcare teams: they could talk to the staff about the situation and what evidence was needed, write internally to healthcare professionals to request information, or ask receptionists to print things off. Being known and trusted personally meant staff were willing to support them and access to information was swifter and easier.

Improved knowledge of individual needs

By working collaboratively on individual cases, both health and advice teams gained a better understanding of the person's needs. This relied on communication between teams to inform each other about the situation and provide progress updates. Advisors gained important knowledge of the health condition, and healthcare professionals were informed about welfare circumstances that might be affecting patients' health or care. This meant that both teams were able to provide more effective supportive for people.

Increased subject expertise

Through communication between teams, both healthcare professionals and welfare rights advisors broadened their understanding of interrelated issues: advisors learnt about health-related needs, while healthcare professionals developed an understanding of the welfare system and rules about welfare entitlements. This increase in expertise came about through working closely together: having discussions on the job about individual cases, consulting each other about ways forward and providing information and training sessions.

Impacts for organisations

There was no data in the interviews identifying specific determinants of the organisational outcomes ('Provided a resource to meet non-medical needs' and 'Facilitated hospital discharge'). Both outcomes could be expected to depend on the welfare rights service being sufficiently utilised by healthcare teams.

4.6.3 Cross-case comparison of impacts

This section presents a comparison of the observed outcomes across the case studies. Qualitative Comparative Analysis was not used for this outcome because it could not be categorised in a binary way: there were many impacts, and services could be impactful in some ways and not in others. Instead, the reported impacts were listed for each case study, and a comparison table was drawn up showing reported impacts according to partnership features.

Universal impacts

Table 4-14 maps out the impacts that were reported across the case studies. Some impacts were experienced universally, regardless of the service model and context. This included the benefits for patients, which were driven by features common to all the partnerships: the connection between the services facilitated improved access to legal assistance; the work of the legal service improved socioeconomic circumstances, which in turn supported mental health and wellbeing; and the ease of access and quality of support improved the experience of patients. Another impact reported across all the case studies was that partnerships provided a valuable resource for health services in addressing the non-medical needs of patients, due to the support they offered healthcare teams through their existence.

Impacts dependent on collaborative working

Some impacts were dependent on achieving a minimum level of engagement from the care teams, at least to the point of making referrals and exchanging medical information when necessary. This included enabling care teams to focus on their core roles (which occurred as a result of referring on for the welfare issues when they arose) and facilitating access to information for the legal casework (which required communication and willingness to provide support to the advice teams). In partnerships with closer collaborative working practices, improvements in knowledge and expertise were reported among the health and advice teams, generated through the learning that came from greater communication.

Impacts dependent on context

Facilitation of hospital discharge was reported only in the context of inpatient hospital services.

Table 4-14: Reported impacts across case studies according to collaborative working activities and service context

	Impact	**Experienced universally**	**Experienced where a minimum level of care team engagement**	**Experienced where close collaborative team working**	**Context-dependent**
Impacts for patients	Improved access to legal assistance	✓			
	Improved socioeconomic circumstances	✓			
	Improved mental health and wellbeing	✓			
	Improved patient experience	✓			
Impacts for staff	Enabled care teams to focus on core role		✓		
	Facilitated access to information for legal casework		✓		
	Improved knowledge of individual needs			✓	
	Increased subject expertise			✓	
Impacts for organisations	Provided a resource to meet non-medical needs	✓			
	Facilitated hospital discharge				✓

4.7 SUMMARY

4.7.1 Study overview

This study involved nine diverse health-justice partnerships across England and aimed to identify factors which influenced implementation outcomes. Data were collected through one-to-one semi-structured interviews with professionals working in the partnerships, including welfare rights advisors, health and social care professionals, service managers and funders. Three main outcomes of implementation were investigated: i) collaborative working; ii) sustainability; and iii) partnership impacts. The analysis explored the outcomes that had been achieved by the partnerships, examined the causal pathways leading to those outcomes, and compared differences in outcomes and determinants across the case studies. Together this provided strong evidence of the factors influencing partnership success. Implementation theory was used to inform the analysis and generate insights that could be generalised beyond the included case studies.

4.7.2 Summary of findings

The case study partnerships

Service delivery

The case study partnerships were based in health settings that included GP practices, hospitals, hospices and mental health services. The most common legal issues addressed were welfare benefits, debt and housing. All the advice services offered assistance up to casework level and sometimes beyond, including representation at tribunals. Advice was most mostly delivered face-to-face, although the pandemic had necessitated a switch to remote working at the time of study. Two were telephone-based, one of which had placed landlines in GP practices offering patients a direct connection to the advice team, and the other had a telephone number that patients and healthcare professionals could call. The face-to-face services were offered on site in the health settings so that patients could receive advice in their place of care. All the partnerships had referral mechanisms to receive referrals directly from care teams into the advice service.

Two partnerships had integrated care delivery by embedding welfare rights advisors within multi-disciplinary care teams (in mental health and HIV services). The advisors became members of the teams, participating in team meetings and other daily activities together. This was the closest approach to joint working in the case studies. Two partnerships involved multi-agency working, in which the NHS had partnered with several local third sector organisations: they worked as a group to deliver a package of support for a particular population (one was geographically bounded, the other focussed on mental health settings in the locality).

Funding came from a wide range of sources, including local authorities, the NHS, charities and a university. Some involved joint funding arrangements, in which the partnership had income from more than one funding source or was funded using integrated care budgets.

Issues relating to partnership design

Achieving equitable access for patients was a challenge in primary care because there were a large number of sites to cover with relatively small advice teams. One service excluded patients who were not registered at particular GP practices. Other partnerships had opened the service to any local patient or used remote methods to extend the reach of the service.

Staffing capacity of the welfare advice services was often limited: one partnership involved a single welfare rights advisor, and most other teams were between three and six people. In the face of high demand, some of the welfare rights services had boosted their capacity by drawing on volunteers or building connections with other local advice agencies for additional support.

Some of the primary care-based services reported efficiency problems, including difficulties generating sufficient referrals or patients not attending appointments. This had driven the development of remote models of delivery.

Collaborative working

Collaborative working activities

Collaborative working activities happening in the partnerships included identifying welfare needs, making referrals, exchanging information, jointly contributing to casework, engaging in secondary consultation and providing feedback on case outcomes. Levels of engagement in these activities varied significantly, being limited in some partnerships to occasional referrals and exchange of personal information if necessary.

Pathways to collaborative working

Mechanisms influencing engagement in collaborative working included the following broad themes: ‘willingness’ (subthemes: ‘sentiment towards the partnership’, ‘perceived value of the partnership’ and ‘alignment with purpose’), ‘confidence’ (subthemes: ‘trust between teams’, ‘quality of relationships’, ‘habits & norms’) and ‘ability’ (subthemes: ‘knowledge levels’, ‘opportunities to interact’ and ‘workability of systems’). As well as directly influencing engagement, many of these mechanisms interacted with each other. The patterns suggested a positive cycle may occur, in which collaborative working is strengthened over time as colleagues participate, build relationships and develop appreciation for the partnership.

Contextual factors influencing these mechanisms included those relating to service delivery (‘co-location of services’, ‘learning opportunities’, ‘staff turnover’, ‘levels of welfare need among patients’ and ‘organisational impacts of welfare issues’) and service management (‘evaluation’, ‘promotion’ ‘brokering relationships’, and ‘alignment of branding/identity’).

Cross-case comparison of collaborative working

Drawing on the implementation theory, three key conditions were selected for comparison across the case studies. These were: ‘communication opportunities’, ‘collective commitment’ and ‘leadership facilitation’.

In the four case studies where collaborative working was close, ‘communication opportunities’ and ‘collective commitment’ were high; this suggests these conditions are *necessary* for the positive outcome. The solution formula also suggests that this combination of conditions is *sufficient* for the positive outcome. Leadership facilitation was alone neither necessary nor sufficient for the positive outcome.

In the five case studies where collaborative working was not close, ‘communication opportunities’ and ‘collective commitment’ were both not high; this suggests these conditions are *necessary* for the negative outcome. The solution formula also suggests that this combination of factors is *sufficient* for the negative outcome. Leadership facilitation was alone neither necessary nor sufficient for the negative outcome.

Sustainability

Sustainability of partnerships

The partnerships varied in their length of existence from less than five years to almost thirty, with some experiencing significant changes in scale or ways of operating during that time. Six of the case study partnerships were ongoing at the time of the study, while three were discontinued shortly before or during the course of the research. Discontinuation had occurred at different points in the partnerships' lifetimes: after the pilot stage, after a decade and after more than two decades of operation.

Pathways to sustainability

Mechanisms influencing continuity included the following broad themes: 'willingness' (subthemes: 'sentiment towards the partnership', 'perceived value of the partnership' and 'alignment with purpose'), 'confidence' (subthemes: 'use of evidence', 'local reputation' and 'funder-provider relationships') and 'ability' (subthemes: 'funding sufficiency', 'material resource sufficiency' and 'support in kind'). As well as directly influencing engagement, many of these mechanisms interacted with each other. Most of the identified links were with 'willingness', showing how several factors influenced the support of people at strategic level. There was also a link between willingness and funding sufficiency, showing that senior leaders could act to gain and protect resources when they were supportive towards the project; however, this relationship did not invariably play out because there was not always sufficient flexibility with budgets.

Contextual factors influencing these mechanisms included those relating to external factors ('changing economic and political environment' and 'changing health policies and structures') and service management ('evaluation', 'promotion', 'engagement with funders' and 'responsive leadership').

Cross-case comparison of sustainability

Drawing on the implementation theory, three key conditions were selected for comparison across the case studies. These were: 'resource sufficiency', 'strategic commitment' and 'proactive leadership'.

In the six case studies that were ongoing, 'resource sufficiency' was sufficient, 'strategic commitment' was high and 'proactive leadership' was highly active; this suggests these conditions are all *necessary* for the positive outcome. The solution formula also suggests that this combination of factors is *sufficient* for the positive outcome.

In the three case studies which had discontinued, 'resource sufficiency' was not sufficient, suggesting that this condition is *necessary* for the negative outcome. The solution formula also suggests that insufficient resources alone is *sufficient* for the negative outcome. 'Strategic commitment' and 'proactive leadership' were neither necessary nor sufficient for the negative outcome.

Impacts

Impacts of partnerships

Interviewees reported that the partnerships were making a positive difference in a range of ways. For patients, the partnerships: improved access to legal assistance, improved socio-economic circumstances, improved health and wellbeing and improved patient experience. For staff, the partnerships: enabled care teams to focus on core role, facilitated access to information for legal casework, improved knowledge of individual needs and improved subject expertise. For organisations, the partnerships: provided a resource to meet non-medical needs of patients and facilitated hospital discharge.

Pathways to impacts

The connections between organisations (co-location and referral links) improved access to legal assistance for patients, because they were referred or saw the service and made their own way. The work of the legal service itself (welfare rights advice and casework) led to improved socio-economic circumstances and improved health and wellbeing among patients. Certain patient outcomes contributed to others: gaining access to legal assistance improved patient experience, and positive socio-economic outcomes improved health and wellbeing.

Collaborative working was the mechanism that brought about the impacts for staff. Making referrals enabled healthcare professionals to focus on their core roles, data exchange improved access to information for legal casework, and communication and discussion improved professionals’ knowledge of individual needs and subject expertise in relation to both health and welfare issues. Collaborative working also contributed to some of the outcomes for patients: identifying need and making referrals improved access to legal assistance, exchanging information improved socio-economic circumstances (by supporting welfare case outcomes) and coordination between teams improved patient experience by streamlining the support.

Cross-case comparison of impacts

Certain impacts were experienced universally across the case studies, due to the connection between organisations. These included all the benefits for patients, as well as (for organisations) providing a resource to meet non-medical needs of patients.

Two outcomes were experienced where there was at least a minimum level of engagement in collaborative working; these were the staff impacts: enabling care teams to focus on core role and facilitating access to information for legal casework. Two outcomes were only experienced where there was close collaborative team working;

these were the staff impacts: improved knowledge of individual needs and improved subject expertise.

One outcome was specific to the context and only reported in the hospital case studies: facilitated hospital discharge.

4.7.3 Questions arising

The comparative case study provided examples of diverse health-justice partnerships across England. It illustrated different approaches to designing health-justice partnerships, presented detail on the management and delivery processes, and highlighted some of the challenges to be considered in developing partnerships. The analysis defined key outcomes that constitute implementation ‘success’, and examined the causal pathways leading to those outcomes. The evidence generated through this study provides information that is relevant to implementers and could support successful design and delivery of health-justice partnerships in England. In order to facilitate use of this evidence in practice, it should be translated into outputs that are accessible for practitioners and policy makers. This leads to the research question that is investigated in the following chapter: ‘What tools or resources would be helpful to support the implementation and scaling up of health-justice partnerships?’

CHAPTER 5. STAKEHOLDER ENGAGEMENT

5.1 INTRODUCTION

The stakeholder engagement event was undertaken as the final activity of the PhD. It involved a webinar in which the main results of the study were presented, followed by facilitated small group discussions among attendees about their own experiences of the issues raised. The event aimed to begin the dissemination of findings to stakeholders, as well as to gain their input to inform study outputs and future research and policy directions. This chapter describes how the event was delivered and the findings from stakeholder engagement.

5.2 AIMS

The stakeholder engagement event gathered information to answer the final research question of PhD: "What tools or resources would be helpful to support the implementation and scaling up of health-justice partnerships?"

The aims of the event were:

i) To communicate the findings to stakeholders with an interest in the research.
ii) To provide an opportunity for questions, discussion and feedback on the work.
iii) To explore stakeholders' experiences of the issues raised and priorities for future research and policy activity.
iv) To gather feedback on proposed recommendations
v) To establish what publication formats would be most useful for communicating the results to stakeholders

5.3 METHODS

The intended stakeholders for the consultation included professionals working in health-justice partnerships or involved in their management, funding or related policy and research.

Table 5-1 presents the activities undertaken as part of the stakeholder engagement, according to the stated aims.

Table 5-1: Aims and activities of the stakeholder engagement

Aims of engagement	**Activities of engagement**	**Resulting data**
To communicate the research findings to stakeholders	Presentation of results in a live webinar	Video recording of the webinar, to be made available following the event
To provide an opportunity for questions, discussion and feedback	Q&A session following the presentation	Video recording of the Q&A session Recording of the webinar chat stream
To explore stakeholders' experiences of the issues raised and priorities for future research and policy work	Discussion groups with talking points	Notes taken during discussion groups Written feedback received by email after the event
To gather feedback on proposed recommendations	Email to webinar attendees inviting feedback on the full list of proposed recommendations	Written responses indicating stakeholders' views on the recommendations
To establish what publication formats would be most useful for communicating the results to stakeholder groups	Poll of webinar attendees	Poll results showing preferred formats

5.3.1 Recruitment

I advertised the webinar six weeks ahead of the event. I created a sign-up page on Eventbrite (see *Appendix 3A*) and emailed contacts with information about the event, inviting them to attend and to extend the invitation to colleagues working in the field. These contacts included: existing research participants (those who had contributed to the Comparative Case Study); people working in other health-justice partnerships across England (contacts from previous research and engagement), contacts in national and local government, people working in advice sector networks and policy organisations, and academic researchers in related fields.

5.3.2 Event format

I held the webinar online as a Zoom meeting, which took place at midday with the aim of enabling practitioners to attend during their lunch hour. *Table 5-2* details the event timings and activities. Talking points for the group discussions are presented in *Appendix 3B*.

Table 5-2: Stakeholder engagement event outline

Time	**Activity**	**Details of activity**
12.02	Welcome and housekeeping	Introduced by a project supervisor
12.05	Introduction to the researcher and the project	Introduced by a project supervisor
12.10	Research presentation	Led by the researcher Provided an overview of the following: • Background and rationale for the study • Main findings of each results section • Recommendations / considerations in relation to each topic
12.45	Question & Answer session	Facilitated by a project supervisor
13.00	Discussion session (End of the main seminar)	One facilitator for each group of around 5 people. Talking points: 1. How do the results reflect your own experiences? 2. What would you like to see happen in future, to support your work in this area?
13.28	Poll on preferred research outputs	Poll question: Which format(s) would you like to receive these results in? Answer options: • Academic research article • Summary report & recommendations • Toolkit / guidance • Poster / infographic • Recorded video explainer • Other
13.30	Thank you and close	

5.3.3 Follow-up with participants

In the week after the event, I contacted participants to provide them with the following information:

- A link to the video recording of the webinar
- A summary of the discussions and links to further information and resources
- A copy of the full list of project recommendations

I invited participants to provide feedback on the recommendations. This consultation aimed to sense-check the recommendations, gauge their impacts in practice and identify any unforeseen barriers to implementing them. I invited participants to consider the following questions:

i. Are these recommendations doable in practice / can you see potential difficulties with any of them?

ii. Would these recommendations make a difference in practice / be effective in improving or sustaining partnerships?

iii. Any other ideas for recommendations, based on your own experience?

5.3.4 Data analysis

I analysed the data collected through the engagement activities (see *Table 5-2* above) rapidly using the following methods:

- I compiled participant feedback in written form (including notes from the discussion sessions, the Zoom chat stream and emails received following the event) into an NVivo project, and broadly coded responses according to the main topics of conversation.
- I downloaded responses to the Zoom poll and converted the data into a chart.
- I reported the written responses to the consultation on recommendations as they came.

5.4 RESULTS

5.4.1 Response rates

Sixty-five people registered to attend the event, and over fifty people signed into the Zoom meeting. The registered attendees included people working in existing health-justice partnerships in a variety of roles (healthcare professionals and welfare rights advisors, service managers and funders), people working in central government departments and local councils across England, professionals working in welfare rights advice sector organisations and the NHS, related charities and funding bodies, and academic researchers.

Twenty-seven attendees plus six facilitators stayed on to take part on the discussion sessions. Poll responses were received from twenty-three participants. Feedback on recommendations was received from two participants.

5.4.2 Group discussions

This section summarises participants' thoughts and feedback in relation to the issues raised during the engagement event. The feedback is presented according to the topics of discussion and covers the challenges, potential solutions and suggestions for the future.

Service models

Links with social prescribing

More joined-up thinking is needed on how health-justice partnerships can integrate with social prescribing models. A large proportion of patients' needs arising in social prescribing schemes are related to welfare rights, yet link workers are ill equipped to deal with legal issues. Participants felt it was important that health-justice partnerships should link in with social prescribing given that it is now the dominant approach to cross-sector working in the NHS. One participant had argued locally for an advice-led social prescribing model but was ignored, highlighting that the importance of welfare rights advice within social prescribing is not always understood. Others were piloting hybrid roles: specialist link workers who are qualified welfare rights advisors, or were trained to address simpler welfare issues and could refer on for more complex ones. There was an interest in hybrid roles given the rising need for welfare support in the population, but also a concern that it would be a lot for one individual to take on and could lead to the erosion of funding for specialist welfare rights services over time.

Not all health-justice partnerships can link in with social prescribing, which is predominantly a primary care-based activity. Health-justice partnerships based in hospitals and other specialist care settings are very important to maintain.

Local design issues

There is a need to tailor the work around funding and different funder requirements, which means that services may not always be the best fit for local needs or patient groups. Services will differ in their capability to use population data to inform how services are targeted: local services may lack the expertise, staffing capacity or data access and infrastructure to do this data analysis. There is also the challenge of geographical boundaries, which patients do not see but commissioners work to. There is an unequal distribution of health-justice partnerships at national level.

Formal integration

There are difficulties trying to formalise what are sometimes quite informal partnership arrangements with the NHS. The development of Integrated Care Systems is helping to pull things together and enable greater co-working between sectors. One participant had experienced difficulties working with primary care due to GPs charging rent, but other parts of the NHS were now reaching out and asking to consider how they can collaborate and jointly commission some of the work.

Need for further information and support

It would be good to understand more about the differences between health-justice partnership service models and elements/components of each. It would be useful to have information about how these models can be transferred into different health settings, for example a template showing how this process should work. One participant felt that it would be helpful to have a consistent 'off the shelf' model for health-justice partnership which could be adapted and delivered across Integrated Care Systems.

In the social prescribing field, there is appetite for evaluations of different models (including those using specialist welfare rights link workers) to understand which approaches work well. From the legal perspective, it would be useful to understand how different models address legal need and facilitate access to the spectrum of legal services (from generalist to specialist issues).

Engaging with healthcare professionals

The challenges

Several people working in welfare rights advice services reported having difficulties engaging with healthcare professionals. They agreed that partnership working was the best way to achieve good outcomes, but it takes a lot of continued work and effort. Relationships took a long time to build, and it could be very difficult to communicate the purpose and importance of the partnership and get that message to stick. Many healthcare professionals thought welfare rights was out of their remit. Others lacked confidence making referrals because they were not able to identify welfare needs accurately, not being part of their core skill set.

Participants had found GPs particularly hard to engage with, who often appeared not to value the partnerships highly for patient care. Even in places where partnerships were well established, some GPs would not support welfare casework unless the client paid (e.g. for letters or medical evidence) which is detrimental to the outcomes for individuals. Communication was made difficult by high staff turnover rates, and it was challenging to arrange to have conversations with GPs that were not under time pressure. Primary care navigators and receptionists had sometimes been helpful and acted as go-betweens between GPs and welfare rights advisors.

Solutions and success stories

A clinician participant had been encouraged by the interest shown among medical colleagues once they understood the issues around social welfare and the impact on the people they look after. It is very important that they see this as part of their role, alongside the 'typical' clinical care. It needs to be seen as a health intervention, and language and education are key in communicating this: it should be highlighted as a tool to support their work and to help them deal with non-clinical issues affecting patient health. This requires a cultural shift towards recognising that socioeconomic factors impact on health outcomes.

Several participants felt that including this in core training for clinicians and social prescribers would be useful, to help them recognise welfare rights issues and make appropriate referrals. Particularly the legal language is not well understood, yet refers to many of the same issues they might term ‘social problems’. A shared language and understanding is needed to effectively communicate the relevance and benefits of working with welfare rights advice services. One participant was developing education using patient stories to communicate the message, and another was providing input in the GP training programme to explain the connections and value early on. Courses on housing rights attended by social prescribing link workers had proved very successful in improving their knowledge, skills and confidence.

It was recognised that some medical staff do understand the importance of social welfare issues but do not know what to do about them or where to go for assistance, particularly in hospital settings where there may be fewer links with services in the community.

Funding and sustainability

The challenges

Securing funding for the partnerships (particularly longer term) is an enormous challenge and this creates a high turnover rate. Some GPs were charging rent to the welfare rights services, causing them to explore moving elsewhere to develop health partnerships.

Participants had found that agreeing who should fund the partnerships was a key issue, and health services do not see it as their responsibility. While everyone agrees that early and timely access to welfare advice has health benefits, there is a concern that if the NHS funds this then they’ll have to fund other social care and it could become a slippery slope. One participant felt there was a moral responsibility for statutory services to support people with welfare rights, rather than relying on charities to fill the gap.

People had experiences of individual commissioners ‘getting it’ rather than having the work strategically embedded across commissioning bodies.

Ideas for ways forward

Participants agreed that joint funding was a potential way forward in terms of resourcing, and there was a need for collaborative approaches to commissioning.

Communicating the purpose and value of the partnership was important for securing strategic support, and participants felt there was a need to understand why partnerships were being set up and what the motivation behind it was. In one reported case, the ethos behind their partnership came from thinking about addressing the social determinants of health. Framing things in the light of tackling health inequalities could also be useful as a way of messaging it. Another reason health services may be interested is a commitment to making health systems ‘more attuned to patient need’.

One suggestion was to make greater use of anchor institutions, who could build minimum standards for ensuring equitable access to justice and work towards delivering them.

Evaluation

The challenges

It is challenging to define the success of partnerships, as they are complex interventions in complex systems of care. It is also difficult to measure impact and describe success in numbers. There is a need for further impact research to help make the case for embedded welfare advice services; for example, it would be useful to have evidence in relation to reduced hospitalisations, cost efficiencies / financial savings for the NHS, how this makes the system more attuned to patient needs, how effective it is in resolving legal problems and expanding access to advice. Local services need academic support to do this effectively, rather than attempting complex research alone. There is also a need for more consistent evaluation and performance measures to monitor the work routinely, including those that could be gained from clinical records.

Suggestions

Partnerships with academic institutes really help to make the case locally for the service, because it gives the argument gravitas.

Participants had found that involving the funder in identifying shared evaluation measures from the outset helps buy-in, by generating information that meets their aims and supports what they want to achieve.

The National Academy for Social Prescribing has a list of impact measures that could be useful to review. Also review SNOMED CT, the use of which is a national requirement (captures clinical terms within electronic patient record systems).

Resources for professionals

Participants wanted opportunities to showcase their work and link in more widely with similar projects in the UK, because often they felt they were just talking to their own local silos. They had found the seminar helpful to hear about what others were doing and wanted to link up and form a network. They wanted opportunities for discussion about what people were doing; for example, how they were getting funded and how they were going about evaluation. They wanted opportunities to collaborate and get advice from other services on how to go about things; for example, how to ‘get into health’, where to start and how to communicate at a system level about what they are doing.

There was a strong appetite among participants to have good practice shared. They were keen to have online resources providing examples of good practice, sharing evaluation tools, and sources of evidence they could bring to potential funders.

National-level action

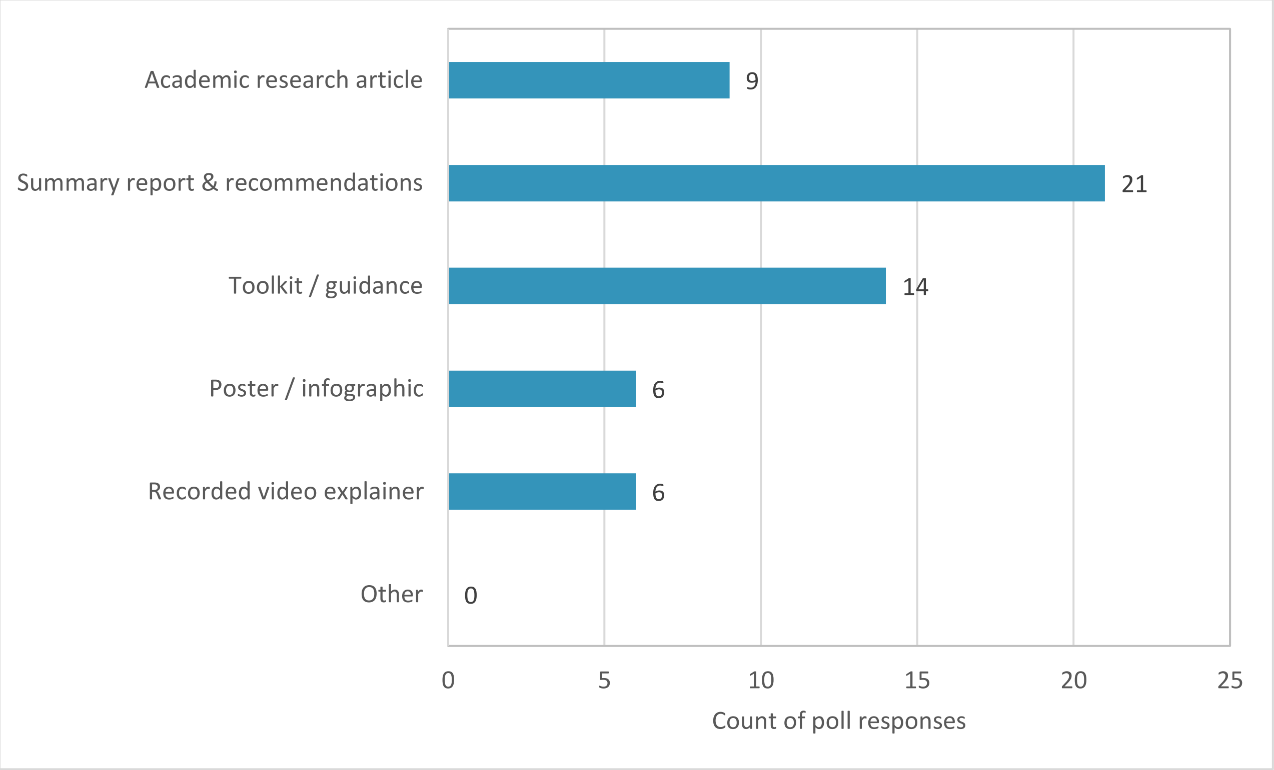
Knowing how to get health-justice partnerships integrated systematically within the NHS in a challenge and there are multiple NHS structures and systems to navigate. One suggestion was that each part of the system could usefully have a ‘project sponsor’: a specific role (that could be externally funded) to promote uptake and integration of health-justice partnerships into their bit of the system, providing practical facilitation as well as advocacy.

There was felt to be a need for more campaigning and awareness-raising nationally. Greater recognition of these partnerships at national level would help people to make the case locally for developing and sustaining these partnerships. It would also help improve understanding among clinicians and the public about the purpose and role of the partnerships. If possible, it should be embedded within national health service strategies to encourage wider adoption.

5.4.3 Preferred research outputs

Figure 5-1 shows the Zoom poll responses to the question “Which format(s) would you like to receive these results in?” The most popular response was “Summary report & recommendations”, followed by “Toolkit / guidance”.

Figure 5-1: Poll responses on preferred output formats



5.4.4 Feedback on recommendations

The feedback received on the proposed recommendations indicated that they were sensible, desirable and would make a difference. There were comments raised about how some of them could be put into practice, highlighting issues that might need to be considered locally:

- Patient input at service design stage is more difficult to obtain than staff input – who would be involved & how would that happen?
- Equitable access across regions is good as an aim, but would depend upon adequate funding & good staffing & IT resources.
- Good, robust referral pathways might be cheaper/more efficient than embedding welfare rights advisors within multi-disciplinary teams. This could also broaden the areas of law covered, to help people with multiple legal issues.

One participant provided additional thoughts on the existing recommendations, to add detail about how collaborative working could be supported:

- The use of interdisciplinary meetings can be useful to improve interaction between teams, ensuring tasks, responsibilities and required input from different professionals is clear. The use of relevant tools can also be a positive way to establish clear communication with other staff and map out goals with clients.

- Ensure that partnerships have clearly set out having access to the relevant tools for information sharing and access to information/data that embed collaborative ways of working and adhere to confidentiality processes.

Suggestions for additional recommendations were also received:

- Establish a ‘code of practice’ for health-justice partnerships that can be used to inform future best practice (e.g., staff competencies, goals, responsibilities, norms, values, ways of working) including any key challenges.
- Achieve buy-in from the service user perspective.

5.5 SUMMARY

5.5.1 The event

The stakeholder event brought together people working within health-justice partnerships and related areas of policy, research and practice. In addition to sharing the study findings, the event also sought input from stakeholders. This related to their own experiences, study outputs and priorities for future work in the field.

5.5.2 Summary of findings

Topics of discussion

Table 5-3 summarises the experiences and suggestions of participants, according to the main topics of discussion.

Study outputs

The participants’ preferred format in which to communicate the study findings was a summary report and recommendations. Some considerations and suggestions were received to help formulate the final recommendations.

5.5.3 Conclusion

The stakeholder consultation gathered valuable information from stakeholders on the challenges they experience and their needs, wishes and suggestions for future work in this field. The results suggest there is a strong appetite for a professional peer learning network, and development of resources to support practice. This could include guidance on implementation, evaluation and communications/messaging. Training courses would be valuable for implementers, and awareness-raising nationally would help to support action being taken across the country.

Table 5-3: Participant experiences and suggestions

Topic	**Participant experiences**	**Participant suggestions**
Service models	• Welfare rights services are not included consistently in social prescribing models. • Service models are being trialed involving specialist welfare rights link workers. • Partnerships are being developed under the new ICSs.	• There is a need to understand how health-justice partnerships can fit best within these NHS structures. • There is an appetite for more clearly defined service models, and guidance on how they can be adapted in different settings. • There is a need to understand how service models differ in their effectiveness.
Engaging with health services	• Engaging with health professionals was widely experienced as a challenge. • Health professionals often did not understand the importance, felt it was outside their remit or lacked the time and knowledge to engage.	• There needs to be a cultural shift towards understanding welfare rights advice as a health intervention. • Education and training opportunities had been helpful and well-received by health professionals. • Understanding the motivation for partnerships among health services would help in communicating the purpose and value.
Funding and sustainability	• There were challenges in securing funding and agreeing which organisations should be funding the partnerships. • It can rely on individual commissioners' buy-in rather than being strategically embedded. • Some GPs were charging rent to welfare rights services.	• Joint commissioning approaches could help. • Involving funders in identifying shared evaluation measures from the outset helps buy-in.
Research and evaluation	• Evaluation was a key challenge for partnerships, both defining relevant outcomes and being able to measure them effectively.	• There is a need for more consistent performance measures for routine monitoring. • There is a need for more impact research (undertaken with academic support) to help make the case for partnerships.
Resources for professionals	• Participants wanted opportunities to showcase their work and link in with other professionals in the field. • They wanted opportunities to discuss their work, share good practice and collaborate.	• There was appetite for a professional network on health-justice partnerships. • There was appetite for online resources, including practice examples and evaluation tools.
National-level action	• It is difficult to know how health-justice partnerships can become integrated systematically in the NHS • Greater recognition at national level would help make the case locally and improve understanding among potential partners.	• Each part of the NHS could have a 'project sponsor' to promote uptake and integration in that part of the system. • There is a need for more campaigning and awareness-raising nationally.

CHAPTER 6. DISCUSSION

6.1 THESIS OVERVIEW

This PhD research focuses on organisational partnerships between healthcare and legal services (‘health-justice partnerships), which integrate welfare rights advice with patient care.

Chapter 1 of the thesis introduces the background and rationale for these partnerships, which exist across the UK and internationally. Service integration addresses important policy goals for both health and legal sectors; however, approaches to health-justice partnership vary widely and implementation success is variable. The research presented in the subsequent chapters aims to generate evidence to inform the implementation of health-justice partnerships in practice.

Chapter 2 presents a systematic scoping review of international literature, which was undertaken to explore the extent of current research in the field and inform the direction and focus of the primary research study. The review synthesises evidence on a range of topics, including partnership characteristics, stated objectives, measured outcomes and reported issues relating to implementation.

Chapter 3 sets out the methodology used for the comparative case study. The study was informed by the General Theory of Implementation, which was used to propose causal influences to investigate, and to guide the data collection and analysis. The research involved nine health-justice partnerships across England. The case studies were diverse, with different service models and settings. Data were collected through interviewing members of staff, including people in frontline, management and funding roles. The data analysis explored the outcomes that were achieved in each case, and the underlying determinants of those outcomes.

Chapter 4 presents the findings of the comparative case study. The characteristics of the partnerships are firstly described, providing details of how service delivery was organised. Findings in relation to three implementation outcomes are then presented: i) Collaborative working, ii) Sustainability, and iii) Impact. A description is provided of each outcome, followed by an analysis of the causal pathways leading to that outcome, and a comparison of the outcome and underlying determinants across the case studies. Together, this analysis identifies the major influences on implementation success and the mechanisms through which their effects occur.

Chapter 5 describes a stakeholder engagement event, in which the findings of the study were presented and feedback was obtained on study outputs, recommendations and priorities for research and policy. This provides a direction for future activities to support the implementation and scale-up of health-justice partnerships nationally.

6.2 DISCUSSION OF PRINCIPAL FINDINGS

The overarching aim of this research was to generate new evidence to inform the successful delivery of health-justice partnerships in practice. The findings are discussed in relation to the original research objectives.

6.2.1 Objective 1: Assessing the extent of current evidence

Partnership characteristics

The systematic scoping review highlighted a number of central themes in the characteristics of health-justice partnerships: largely, they offered legal assistance with poverty-related issues, were provided by non-profit organisations and focussed on low-income and deprived groups. However, there was also great diversity in the contexts of the partnerships: they were based in many different health settings, used different methods to integrate care and involved different collaborative working activities. There was no evidence to suggest that any one approach could be considered best, and the most suitable approach may depend on a number of local factors; for example, the needs of target population, the type of health setting and local working practices, the aims of the partnership, and the resources available. Drawing on issues highlighted in the implementation evidence section, relevant indicators of a successful service model could include responsiveness to local needs, accessibility to patients and fit with local practice. A successful partnership could be conceptualised as one that delivered assistance on issues that were prevalent among the target population, in a way that facilitated equitable access, and integrated well within the context of other local service activities.

Impacts evidence

There was strong evidence for the effectiveness of health-justice partnerships in resolving legal problems and thereby improving the socioeconomic circumstances of individuals, particularly with regard to income and financial position. These outcomes were reported from all regions and service types, and demonstrate the important role of health-justice partnerships in addressing social determinants of health. There was also strong evidence that health-justice partnerships improve access to legal assistance for people who would otherwise not seek help with social welfare issues, facilitating access to justice among harder to reach groups.

The impacts of health-justice partnerships on individuals' health has been the subject of debate(Allmark *et al.*, 2013). The reviewed publications had examined different health outcomes (mostly self-reported), among different patient groups, for different legal interventions and over different time periods. Broad generalisation is therefore not possible from the current evidence. Health impacts are likely to depend on the patient population; for example, age and health status may affect the extent to which health improvements would be possible. They may also depend on the types of legal issues: some (such as poor housing conditions) may have direct and tangible effects on physical health, while others may primarily act through chronic stress. Direct effects on mental health are very clear from the existing research, and overall there was strong evidence among the studies (both quantitative and qualitative) for improvements in mental health, particularly stress, depression, anxiety and general wellbeing, and that these improvements occurred as a direct result of the legal interventions(Moffatt *et al.*, 2004; Moffatt, Mackintosh, White, Howel and Sandell, 2006; Moffatt and Scambler, 2008; Moffatt and Mackintosh, 2009; Burrows *et al.*, 2011; Woodhead, Khondoker, *et al.*, 2017).

Of the literature reviewed in this study, only three papers used a control or comparison group to assess changes in health; these were all high quality peer-reviewed publications from the UK undertaken in a primary healthcare setting(Moffatt, Mackintosh, White, Howel, Sandell, *et al.*, 2006; Gabbay *et al.*, 2017; Woodhead, Khondoker, *et al.*, 2017). Since the literature search was conducted, two further studies reporting results of randomised controlled trials have become available. Howel et al. 2019(Howel *et al.*, 2019) found no effect on a range of health outcomes among people aged ≥60 years receiving welfare rights advice delivered through primary care in the UK; however, a true effect may have been masked by poor intervention targeting and contamination between trial arms. Bovell-Ammon et al. 2020(Bovell-Ammon *et al.*, 2020) found significant improvements in parent and child health among medically complex families receiving a housing stability intervention via various health settings in the USA. This was a multi-component intervention and the study was relatively small, therefore the effects of the legal assistance could not be separated out; however the overall findings showed significant improvements in both mental and physical health compared with families not receiving the housing intervention.

There were some areas where the evidence was of lower quantity and quality. For example, no studies had assessed prevention directly, although many provided evidence of wider social benefits which may prevent ill health in the long term (such as improved living conditions, social participation and access to supportive services). Few studies had measured direct effects on inequalities; however, the benefits of health-justice partnerships as a whole are likely to accrue to those of lower socioeconomic status given the nature of the social welfare issues they address and their focus on low income and disadvantaged groups. Studies reporting impacts on health service utilisation showed inconsistent patterns and mostly lacked appropriate comparative evidence. This outcome may depend on the characteristics of local services; for example, target patient groups (e.g. age and health status), legal issues addressed (e.g. whether they are significantly related to service utilisation) and partnership activities (e.g. whether there is active screening and early intervention). Further research would be needed to investigate how health service utilisation outcomes may be influenced by the service context. The opposite goal (increased health service use) is relevant in situations where patients may face barriers to healthcare access, and the studies highlighted a role for health-justice partnerships in facilitating engagement with needed healthcare. Other impacts for health services and patient care had been explored to a lesser extent and were not the focus of much high quality research; benefits identified qualitatively included supporting healthcare professionals to manage patients' non-medical needs and improving both practitioner and patient experience. Catalysing systemic change through legal and policy action was more rarely reported in the literature, however case studies demonstrated the wide-reaching effects of these activities in protecting the health of populations.

Implementation evidence

The majority of implementation evidence was not presented in academic research papers, but in organisational reports and other grey literature; this demonstrates the prominence in practitioner-generated evidence in relation to implementation. Much of the information was also presented as part of background descriptions of projects, rather than being a topic of research investigation; this meant the level of detail was often minimal, largely anecdotal and of low quality. The review also identified a lack of research drawing on implementation science theories. Using theories increases the rigor of implementation research by basing the interpretation on existing theoretical understanding, and producing explanations that are generalisable beyond the immediate example being studied(Foy *et al.*, 2011). Overall, the review identified that existing implementation evidence was of low quality and that further robust research would be valuable.

As a starting point for further investigation, the intended outcomes of implementation needed to be specified; however, they had not been defined in the existing literature: papers tended to describe things that had gone well or less well with the projects, without specifying the objectives that would have indicated successful implementation. However, looking at the descriptions of implementation in the literature, two main challenges were identified: i) collaborative working between health and legal teams; and ii) sustainability of the partnerships over time. These were compatible with outcomes that have been proposed in the literature as suitable for assessing implementation(Proctor *et al.*, 2011).

To understand how implementation outcomes are achieved, it is necessary to investigate their underlying determinants. In the included literature, there were few studies evaluating implementation processes and explaining underlying reasons for observed success of failure. However, the publications did identify some consistent themes in relation to reported barriers and facilitators of service delivery; these included issues relating to appropriate partnership design, sufficient resources (both knowledge-related and material), strong management, conducive professional culture, good communication, and individual abilities and intentions. Identification of these determinants offered a useful starting point for developing theoretical propositions to investigate in the primary research study.

Given the relative immaturity of the literature on implementation of health justice partnerships, other literature sources may have been useful to review including the research on the practice of partnering and integrated practices in other settings.

6.2.2 Objective 2: Identifying determinants of implementation success

Service design

It was clear from the literature that no single approach to designing a health-justice partnership could be considered best, and that what works well and is most appropriate is likely to depend heavily on the local context. Therefore, the primary research did not seek to define best practice; however, in exploring how the partnerships operated, there were some clear challenges relating to service design that should be considered when implementing partnerships.

Demand

Demand for the advice services could be high, with waiting lists in some places indicating substantial unmet need. Some of the advice services drew on volunteers to help boost their capacity, which in one case was a significant proportion of their workforce (around 80%). While use of volunteers can clearly improve capacity, it may not be suitable if it leads to an unstable and unspecialised workforce. This may be an important consideration when working with patient groups who have rare or complex needs, as staff with specialist knowledge would be required. Another approach was to form connections with other local advice agencies or law firms, who could be drawn on to help with certain specialist issues. Local advice networks could be a useful resource to tap into when planning health-justice partnerships, to leverage support and expertise. Offering training and secondary consultation to healthcare professionals also helped to manage referral demand, by enabling them to pass on basic information to patients and answer simple welfare-related questions.

Access

Achieving equitable access for patients was a challenge while operating with limited resources. This issue was particularly prominent in population-wide services delivered through primary care, where there were a large number of sites to cover across a region. One service excluded people based on which practice they are registered with; this creates a postcode lottery and should be avoided. Other services allowed patients registered at nearby practices to attend or used remote methods to widen access. One way of reaching across a region with in-person services could be to have advisors associated with Primary Care Networks and open access to patients covered by the network, as occurs with some specialist primary care and social prescribing services(Baird and Beech, 2020). Remote services can offer quick and convenient access to advice(Citizens Advice Chesterfield, 2021) and may be easier for people with mobility issues. However, certain groups may need or prefer face-to-face services, including people with certain disabilities (such as hearing or visual impairments), mental health issues, and those with limited ability to access or use to technology(Sechi, 2020). Judgements about the use of remote services should therefore be made in relation to the target population, and a combination of remote and face-to-face delivery could be considered.

Efficiency

In some places, efficiency had been a challenge for face-to-face services; for example, appointments not being filled, patients not turning up to appointments or not needing the full appointment time. One suggestion was to offer drop-in sessions to improve efficiency, at least for initial appointments which could then be followed up remotely. However, in places with high levels of demand, drop-in arrangements had led to queues down the corridor which was not appropriate in confined spaces and very busy health services. Consideration should therefore be given locally to the most suitable approach for each setting. Some services were offered flexibly, using a combination of drop-ins, booked appointments and remote delivery to achieve the most efficient use of staff time.

The contribution of service design to successful implementation

Implementation outcomes that relate to intervention design have been proposed in the literature, including the feasibility, acceptability and appropriateness of interventions(Proctor *et al.*, 2011). Similar issues were highlighted in the literature on implementation of health-justice partnerships, including the importance of services being attuned to the needs of patients and healthcare professionals and fitting well with local practice. Currently there is little research evidence to inform targeting of services, and studies have not assessed the prevalence of legal needs in different healthcare settings or between patient groups. To some extent there is likely to be a need everywhere, due to the prevalence of welfare issues in the population and the close links with poor health, as presented in Chapter 1. However, where resources are limited, it would be appropriate to consider local welfare needs in order to inform where services are targeted and what type of support they offer. Local data could indicate where welfare needs are high or where advice provision is low; for example, data sources used in evaluating advice provision include indices of deprivation, statistics on employment, income, debt and benefits receipt, and surveys of local providers(Advice Services Alliance, 2020). Consulting with patients and staff could also help to ensure the service is responsive to local needs and designed in an accessible way. Good examples from the case studies included services that drew on patient consultation exercises, and that utilised staff steering groups to guide the development and ongoing improvement of the service.

The study did not specifically investigate which approaches to service design might be most appropriate for whom and in which circumstances. This is a question that could be investigated in further research drawing on patient perspectives; however, the comparative case study did generate some potentially useful insights. Partnerships involving closer collaborative working led to additional impacts for staff that included improved knowledge of individuals' needs and increased subject expertise: collaborative working increased the ability of staff teams to respond to complex needs and to support patients who were less able to communicate and advocate for themselves. This improved the outcomes that could be achieved for individuals. Multi-disciplinary teamwork may therefore be particularly valuable where the service users have significant mental health issues or disabilities, or face severe and multiple disadvantage that involves both health and welfare issues (e.g. intersecting mental health, homelessness, offending, gender based violence and substance abuse). In health settings where the needs are generally less complex, a system that simply directs patients to sources of advice may be sufficient and will still have benefits for improving access to legal assistance and resolving welfare rights issues. This is also less resource intensive and potentially more feasible when aiming to cover larger geographical areas. Efforts to scale up health justice partnerships should consider targeting more intensive, collaborative approaches for patient groups with complex needs, and in other areas using lighter-touch approaches such as referral systems.

Collaborative working

Two separate analyses were used sequentially to explore the factors that influenced engagement in collaborative working. The Process Tracing results provide a detailed picture of the relationships linking contexts, mechanisms and outcomes. The QCA results distil this complexity into three core conditions that influence collaborative working. The passage below compares the findings from the two methods, with each other and with the original theoretical propositions. The results are then interpreted and discussed in the context of other research.

Comparison of findings from separate analyses

‘Willingness’ among teams was a key mechanism that influenced engagement in collaborative working. Sentiments were determined by whether staff perceived the partnership to be valuable and aligned with their own purpose. The willingness theme corresponded closely to the condition ‘collective commitment’ in the cross-case comparison, which was a necessary condition: collective commitment was high where collaborative working was close. This represented teams where positive sentiments were strong and widespread, collaboration had become a natural part of the everyday working culture and welfare rights advisors were accepted members of care teams. Where collective commitment was not high, staff were more variable in their attitudes towards the partnership the levels of engagement in collaborative working were lower.

The ‘ability’ mechanism represented factors that enabled or prevented teams engaging in collaborative working, both practical issues (physical and administrative barriers /facilitators) and knowledge levels (awareness and understanding). The ability theme corresponded most closely to the condition ‘communication opportunities’ in the cross-case comparison, which represented the ability of teams to interact and communicate (both physically and digitally) to enable collaborative working. This was also a necessary condition: having regular interaction and communication during daily work was a key characteristic of teams where collaborative working was close.

The ‘Confidence’ mechanism represented more subtle social influences on whether people would engage in collaborative working, including trust between teams, quality of relationships and habits and norms. It was not possible to assess these clearly at service level for the cross-case comparison; however, it was possible to observe the activities being undertaken that influenced these mechanisms, in the form of leadership facilitation. ‘Leadership facilitation’ referred to the level of activity and effort going into facilitating and encouraging collaborative working, through providing training, undertaking evaluation, promoting the service, brokering relationships and branding the partnership formally. Highly active facilitation contributed to collaborative working being close, but was not alone necessary, and may be most important in the early stages of partnerships to initiate new systems.

Comparison of findings with theoretical propositions

In the General Theory of Implementation, the ‘Capability’ domain refers to the qualities of the complex intervention: whether it can be made workable and integrated into practice. The original theoretical proposition (based on evidence from the literature) had been that this would depend on: responsiveness to needs of patients and healthcare professionals, ease of use for patients and healthcare professionals, clarity of processes for joint working, and opportunities for interaction between staff in the partner services. The first three issues did not appear to be significant determinants of engagement in collaborative working in the case study partnerships: there was no evidence that the services were not needed or that systems were confusing and difficult. The more prominent issue was whether staff were able to engage due to barriers relating to physical separation, administrative issues and sometimes time limitations.

The ‘Capacity’ domain refers to the social-structural resources available to agents: material resources, knowledge and information resources, social norms and roles. The original theoretical proposition (based on evidence from the literature) had been that this would depend on: sufficient funding and material resources, awareness of the legal service among healthcare professionals, staff knowledge of the rationale and processes for joint working, and strong working relationships. Funding did not appear relevant to collaborative working, but rather to the sustainability outcome. Material resources were relevant in the context of having physical space and necessary IT: the effect of this was to enable communication, which is captured under ‘Capability’ above. Knowledge, awareness and strong working relationships were all identified as important mechanisms in determining engagement in collaborative working.

The ‘Potential’ domain refers to the social-cognitive resources available to agents: individual intentions and shared commitments. The original theoretical proposition (based on evidence from the literature) had been that this would depend on: commitment of individuals at all levels and joint goals of collaborating organisations. Commitment among team members was clearly a strong determinant of engagement in collaborative working in the partnerships. Commitment among people at strategic level, as well as joint organisational goals, were not relevant to collaborative working but were to the sustainability outcome.

Interpretation of findings

Both the data and the theory indicate that there are two consistent determinants of engagement in collaborative working: whether teams are willing to work together (through collective commitment) and able to work together (through opportunities to communicate). The additional themes identified (such as knowledge, trust and relationships) seem to have an important reinforcing effect, and can be encouraged by the active leadership facilitation.

There was a prominent pattern across the case studies in which collaborative working was closer in acute care settings, where staff interacted face-to-face on a regular basis: they worked in the same physical spaces, attended meetings together and were able to communicate spontaneously. The closest collaborative working arrangements were multi-disciplinary teams, in which welfare rights advisors were embedded; however, joint working was still close in the other acute settings where the advisors worked in the same departments. In primary care and remote services, interaction between teams was more limited and day-to-day collaboration on patient cases was much less common. Activities of joint working were mostly limited to receiving referrals (which could be infrequent) and communicating about medical evidence should this be required (which was sometimes done via the patient rather than between professionals). Physical barriers were evident: advisors and GPs rarely crossed paths during the day, and joint meetings occurred infrequently. In some places administrative barriers were also noted, for example not having secure data exchange systems and not regularly seeking consent to share data.

Insights from related literature

Research on collaborative working in primary care has shown that while co-location is intended to facilitate cross-sectoral collaboration, it does not necessarily have this effect in practice: communication can be inhibited by physical separation (being on different floors or in detached rooms), GPs’ work routines (busy workdays with back-to-back consultations) and lack of shared client record systems(Lawn *et al.*, 2014; Scheele and

Vrangbæk, 2016). Creating shared workspaces can facilitate effective teamwork, but this is at odds with how most GP practices work(Baird *et al.*, 2020). Where shared workspace is not possible, creating regular opportunities for informal communication through team meetings, team-building activities and technology can help to achieve some of the same benefits for trust and team identity(Baird *et al.*, 2020). The same principles could be applied in partnerships working remotely, where teams do not interact during daily work. A study of telemedicine teams found that virtual hubs could create similar levels of team cohesion as standard co-located practice(Patel *et al.*, 2021). Making use of technology can also improve integration and collaboration between services, through shared electronic health records and improved professional-to-professional consultation(Castle-Clarke *et al.*, 2016).

Behaviour change is central to implementing new ways of working and can be challenging to introduce and sustain. Effective interventions for promoting professional behaviour change in healthcare include those focussing on education and information (such as educational meetings, materials and outreach), action and monitoring (such as audit, feedback and reminders)(Johnson and May, 2015). Leadership is critical in facilitating implementation, and has many important functions such as influencing organisational culture, motivating teams, ensuring clear processes and providing learning opportunities(Li *et al.*, 2018). Middle-level managers play a critical role in obtaining and diffusing information and resources to support implementation(Birken and Currie, 2021). Clinical champions facilitate practice change through improving buy-in(Bunce *et al.*, 2020) and improvements in implementation leadership have been shown to increase uptake of evidence-based practices(Williams *et al.*, 2020). Gaining support across multiple levels of leadership can persuade people to engage and help to overcome the micropolitics of introducing change(Rogers *et al.*, 2020). This literature suggests that supporting leadership capabilities could help improve successful implementation of health-justice partnerships, by encouraging and facilitating team engagement. Additionally, providing opportunities for professional education and inter-disciplinary learning could improve staff understanding and motivation for partnership working.

Sustainability

Two separate analyses were used sequentially to explore the factors that influenced sustainability of partnerships. The Process Tracing results provide a detailed picture of the relationships linking contexts, mechanisms and outcomes. The QCA results distil this complexity into three core conditions that influence sustainability (continuity). The passage below compares the findings from the two methods, with each other and with the original theoretical propositions. The results are then interpreted and discussed in the context of other research.

Comparison of findings from separate analyses

The ‘willingness’ mechanism represented how willing people at strategic level were to provide resources to support the partnership on an ongoing basis. Sentiments were determined by whether they perceived the partnership to be valuable (meeting a significant need locally and delivering high quality outcomes) and aligned with their own organisational priorities. The willingness theme corresponded closely to the condition ‘strategic commitment’ in the cross-case comparison. Strategic commitment was high in all the partnerships that were ongoing, demonstrating that this was a necessary condition for sustainability.

The ‘ability’ mechanism represented whether sufficient funds and other material resources (such as staff and physical space) were available to enable the partnership to operate. The ability theme corresponded closely to the condition ‘resource sufficiency’ in the cross-case comparison, which represented the financial situation and whether the partnership could apparently be afforded. Sufficient resources were a necessary condition for continuity of the partnerships, and insufficient resources alone were sufficient to bring about their termination.

The ‘confidence’ mechanism represented the sources of information and evidence (both hard and soft) that contributed to impressions of the partnership and influenced decision-making. This included use of evaluation data, the local reputation and profile of the service, and relationships between funders and providers. It was not possible to assess these clearly at service level for the cross-case comparison; however, it was possible to observe the activities being undertaken that influenced these mechanisms, in the form of proactive leadership. ‘Proactive leadership’ referred to the level of activity and effort on the part of service managers to evaluate the service, promote it widely, champion the work in local forums and engage proactively with funders to review, develop and improve the service. There was highly proactive leadership in all the ongoing partnerships, suggesting this was a necessary condition for sustainability.

Comparison of findings with theoretical propositions

The General Theory of Implementation appeared less relevant to the sustainability outcome. The ‘Capability’ domain relates to the qualities of the complex intervention and whether it can be integrated into practice, and is therefore only relevant to the collaborative working outcome (as discussed above). However, the original theoretical propositions (based on evidence from the literature) do represent some of the important determinants of sustainability. The ‘Capacity’ domain includes the critical issue of material resources, as well as knowledge and strong working relationships (at strategic level) which seemed to contribute to positive perceptions of the service. The ‘Potential’ domain includes the commitment of individuals at all levels and joint goals of collaborating organisations. These issues were identified as important factors influencing decision-making.

Interpretation of findings

Both the data and the theory indicate that there are two consistent determinants of the ongoing continuity of partnerships: whether funders are willing to provide resources (through strategic commitment) and able to provide resources (through sufficient funds). The additional themes identified (such as evidence, local reputation and relationships) are important in influencing the decisions that are made, and can be encouraged by the efforts of proactive leaders in both health and legal organisations.

Partnerships that had discontinued had all done so due to resource problems for the welfare rights advice services: two had had their funding removed and a third had had their rent raised and could no longer afford to operate in the health setting. In one service that was council funded, resources were severely strained due to income cuts: the local welfare rights unit as a whole had been cut back considerably, and while a core generalist advice service was maintained, it was felt that specialist health outreach roles could not be justified. In another case that was NHS funded, services were under increasing pressure and efficiency savings had to be found; the welfare rights service was not felt to be providing a service that was clearly relevant and effective in relation to health. These examples illustrate a clear problem: health-justice partnerships can appear to be tangential to the purpose of both health and welfare funders, when viewed through the lens of individual organisational goals. There was recognition among funders that the services were valuable for individuals, but it sometimes appeared that the value accrued to another organisation or that someone else should be responsible for supporting it. This became a prominent consideration when finances were under strain and cuts needed to happen somewhere. However, this issue was not observed in partnerships that were jointly funded, highlighting the potential importance of joint contributions in supporting these initiatives. When working towards a shared vision for the local area (such as addressing social determinants of health, acting on prevention, reducing health inequalities or providing person-centred services) the relevance of these partnerships becomes clear.

Decisions to allocate funds clearly depended on the willingness and commitment of those at strategic level. Funders had different goals and priorities, which ranged from providing a positive patient experience to making financial savings. Sometimes these were shaped by the type of organisation (for example, charities tended to be patient-led in their aims), politically determined (for example, by the local party in power) or influenced by the values of those in leadership positions. It is therefore important to understand the objectives and drivers of the funding organisation and to communicate the achievements of the service through this lens. Undertaking evaluation was important to make the case for investment in the partnership, and contributed to positive perceptions of its value. However, some expectations were very difficult to meet; for example, demonstrating improvements in health and contributing to financial efficiency. While this was not easy in routine service evaluations, some partnerships were using relatively simple approaches to ensure they could gather relevant information, and were communicating it in a narrative that made the importance clear. Others were doing little in the way of evaluation and were not communicating the relevant outcomes. Supporting the capability of partnerships to evaluate and communicate their achievements could therefore help with sustainability of services. Several of the welfare rights service managers were also working closely with funders to develop appropriate evaluations and to monitor and improve their work; this helped to ensure that satisfactory information was fed back, and that the service continued to evolve and meet expectations. Engaging with funders was a critical role for service managers, and while mostly this seemed very well done it was not universally so. Developing leadership capabilities could therefore also help support sustainability.

Insights from related literature

Sustainability is one of the least researched and understood issues in implementation science, despite its clear importance: if new practices are not maintained after initial adoption, their intended benefits will not be felt(Urquhart *et al.*, 2020). Previous implementation research has identified similar themes to those described in this study. A review of sustainability in community public health interventions found that commonly reported barriers included limited funding or ending of funding, lack of resources, competing demands and unsupportive organisational leadership(Hailemariam *et al.*, 2019). Resources and funding for developing inter-organisational partnerships are commonly lacking(Auschra, 2018). Alignment of interests is also important: organisations may have different individual goals, which may be prioritised over the collective interest of the partnership, or which may directly conflict(Auschra, 2018). Collaborative partnerships are more likely to be sustainable if they can develop alignment in four key areas (shared purpose, governance, finance and shared data) but there has been little research into strategies by which this can be effectively achieved(Lanford *et al.*, 2021). Co-financing is one option for supporting health-promoting services, which advance common goals of different sectors(Barnfield, Papartyte and Costongs, 2019). This does not require additional funds, but requires organisations to coordinate the planning, governance and financing of services.

The issue of whose responsibility it should be to support health-justice partnerships pertains to the issues of prevention and health inequalities more broadly: preventative and health-promoting services that address social determinants of health are vital for population wellbeing but fall outside the immediate remit of the health system. The current move towards Integrated Care Systems in the NHS may facilitate progress in this area, by pooling local resources and bringing together organisations to work towards common goals(Charles *et al.*, 2021). Some have also argued the need for government intervention, to bring together different areas of public policy and develop a coordinated response that will ensure the necessary action and investment(Genn, 2019; Knapp and Wong, 2020).

Impact

Two separate analyses were used sequentially to explore the factors that influenced impacts of the partnerships. The Process Tracing results provided insight into what had given rise to each impact (whether aspects of service design or delivery). Impacts were then mapped out across the case studies to identify patterns of impact according to service features. The passage below compares the findings from the two methods with each other. The theoretical propositions were not relevant for the impact outcome, because they relate to implementation processes.

Comparison of findings from separate analyses

Being a qualitative study, this research could not quantify differences in the impacts between case studies; however, it was able to identify patterns in where the reported impacts were present or absent, and to identify mechanisms through which these impacts were generated. This gives an indication of how impacts may relate to service design and delivery.

In the cross-case comparison, the impacts for patients were reported in all the case studies. The Process Tracing results describe how these impacts were generated. Some of them came about independently of collaborative working between health and legal teams: improved access to legal assistance was partly due to the links between services (patients would see it advertised and make their own way); improved socio-economic circumstances and improved wellbeing were attributable to the work of the legal service (which provided an effective intervention and valued reassurance); and improved patient experience was partly due to accessing the legal assistance (which helped people with anxiety-provoking issues). However, some of these impacts were strengthened through collaborative working between health and legal teams: active identification and referral facilitated more consistent access for patients; discussion and exchange of medical evidence led to better success rates in welfare cases; and coordination of care between teams led to a smoother experience for patients in gaining assistance for their needs.

In the cross-case comparison, impacts for staff were reported where there was at least some communication between health and legal teams. The Process Tracing explained how this was occurring. Being able to refer patients meant that healthcare professionals could focus on their core roles, and being able to communicate with healthcare teams meant welfare rights advisors could gain access to the evidence they needed to support legal casework. Greater engagement in collaborative working (such as consulting each other and providing feedback on case outcomes) led to additional benefits in terms of improved knowledge and expertise.

Interpretation of findings

The analysis identified a range of outcomes for patients, staff and organisations. For patients, the dedicated in-house welfare rights services were expert and trusted sources of advice, were easily accessible at a time and place of need, and offered effective assistance on issues that were significantly impacting on their lives. This led to positive outcomes for welfare circumstances, mental wellbeing and patient experience. These findings correspond closely to those of other literature investigating the impacts of health-justice partnerships, and demonstrate an important role in improving access to justice for people with legal needs, addressing social determinants of health, supporting health and wellbeing, and providing care that is responsive to the needs of patients.

For healthcare staff, the in-house welfare rights services were a valued resource that they could draw on, to refer patients to or to ask for welfare-related information. Similarly, the welfare rights advisors valued the relationship with the health service, which enabled them to source important health-related evidence and achieve the best welfare outcomes for their clients. This demonstrates that collaboration can lead to more effective working for all involved: by drawing on each other’s expertise, the health and legal teams have greater capacity to respond to the needs of individuals and resolve inter-related problems. At the organisational level, integrated working improved the capacity of healthcare organisations to respond to the complex needs of patients, enabling a more personalised service for individuals and helping to address inefficiencies like delayed hospital discharge.

While some of the impacts were attributable simply to having connections between the organisations (which enabled access and the associated benefits for patients), many impacts were attributable to (or strengthened by) collaborative working between health and legal teams. This suggests that implementation efforts should aim to maximise collaborative working where possible, in order to achieve the best outcomes for patients and staff.

Insights from other literature

Previous research has used logic models and theories of change to hypothesise how health-justice partnerships may lead to impacts. Two studies based this on the effects of the legal intervention itself, without reference to how it was implemented: they showed how welfare rights advice can improve financial and material circumstances, with consequential benefits for health and social outcomes(Moffatt, Noble and White, 2012; Allmark *et al.*, 2013). This hypothesis aligns with evidence gathered in this research, both through existing literature and the interviews with professionals; however, it does not consider the role of implementation in generating impacts. Other research has shown that co-locating services alone is unlikely to lead to positive outcomes for GP practices, but that coordinated working would be necessary to bring about the intended benefits of reduced GP consultations and reduced medical time spent on non-health issues(Woodhead, Collins, *et al.*, 2017). Another study generated evidence on how aspects of implementation were important for impact(Carrick, Burton and Barclay, 2017); for example, receiving referrals from healthcare professionals reduced stigmatisation and improved access to advice; making referrals meant healthcare professionals could focus on medical care and work more efficiently; access to medical records improved the effectiveness of welfare casework; and easier communication resulted in greater knowledge and understanding of legal issues. A recent report on secondary consultation in health-justice partnerships showed that this is an important mechanism for sharing expertise and enhancing the capability of health and legal practitioners to support their clients(Rajan *et al.*, 2021). This literature supports the hypothesis that greater engagement in collaborative working can improve the impacts of health-justice partnerships for both patients and staff.

6.2.3 Objective 3: Informing the development of outputs to support implementation

Feedback from the stakeholder engagement event provided useful indications of the kinds of tools and resources that would be helpful in supporting implementation, which could be a focus for future development activities. The discussions highlighted issues that correlated strongly with some of the themes identified in the research, and provide additional evidence on which to make recommendations.

There was a clear interest in how to go about designing partnerships locally and an appetite for implementation guidance; for example, clarifying different service models, options for service design and how to go about establishing a partnership. Future work on this topic should review existing tools developed for health-justice partnerships internationally, as well as tools supporting implementation of other integrated- or coordinated-care programmes in the UK. Research carried out in the NHS context has produced valuable guidance on supporting the successful uptake and scaling of innovations in healthcare, which could inform the development of new tools(Albury *et al.*, 2018; Horton, Illingworth and Warburton, 2018). Related guidance has been produced previously by the Advice Service Alliance to support local advice organisations in working with healthcare commissioners(Advice Services Alliance, 2015).

Sustainability and resourcing were also a concern, and, related to this, the need for strong evaluation of partnerships. Participants expressed a wish for guidance on evaluation, which was a big challenge for service managers, particularly in demonstrating value to health services. Future guidance should consider the full range of likely impacts, given the wide range of settings in which it might be applied, as well as the diverse goals of funders. Developing a theory of change could be a useful starting point: theory-based approaches can support the evaluation of complex interventions, by providing insight into how and in which circumstances changes occur. Clarifying this logic would help to identify which data would be useful to evidence the impacts(Skivington *et al.*, 2021). Possible data sources should then be scoped out to determine what data are available that could evidence the proposed pathways, and could be collected as part of routine service delivery or simple evaluations. Previous work in this area was carried out by Citizens Advice and produced a pilot health outcomes monitoring toolkit, which recommended using client surveys to collect information on the client profile, mental wellbeing and determinants of health (Citizens Advice, 2014). Importantly, the development of any guidance (both implementation and evaluation) should involve practitioners to ensure it is appropriate and usable for those who will apply it.

Developing a good level of engagement with healthcare professionals was a prominent challenge that participants had experienced; reasons for this included lack of opportunity for interaction and communication, lack of interest or appreciation of the partnership among health teams, as well as limited knowledge and confidence in identifying needs and making referrals. Learning opportunities and training courses had proved valuable, which reflects the wider literature showing the importance of educational interventions for supporting professional behaviour change(Johnson and May, 2015). Developing more information and training resources could therefore support partnerships across the country. A messaging guide could also be useful locally, due to the importance of language and messaging in communicating the value of health-justice partnerships. An example of such a guide has been developed in the United States(Marple, 2015).

Participants expressed that they would value a professional network for mutual support and sharing of learning. Networks unite individuals with common interests and can enable successful change to spread quickly, leveraging the power of social and professional connections(The Health Foundation, 2014). There would be many options for the activities of such a network, which should reflect the needs and wishes of participants; this could include hosting events, providing training and networking opportunities, and producing online resources. Research has shown that the effectiveness of networks depends on having a common purpose, cooperative structure, critical mass, collective intelligence and community building(The Health Foundation, 2014).

Participants felt that more awareness-raising and facilitation at a higher level could help local health-justice partnerships by raising the consciousness of their importance. One suggestion was to have project sponsors associated with different parts of the NHS, who could promote and facilitate uptake of health-justice partnerships. This post could undertake roles such as articulating the vision within the health service, championing the work to senior leaders, and assisting teams to deliver projects by resolving practical issues and ensuring progress.

6.3 STRENGTHS AND WEAKNESSES OF THE RESEARCH

This research drew on a variety of techniques to provide the best possible understanding of the implementation of health-justice partnerships, which are diverse and complex interventions. This included undertaking a detailed review of the literature, developing theoretical propositions, carrying out primary research with health-justice partnerships to collect new data, analysing that data in a number of ways (both theory-generating and theory-testing), and involving stakeholders in shaping project outputs. Together, this work provides a comprehensive basis for understanding the implementation of health-justice partnerships and informing future research, policy and practice.

6.3.1 Systematic Scoping Review

I used a broad approach for the systematic scoping review, in order to characterise the diverse existing literature. The review addressed a number of questions, drawing together evidence on the nature of the partnerships, their objectives, impacts and implementation. It also included research from different global regions and considered partnerships with diverse service models and settings. This provided a basis for the subsequent research that was as comprehensive as possible, and generated results that would be applicable to a diverse range of health-justice partnerships.

I conducted a wide-ranging systematic search that included both academic and grey literature, ensuring evidence from practice was included alongside academic research. This was important for the implementation evidence, much of which has been reported outside of peer-reviewed academic publications. The study selection process was verified by a second reviewer to ensure the inclusion and exclusion criteria were applied accurately. However, it is unlikely that I uncovered every paper on the topic, particularly in the grey literature where I may not have been aware of relevant sources. It is notable that almost all the publications were from English-speaking countries, which may imply that the search was not sensitive to pick up terminology used in other regions. The quality assessment checklist was developed to enable a consistent approach for quality assessment across all the papers, which were from different disciplines and included different types of research. This means it offers a general rather than specific estimate of quality, and its effectiveness as a tool has not been validated. I did not apply weightings to specific quality criteria such as methods, which might have improved its ability to pinpoint high quality papers.

6.3.2 Comparative Case Study

Study design

This study aimed to explore diverse health-justice partnerships in England and investigate factors that determined differences in implementation outcomes. I chose a comparative case study design because of the advantages it offered for answering the research question. The case-based approach enabled in-depth insight into individual services, drawing on rich qualitative information to understand the local context and implementation processes. The comparison of cases allowed patterns of similarity and difference to be identified; this established trends across the sample and helped clarify which factors were significantly implicated in implementation outcomes. However, the disadvantage of doing multiple case studies and is that fewer data can be collected and processed for each one, due to reduced capacity on the part of the researcher. I considered this trade-off between breadth and depth at the study design stage, and decided the sample size based on what seemed both practical in terms of data collection and analytically meaningful in terms of potential insight.

I drew case studies from a recent survey dataset, which listed the known health-justice partnerships in England and Wales and their main characteristics. This provided an informed starting point for the selection of case studies. I selected case studies purposefully based on a clear logic of comparison, which included having different service characteristics and different implementation outcomes. I defined the selection criteria prior to recruitment and invited services that would cover the relevant criteria most completely. One service declined to participate because the project had ceased, and one consented to participate and subsequently did not respond to further contact; this meant that nine rather than ten case studies were included. However, I was successful in enrolling a diverse sample of case studies with all the desired characteristics, which meant I could still undertake the planned analysis.

Data collection

My success in recruiting for interviews was mixed. Recruitment was done through the primary contact for each service, and I therefore relied on their engagement in circulating and promoting the invitation, which varied. The number of interviews per case study ranged from one to six. Across the board, I was able to interview welfare rights advisors and service managers but found it harder to recruit healthcare professionals and funders. Participants from the health services were often in management, social work and non-medical roles, and it proved particularly difficult to recruit doctors. This may reflect the fact that doctors engaged less with the partnerships during day-to-day work than other health and social care professionals. However, the study was also taking place during the Covid-19 pandemic and I did not approach the recruitment aggressively to respect the additional strain that healthcare professionals were under at the time. The under-representation of doctors and other health professionals in the sample may have influenced the data and meant that important detail was missed. Particularly, I feel that more information on the reasons for negativity and non-engagement among health teams would have been valuable to understand the barriers more fully. While I did interview one doctor who expressed unsupportive views, I mostly got this information second-hand from people's experiences of difficult interactions. In three of the nine case studies, I did not manage to interview someone in a strategic leadership or funding role, which also may have affected the comprehensiveness of this data. For the services that had come to an end, it was somewhat harder to recruit, because staff had moved on or felt they could not remember enough about the project to participate meaningfully. Interviews for these services were therefore mostly from welfare rights advisors and service managers, but did include a funder interview which provided valuable insight into decommissioning processes and some of the reasons that funders may not be fully supportive of the partnerships. One of the services was losing its funding as the study was taking place, which also provided useful insights into sustainability issues.

In the interviews themselves, there may have been some observation bias that could have affected the results. It is likely that people who were more positive about the services would have been more likely to participate in the interviews. Additionally, interviewees may have wanted to portray their services in the most positive light, or may not have mentioned some of the real difficulties or challenges. I tried to pre-empt this by ensuring participants understood the anonymous and confidential nature of the study, and by sampling for participants in a wide range of roles so that the views included were as diverse as possible; however, it is possible that bias was still present to some extent. For services that had come to an end, interviewees may not have remembered things fully, or their perceptions may have been coloured by the outcome; for example, their responses may have been trying to make sense of what had happened or justify the way things were done. Sometimes it was possibly to identify this through differing accounts, but the possibility of recall bias cannot be ruled out completely. To ensure the interviews were as consistent as possible I used a topic guide with a core set of key questions that I asked each person. The interviews were semi-structured so that interviewees could contribute as fully as possible based on their own knowledge and experiences. At the time of interviewing, I was sometimes unaware what the outcome would be for a service (for example, the extent to which collaborative working took place) but at other times I was aware of the circumstances (for example, where services had closed down); this means I may have probed more extensively about certain issues.

Data analysis

Thematic Analysis

I used Thematic Analysis as the first step in the analysis process, to explore the content of the data and gain a comprehensive understanding of the patterns within it. Thematic Analysis is a robust method due to its systematic approach to coding and developing themes(Braun and Clarke, 2014). I used the method independently of any theory, so that the interpretation was based directly on the content of the dataset; this was critical for ensuring all the relevant detail was captured before undertaking further analysis. I dedicated significant time to the familiarisation stage, to become fully immersed in the data and develop initial insights. The inductive coding was done at a fine level of detail and the coding structure was refined iteratively to ensure it reflected the full breadth of the data. A potential weakness of this stage is that the coding structure was predominantly based on my interpretation alone, and while early versions were reviewed by the supervision team, the analysis was not repeated by anyone else. A team of researchers may have contributed additional insights or come to different conclusions from a single researcher.

Process Tracing

I used Process Tracing analysis to explore the causal pathways leading to implementation outcomes. Process Tracing seeks to identify causal mechanisms by studying causal links and making each step in a causal pathway explicit(Schmitt and Beach, 2015). I used the method in an inductive (theory-building) way, starting with the empirical material and inferring the causal pathways from observed evidence(Beach, 2017). Process Tracing has close similarities to Realist Evaluation, which tests underlying theories of ‘what works, for whom, and in what circumstances’ by explaining how an outcome is triggered by a mechanism acting in a context(Pawson and Tilley, 2004). I chose Process Tracing for two reasons: i) it could be used as a theory-generating (rather than theory-testing) method, which was important given that this was an exploratory study and little existing research has theorised causal processes in implementation of health-justice partnerships; ii) it kept the analysis theoretically straightforward: combining two theory-based methods (realist evaluation and implementation theory) may have become too conceptually complex at the interpretation stage.

The analysis was undertaken using the coded dataset, and involved identifying and coding for relationships between themes. I reanalysed the whole dataset, undertaking an extensive search for evidence of these links; however, it is possible that I may not have identified all the pathways that exist, if they were not represented in the data or if I did not find them. The analysis could have been strengthened by undertaking an additional theory-testing step: theory-testing in Process Tracing involves developing empirical tests to ascertain the degree of confidence in a hypothesised causal mechanism in light on the observed evidence(Beach and Pedersen, 2013). I did not undertake this step because QCA was planned as the main theory-testing analysis.

Qualitative Comparative Analysis

The QCA involved quantifying qualitative concepts, in order to systematically compare findings across the case studies. This analysis identified patterns showing how combinations of conditions were associated with outcomes, providing additional evidence of causal relationships. It also determined the role of each causal factor (whether it was necessary or sufficient for the outcome) providing evidence of the critical factors in implementation success. Cross-case comparison identifies patterns of similarity and difference between case studies, which helps to make sense of multiple case narratives(Rihoux and Lobe, 2009) and enables stronger causal inferences to be made than within-case analysis alone(Beach and Pedersen, 2016a). QCA is appropriate for implementation studies because it offers a rigorous approach to comparison while drawing on rich qualitative insights(Kane *et al.*, 2014). The results are also simpler to interpret than qualitative descriptions, and may be easier to act on for practitioners and policy makers.

One disadvantage of QCA is that it leads to some loss on detail, because it involves translating qualitative to quantitative data(Hill, Cooper and Parker, 2019). This was evident to me in carrying out the analysis. Some of the finer details I had identified in the interview data I could not assess at a service level, either because the themes were rarer and did not appear in the data for every service, or because they were things that would have been difficult to assess confidently without additional information. This means I couldn't compare everything that may have been relevant. In order to assign values to conditions, I also needed to group data together to make the assessment, and there was inevitably some variation within the included themes. However, I am confident that my in-depth understanding of the case studies enabled me to do the calibration as accurately as possible, and decisions about how to assign scores were based on careful re-examination of the data in each case study. The process of calibration necessarily involves a degree of interpretation, which relies heavily on the researcher's knowledge of the cases and context(Basurto and Speer, 2012). Critics have stated that this process is arbitrary and can be adapted by the researcher to get the desired results(Wade and Goldstein, 2003). However, the fact that it draws on the researcher's interpretation can also be seen as a strength of the method, because it involves a dialogue between evidence and theory which is important for the validity of any systematic approach to qualitative data analysis(Rihoux and Lobe, 2009; Basurto and Speer, 2012). The use of the implementation theory helped me to select appropriate conditions for the analysis. In QCA, it is important that the selection of conditions is guided by theoretical criteria to ensure the analysis is based on sound reasoning(Berg-Schlosser and De Meur, 2009).

The intermediate solution often seemed to give the best results based on the consistency and coverage scores, and to provide a meaningful solution when interpreted in the light of case examples. The complex formula can be too complex for a theoretically meaningful interpretation, while the minimal formula risks resting on theoretically implausible assumptions(Schneider and Wagemann, 2013).

Combining analysis methods

A key strength of the study was that it combined analysis methods to gain the maximum insight into the research question. The Thematic Analysis and Process Tracing methods provided detailed descriptions of the services and an explanation of the important themes which shaped their outcomes. This was an essential basis for understanding the determinants of implementation success. While undertaking this analysis, I began to see patterns between the services which could potentially explain their different outcomes, however qualitative description could not test these relationships in a systematic way. The QCA built on the detailed qualitative insights and allowed the relationships between factors to be tested and the patterns to be clearly presented. This gave extra clarity to the findings by homing in factors that were necessary and sufficient for particular outcomes. However, QCA if used alone would have been a blunt instrument and its value relied on the insights gained through the prior in-depth qualitative analysis.

Use of theory

Theories play an important role in qualitative research: they provide a conceptual understanding of complex phenomena, and can be used to guide the research process and interpret qualitative findings(Reeves *et al.*, 2008). Theories are used widely in implementation studies to provide a better understanding of why implementation efforts may succeed or fail(Nilsen, 2015). This research drew on the General Theory of Implementation, which was proposed in 2013(May, 2013); however, examples of its practical application in research are missing to date, so it is not possible to compare the conclusions from this study with other research.

My first application of the theory was in developing theoretical propositions to be investigated in the comparative case study. This was based on an analysis of the literature. Many of the themes identified in the literature as potential determinants of implementation success could be matched with the theoretical constructs, however some important ones could not. These included management-related factors such as leadership, service planning and evaluation. These issues were identified as strong determinants of implementation outcomes in both the literature and the comparative case study. They are also likely to apply to other complex interventions and therefore represent a potential gap in the theory.

I also used the theory in developing the interview topic guides, to inform the topics that were included and ensure that data were collected on relevant issues. However, I did not use it in the early stages of analysis. Theories are unlikely to provide a universal explanation, and processes may play out differently in different contexts(Nilsen, 2015); therefore, it was important to explore the data fully before applying a theoretical structure. When used in the analysis, the theory was not an entirely good fit for the data. It appeared more relevant for the collaborative working outcome than the sustainability one, as it was geared towards understanding how new practices become embedded. The ‘Potential’ domain, which refers to individual intentions and commitment, came across strongly for both the collaborative working and sustainability outcomes. However, the other domains did not match so neatly, as discussed above (see discussion sections on Collaborative working and Sustainability).

6.3.3 Stakeholder engagement

The primary stakeholders identified for this research were professionals working in practice and policy. With the study’s focus being on implementation (the processes of service delivery, management and funding), these professional groups could contribute the necessary evidence and would also be the primary users of the research. A limitation of the stakeholder engagement work was that it did not involve service users. While patients/clients may not have insight into implementation processes, their views could help understand what a health justice partnership should importantly offer and what a successfully implemented service would look like from the user perspective. This in turn could inform which approaches to service design / delivery may be most appropriate for whom, and would be a valuable next step for future research.

I involved stakeholders in the early stages of designing the main study, to provide feedback on the potential research questions and study focus. While this was a small-scale activity, it helped significantly in ensuring that important topics were addressed. Towards the end of the project, I held the stakeholder engagement event to communicate the findings with professionals working in the field, and to gain their input in informing study outputs, recommendations and priorities for future work. The event was attended by over fifty people with a related interest, including professionals working in health-justice partnerships, researchers, practitioners and policy professionals. It therefore appeared successful in relation to the dissemination goal. However, there was limited opportunity for in-depth engagement and feedback; for example, I felt the Q&A session needed more time, and the discussion groups could have continued for longer. Despite this, the event did elicit useful information on participants' experiences and valuable suggestions to take forward in future work. It would be worthwhile to provide more opportunities for involvement when the study outputs are in development. Responses to the proposed recommendations were only received from two people, which is less feedback than I had hoped for; however, the feedback indicated that the recommendations appeared both practical and impactful, and provided valuable suggestions for additions and refinements.

6.3.4 Role of the researcher

I began this PhD research with some existing knowledge and experience in the subject of health-justice partnerships. In the preceding two years, I held a role as a researcher evaluating a health-justice partnership pilot, working alongside the service delivery team. This provided me with first-hand experience of working with the clients and health professionals, and also insight into some of the implementation processes and challenges. During this time, I also carried out a mapping study to identify and describe health-justice partnerships across England and Wales. As part of this project, I connected with other services and had conversations about their own experiences, which further increased my understanding of the field. This prior knowledge was useful to me in a number of ways. In the early stages it helped me to find a focus for the research, because I was aware of implementation challenges that were both common and significant for the services. It also helped me in the data collection and analysis, because I had some insight into the situations and issues that were being described and could more readily make sense of the data. However, because I had only worked in one particular setting this insight was not complete, and my personal understanding of the various contexts of the case studies did vary. The fact that I had previous experience in the field also means that I was coming to the study with existing ideas and potential preconceptions. For example, in the interviews I probed about issues I had thought would be significant based on my previous understanding, but sometimes these turned out to be quite insignificant. To minimise my personal influence on the findings, I approached the analysis in a way that was as neutral and objective as possible: I started with a lengthy period of familiarisation with the data, and began coding inductively and at a fine level of detail, rather than using a pre-made coding framework. I kept notes of my reflections as I went along and revised my understanding accordingly. I also had regular meetings with project supervisors as the analysis progressed, to discuss my analysis process and the emergent findings. Drawing on the implementation theory helped to focus my data collection and analysis around issues that were conceptually relevant, in addition to my own insights from the data. Finally, I have drawn on literature from implementation research to help with the interpretation of my findings.

6.4 CONTRIBUTIONS TO THE LITERATURE

6.4.1 Systematic Scoping Review

The systematic scoping review is the first summary of international literature on health-justice partnerships. Previous systematic reviews have focussed on particular geographical regions and particular types of legal intervention, meaning the evidence is limited to a specific context(Adams *et al.*, 2006; Martinez *et al.*, 2017). By adopting a broader scope, this review draws on evidence that has been generated from around the world and therefore presents results that are generalisable to health-justice partnerships in a diverse range of settings. The findings relating to the impacts of health-justice partnerships provide a comprehensive summary of the research that has been conducted to date internationally, and identify gaps in the literature that could inform future studies on impact. The findings relating to implementation are the only summary of their kind to date, as this is the first review to analyse evidence relating to the implementation of health-justice partnerships. The results provide a detailed breakdown of the identified themes and may be a valuable resource for other researchers and practitioners in the field.

6.4.2 Comparative Case Study

To date, much of the research on health-justice partnerships has focussed on assessing service outcomes without considering the role of implementation. Successful implementation is a prerequisite for impact, ensuring that the intervention can take root, become well utilised, continue operating over time and achieving the intended benefits for individuals and organisations. Understanding implementation can inform service delivery in practice and support the development of impactful services. This study made implementation the primary focus of the investigation and is one of the few rigorous academic studies to explore this in detail. As discussed in the systematic scoping review, previous publications have identified various factors that seem important for successful project delivery, but have not clarified desirable outcomes of implementation and the mechanisms through which these are generated. The comparative case study makes significant progress in this regard, and provides evidence on the causal pathways leading to the following implementation outcomes: collaborative working, sustainability and impacts of partnerships. This evidence is valuable for supporting implementation efforts and may be applicable in other similar contexts, such as partnerships between the NHS and voluntary and community sector organisations more broadly. The evidence may also be valuable in informing future impact studies, because it describes how aspects of implementation can affect the impacts that may be generated.

The comparative approach is one of the unique contributions of this research. In the existing literature, the majority of publications focus on single service examples and are therefore specific to a particular context. In England, the literature also focusses predominantly on primary care. The comparative case study provides insight into a diverse range of partnerships and how they can operate in many different settings. By including diverse case studies, the research was able to identify patterns that held true across the included services, and therefore has produced results that can be generalised to health-justice partnerships in a range of contexts.

This is the only research to date to have applied implementation theory to the study of health-justice partnerships. Using the General Theory of Implementation helped to conceptualise the important factors to investigate and to guide the data collection and analysis. However, it did not appear to be an entirely good fit for the data and has not been trialled in other research. Future studies in this area could test the application of alternative implementation theories, which may highlight other determinants of implementation success.

6.5 UNANSWERED QUESTIONS AND FUTURE RESEARCH

This research has provided insight into the major causal influences on successful implementation of health-justice partnerships; however, it has also prompted questions about issues where I had less information and that were not fully answered. Reflecting on the study, I have questions about the role and views of doctors and other health professionals given that they were under-represented in my interview sample:

- Why do doctors engage to a lesser extent than other health and social care professionals in the activities of collaborative working?
- What are the range of views among doctors and other health professionals towards health-justice partnerships, including the main reasons for resistance?

To inform service design options and recommendations, it would be valuable to gain insight from service users about what is important to them:

- What does success in health justice partnership look like from the patient / service user perspective?
- What approaches to service design are appropriate for whom and in which circumstances?

Given the continued use of remote services since the pandemic, I also have questions about how the new approaches will work and what their impacts might be:

- What is the effect of the increased utilisation of remote service delivery on collaborative working and access for clients?
- How can collaborative working be facilitated between teams working remotely in the post-Covid era?

Having done the majority of the data collection during the time of national pandemic restrictions, I am conscious that I was not able to visit and observe the services I was studying, and therefore could have missed important contextual details:

- What additional information could a more in-depth method (such as observation or ethnography) yield in understanding implementation?

Using the General Theory of Implementation in this research, I found that it was not an entirely good fit for the data and there may be alternative theories that could be useful in this field:

- What other implementation theories could provide a useful representation of implementation processes in health-justice partnerships?

Beyond the immediate scope of my study, there are other questions relating to implementation that could be important considerations for further work:

1. How can the intervention be codified to support adoption and spread in new contexts?

‘Codifying’ an intervention involves specifying its components to enable effective replication. This should involve adequate description of the technical components involved in delivering the service, as well as the underlying social, contextual and dynamic forces which influence successful implementation(Horton, Illingworth and Warburton, 2018). There are different approaches to codifying interventions, which can be done by ‘tightening’ (providing fine-grained specifications to replicate the original form) or ‘loosening’ (providing guidance to support adaptation in new contexts, replicating the function rather than the original form). Codifying health-justice partnerships could provide implementers with a recipe for developing new services, and would be a natural development from the study findings.

2. What approaches to health-justice partnership work best, and for whom?

The systematic review identified a wide range of impacts of health-justice partnerships that have been examined in existing research. However, research has not compared the relative benefits of different approaches, and the impacts are likely to vary according to the health setting, patient group and type of legal intervention. Additionally, the comparative case study identified that impacts may depend on the way that services are delivered and to what extent collaborative working is involved. To inform the development and targeting of new services, it would be useful to quantify this variation and understand what impacts might be achieved through different approaches and in different contexts.

3. How can health-justice partnerships effectively integrate with social prescribing schemes?

As social prescribing grows as the dominant form of collaboration between primary care and voluntary and community sector organisations, it is important to understand how health-justice partnerships can fit within this way of working. The comparative case study highlighted the tension that can exist between the two, which had led to the decommissioning of one partnership and the remodelling of another. The stakeholder engagement confirmed this as a pressing issue that practitioners are dealing with, and there have been innovative responses to try and integrate the two. Given that social welfare legal issues are among the most common needs arising, it is important that legal services are designed into social prescribing systems. Further research is needed to understand how this can be done effectively.

4. How can health-justice partnerships operate within the forthcoming Integrated Care Systems?

Integrated Care Systems are developing across the country, consisting of formal partnerships between local health services, local councils, the voluntary, community and social enterprise sector, and others. They will work in partnership to plan and deliver care and support for local populations. While the systems are still under development, they are likely to involve multi-agency partnerships of the kind that were included in the comparative case study (where the welfare rights advice service was one of several community partners working under one umbrella). Understanding approaches to multi-agency working will be of interest for local organisations going forward.

5. What is a sustainable funding model for health-justice partnerships?

Finding and maintaining funding is one of the biggest hurdles for health-justice partnerships. The comparative case study highlighted the challenges for individual funders in justifying investment in the face of public funding cuts and economic shocks. Joint resourcing is a potential way forward, but the benefits and challenges to this have not been researched. Alternative models of funding looking beyond state funding may also be worth investigating.

6. How can health-justice partnerships be effectively evaluated using routine service data?

Effective evaluation plays and important role in demonstrating the value of health-justice partnerships and maintaining strategic support. However, it is challenging to undertake, and the stakeholder event highlighted the need for guidance. A protocol that could be used and adapted locally could help with evaluation efforts and support sustainability. Further work is needed to understand what data would be reasonable for practitioners to collect in the service setting, and how that data could be collected through the clinical process.

6.6 RECOMMENDATIONS FOR POLICY AND PRACTICE

These recommendations stem from the results of the comparative case study and the stakeholder engagement event. They are based on the experiences of practitioners and the evidence generated through this research of the factors which are important in influencing implementation outcomes.

Recommendations relating to service design (for those planning partnerships):

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 groups with high rates of welfare issues).
4. For partnerships aimed at the general population through primary care, try 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 multi-disciplinary teamsto streamline inter-agency working and provide more tailored support.

Recommendations relating to collaborative working (for those delivering partnerships):

7. Regularly promote the partnership among healthcare teams locally, to ensure visibility and ongoing awareness.
8. Provide opportunities to learn about the partnership (e.g. trainings, inductions), to develop the necessary knowledge for joint working.
9. Cultivate relationships with healthcare teams (including health and social care professionals and administrative staff), to build trust in the partnership.
10. Seek project champions in the health service, to help promote and encourage engagement among teams.

11. Create regular opportunities for staff to interact, communicate and get to know each other; for example through interdisciplinary meetings.
12. Provide feedback on the outcomes of referrals to welfare advice, to increase understanding and motivation among referrers.
13. 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 (for those funding and managing partnerships):

14. Evaluate the service in the light of local funder priorities, to demonstrate relevant impacts.
15. Promote the service locally, to raise awareness of its achievements for the local community / patient group.
16. Seek out prominent health service champions, to support the partnership in strategic discussions.
17. Maintain relationships between organisations at strategic level, to develop and improve the service collaboratively over time.
18. 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.
19. Consider joint funding arrangements (where possible locally), to increase the available resources.
20. Partner organisations should jointly contribute non-financial resources to support the partnership, such as rent-free space, administrative support, training or IT equipment.

Recommendations for national action (for policy organisations and researchers):

21. Convene a professional peer network / community of practice, to capture and share learning across services.
22. Develop implementation guidance, to support replication and wider adoption of health-justice partnerships.
23. Develop guidance on evaluation, to support local services in evidencing their impacts.
24. Develop training resources, to support capability and readiness for cross-sector working among health and legal teams.
25. Campaign at a national level for greater recognition and support from both health and legal sectors.

26. 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 health/social care services, addressing inequalities. Also finer breakdowns, e.g. where there is the greatest benefit (by patient groups / types of issues).

6.7 CONCLUSION

Health-justice partnerships work towards important goals for population health and access to justice. Through legal advice services, the law can be mobilised to resolve social welfare issues and improve the socio-economic circumstances of individuals. In turn, this addresses powerful determinants of health and plays an important role in supporting and improving wellbeing. These goals are particularly pertinent in today's economic and political context. The last decade has seen rising poverty, widening health inequalities and reduced access to social welfare legal advice. The imperative for action on these inter-related issues is reflected in current health and legal policies, which advocate for greater integration of services across sectors. It is therefore a time of opportunity for more widespread adoption of health-justice partnerships, which could contribute to the broader systems change towards integrated working that is required to address population needs. This research provides new evidence to support the implementation of health-justice partnerships in practice and informs priorities for future research and policy activity.

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APPENDICES

APPENDIX 1 SCOPING REVIEW MATERIALS

Appendix 1A Literature sources

Academic databases	**Websites**
Cochrane Library Cumulative Index to Nursing and Allied Health Literature (CINAHL) Embase Health Management Information Consortium (HMIC) Legal Journals Index Medline NICE Evidence PsycINFO Social Care Institute for Excellence (SCIE) Social Services Abstracts Social Policy and Practice The King's Fund Library Database	Age UK Association of Palliative Care Social Workers Centre for Mental Health Citizens Advice Health Justice Australia JUSTICE Law and Justice Foundation Law Centres Network Legal Action Group Local Government Association Macmillan Cancer Support Maggie’s Mind Ministry of Justice Money and Mental Health National Center for Medical-Legal Partnership National Institute for Health and Clinical Excellence NHS England NHS Improvement

	Open Society Foundations Pathway Public Health England Release Scottish Improvement Service Shelter Social Action for Health Social Care Institute for Excellence Social Prescribing Network The Health Foundation The King’s Fund The Legal Education Foundation Youth Access UCL Centre for Access to Justice

Appendix 1B Keyword search strategy

Concept	**Search terms**
Social welfare legal advice	(advice service* OR (legal ADJ2 advice) OR (legal ADJ2 rights) OR (legal ADJ2 service*) OR (legal ADJ2 assistance) OR (civil ADJ2 rights) OR (rights ADJ2 advice) OR (social welfare ADJ2 advice) OR (social welfare ADJ2 rights) OR social welfare OR (welfare ADJ2 advice) OR (welfare ADJ2 rights) OR (benefits ADJ2 advice) OR (debt ADJ2 advice) OR (financ* ADJ2 advice) OR (financ* ADJ2 rights) OR (housing ADJ2 advice) OR (homeless* ADJ2 advice) OR (housing ADJ2 rights) OR (employment ADJ2 advice) OR (employment ADJ2 rights) OR (education ADJ2 advice) OR (education ADJ2 rights) OR (community care ADJ2 advice) OR (community care ADJ2 rights) OR (immigration ADJ2 advice) OR (immigration ADJ2 rights) OR (family ADJ2 advice) OR (family ADJ2 rights) OR (discrimination ADJ2 advice) OR (discrimination ADJ2 rights) OR citizens advice).ti,ab,kw.
AND	
Healthcare	(health service* OR healthcare OR health-care OR health care OR medical service* OR medical care OR patient* care OR (patient* ADJ2 care) OR patient* health OR (patient* ADJ2 health) OR care delivery OR (care ADJ3 delivery) OR care pathway* OR primary care OR primary healthcare OR primary health OR general practice* OR family practice* OR secondary care OR secondary healthcare OR secondary health OR hospital* OR emergency care OR urgent care OR hospice* OR social prescri* OR health center OR health centre OR medical center OR medical centre).ti,ab,kw.
OR	
Health Justice Partnership	(medical legal partnership* OR medical-legal partnership* OR health justice partnership* OR health-justice partnership* OR hospital-legal partnership* OR health law partnership*).ti,ab,kw.

Appendix 1C Indexing terms

	Medical Subject Headings (MeSH)	**Other indexing terms**
Social welfare legal advice	Civil rights Legal Services Social Welfare	Community welfare services Legal processes Social welfare users Welfare rights Welfare rights advice centres Welfare services
Healthcare	Delivery of health care Health Services	Health care delivery Health care services Patient care

Appendix 1D Inclusion and exclusion criteria

	Inclusion criteria	**Exclusion criteria**
Types of legal service	Research reporting on legal services within the study scope (see Table 2-1)	Research reporting on legal services not within the study scope (see Table 2-1)
Health service setting	Statutory or non-statutory healthcare providers, in which social welfare legal assistance is integrated into patient care in some way (includes situations where separate organisations collaborate, and where an umbrella organisation provides both healthcare and legal services as an integrated support package)	Services providing either healthcare or legal assistance (not both) and without collaboration that brings these services together
Information reported	Research reporting the following information regarding the delivery of integrated health and legal services: Nature of legal intervention and its link with healthcare Aims, objectives or targets Outputs or impacts Implementation processes	Research not reporting any of the following information regarding the delivery of integrated health and legal services: Nature of legal intervention and its link with healthcare Aims objectives or targets Outputs or impacts Implementation processes
Language	Publications printed in English	Publications not printed in English
Publication date	Publication date between 1st January 1995 and 13th December 2018	Publication date before 1st January 1995 or after 13th December 2018
Text availability	Full text obtainable	Full text not obtainable
Research type	Primary studies of any research design (both quantitative and qualitative), reviews and grey literature reports	Publications not presenting empirical results, or those presenting vignettes only
Publication type	Peer reviewed journal articles, reports, service evaluations	Editorials, discussion papers, opinion pieces, letters and commentaries

Appendix 1E Data extraction headings

Main heading	**Sub-headings**
Characteristics of publications	Publication date, Geographical location, Publication type, Discipline of publisher
Characteristics of research studies	Study objectives, Research questions, Study design, Methods, Data collection, Outcome measures, Analysis, Application of theory
Descriptions of services	Aims/objectives, Target population, Legal intervention, Health service setting, Nature of links between services, Shared activities, Funding
Outcomes reported	Legal case outcomes, Access to assistance, Health outcomes, Social determinants, Staff outcomes, Organisational outcomes, Systems and policy change
Implementation-related information	Practical issues, Service planning and development, Management, Communication, Relationships, Professional culture

Appendix 1F Quality assessment tool

	Criteria	**Meaning**
Context	Engagement with existing evidence and theory	Adequately presents existing knowledge/ research evidence relevant to the context Demonstrates understanding of the relevant issues and sources Sets out hypotheses / theories of change
	Clear description of context/setting	A detailed description of the setting and context in which the service operates e.g. details of location, health service, legal service, target population, service aims
	Clear description of intervention	A detailed description of the activities of the service e.g. legal intervention, links with healthcare, operational details
Methods	Relevant research problem	Research problem is clearly stated and defined. Research problem is grounded in the context (including current debates, social context, knowledge gaps, theories). Practical applications of the research are considered.
	Clear definition of research aims/questions	Research aims and/or questions are clearly stated and defined. Research questions are related to the problem context.
	Appropriate study design/methodology	The processes of undertaking the research are clearly described. The study design is appropriate for addressing the research questions. The methods fit the purpose and are sufficient to generate the evidence required.
	Appropriate selection of data subjects/ sources	Selection of data subjects and/or sources is well described Sampling procedure is inclusive of all relevant participants / data sources
	Appropriate information gathering	Data collection procedures are clearly described Choice of outcome measures is fitting and sufficient Data collection is of sufficient duration and completeness
	Rigorous analysis	Analysis of study data is clearly and comprehensively explained Appropriate analysis methods are employed

	Use of theoretical foundation	The approach is informed by appropriate theories relevant to the context Theories are developed or examined
Reporting	Clear and comprehensive reporting	Results are clearly presented in full Language is clear, precise and understandable Report is well structured
	Critical evaluation	Information is critically evaluated Potential bias or confounding is discussed and taken account of if possible Alternative explanations are considered
	Critical reflection	Limitations of the research are discussed The role/standpoint of the researcher is disclosed and its impact considered Potential influence of context-specific cultural factors is considered
	Valid conclusions	Conclusions are linked to study's results and other existing evidence Interpretation is logical and transparent Argument is well-crafted
	Transferability	The research makes a significant contribution to knowledge or practice The application of the findings in other contexts is discussed (generalisability)
Formal assessments	Peer reviewed	The publication has undergone peer review
	Consideration of ethical issues	Ethical challenges are considered and responded to The research has undergone a process of ethical review

Appendix 1G Characteristics of studies reporting HJP service outcomes

Publication	**Service setting**	**Study design**	**Outcomes reported (themes)**	**Peer reviewed?**	**Quality rating**
Abbott 1999	UK, primary care, welfare benefits advice delivered in health centres	Observational, Mixed methods. Retrospective review of service records, before-and-after follow-up surveys with clients, interviews with service users and primary care staff	Access to assistance, Legal, Health, Prevention, Healthcare support	No	Medium/High
Abbott et al. 2006	UK, primary care, welfare benefits advice delivered in general practices	Observational, Quantitative. Before-and-after follow-up, structured interviews with clients	Legal, Health, Prevention	Yes	Medium/High
Abbott and Hobby 2003	UK, primary care, welfare benefits advice delivered in general practices	Observational, Quantitative. Cross-sectional survey of clients	Access to assistance, Legal, Health	Yes	Medium/High
Arad Research 2015	UK, primary care, community care and hospital settings across Wales, co-located welfare advice sessions	Observational, Mixed methods. Retrospective review of service records, interviews with clients, consultations with project managers and directors	Access to assistance, Legal, Health, Prevention	No	Low/Medium
Atkins et al. 2013	USA, women's healthcare, legal services for pregnant women on low incomes	Observational, Quantitative. Before-and-after follow-up survey with clients	Health	No	Low/Medium
Bateman 2008	UK, variety of healthcare types, welfare benefits advice delivered in healthcare settings	Observational, Mixed methods. Cross-sectional survey of advice providers, interviews with project staff, healthcare professionals and service users	Access to assistance, Legal, Health, Care delivery	No	Low/Medium
Beck et al. 2012	USA, children's hospital, legal services to address housing problems for low income families in poor living conditions	Observational, Quantitative. Retrospective review of service records	Legal, Systemic change	Yes	Medium/High
Bird 1998	UK, mental health services, welfare advice and assistance delivered in health settings	Observational, Qualitative. Cross-sectional, interviews with clients, advice staff and mental health professionals	Access to assistance	Yes	Low/Medium
Burrows et al. 2011	UK, primary care, welfare rights advice in general practices	Observational, Qualitative. Cross-sectional data collection, semi-structured interviews with clients, healthcare professionals and advisors	Access to assistance, Legal,	Yes	Medium/High

			Health, Prevention, Healthcare support		
Carey and Tolopilo 2008	Ukraine, harm reduction programmes and HIV/AIDS services, legal assistance for people suffering from drug dependency, people living with HIV/AIDS, and commercial sex workers	Observational, Qualitative. Cross-sectional, interviews with legal professionals, clients and service providers	Access to assistance, Prevention, Healthcare support, Systemic change	No	Low/Medium
Carrick et al. 2017	UK, primary care, welfare advice delivered in general practices	Observational, Mixed methods. Social return on investment modelling, based on service records, stakeholder consultations, client surveys and staff interviews	Access to assistance, Legal, Health, Prevention, Healthcare support	No	Medium/High
Citizens Advice and the Royal College of General Practitioners 2018	UK, primary care, welfare advice outreach sessions in GP surgeries	Observational, Mixed methods. Cross-sectional data collection, general practitioner survey, service case studies	Access to assistance, Healthcare support	No	Low
Citizens Advice Camden 2017	UK, primary care, welfare advice delivered in general practices	Observational, Mixed methods. Cross-sectional, data collection, post-intervention client survey, telephone interviews with clients and healthcare providers	Access to assistance, Legal, Health, Prevention, Healthcare support	No	Low/Medium
Community Sense 2015	UK, primary care, welfare advice outreach sessions in GP surgeries	Observational, Mixed methods. Retrospective review of service records, cross-sectional patient and staff surveys, stakeholder interviews, patient case descriptions	Access to assistance, Legal, Health, Healthcare support	No	Low/Medium
Coppel et al. 1999	UK, primary care, welfare advice delivered in a general practice	Observational, Mixed methods. Retrospective review of service records, post-intervention survey of clients, semi-structured interviews with primary care staff	Access to assistance, Legal, Care delivery	Yes	Low/Medium
Eynon et al. 2010	UK, intensive care, legal assistance relating to personal injury for patients in intensive care	Observational, Quantitative. Retrospective review of service records	Legal	Yes	Low/Medium

Fleishman et al. 2006	USA, hospital-based cancer centers, legal services for poor and chronically ill cancer patients	Observational, Mixed methods. Cross-sectional client survey	Access to assistance, Legal, Health, Care delivery	Yes	Low/Medium
Focus Consultants 2017	Canada, children's hospital, legal advice and representation for low income families	Observational, Mixed methods. Retrospective review of service records, interviews and surveys with clinicians, lawyers and clients	Access to assistance, Legal, Health, Systemic change	No	Low/Medium
Frost-Gaskin et al. 2003	UK, community mental health services, welfare benefits assistance provided in health centres for people with mental health problems	Observational, Mixed methods. Before-and-after follow-up, case histories	Access to assistance, Legal, Health	Yes	Medium/High
Gabbay et al. 2017	UK, primary care mental health services, debt advice delivered in general practices for adults with depression	Experimental, Mixed methods. Before-and-after follow up with control group, qualitative interviews with clients, clinicians and advisors	Legal, Health	Yes	High
Galvin et al. 2000	UK, primary care, welfare rights advice in general practices for patients and carers	Observational, Mixed methods. Cross-sectional data collection, client survey, interviews with clients and advisors, focus group with general practitioners	Access to assistance, Prevention, Care delivery	Yes	Medium/High
Greasley and Small 2005a	UK, primary care, welfare advice sessions delivered in general practices	Observational, Mixed methods. Cross-sectional, practice manager survey, focus groups with advisors and primary care staff	Access to assistance, Health, Prevention, Healthcare support, Care delivery	Yes	Medium/High
Greasley and Small, 2005b	UK, primary care, welfare advice delivered in general practices	Observational, Quantitative. Retrospective review of service records	Access to assistance, Legal	Yes	Low/Medium
Harding et al. 2002	UK, primary care, welfare advice sessions delivered in general practices	Observational, Quantitative. Cross-sectional survey of practice managers	Access to assistance	Yes	Medium/High
Harding et al. 2003	UK, primary care, welfare rights advice delivered in general practices	Observational, Quantitative. Cross-sectional survey of general practitioners	Access to assistance, Healthcare support	Yes	High
Hernández 2016	USA, community health centers, legal assistance for housing problems for patients on low incomes	Observational, Qualitative. Comparative case study, semi-tructured interviews with clients and comparison group	Access to assistance, Legal	Yes	Low/Medium

Hoskins et al. 2005	UK, primary care, welfare benefits screening and advice for patients aged over 64 years with care needs	Observational, Quantitative. Prospective collection of service process and outcome data	Access to assistance, Legal	Yes	Medium/High
Hoskins and Smith 2002	UK, primary care, welfare rights assessment and assistance for physically or mentally frail patients aged 65 years and over	Observational, Mixed methods. Retrospective review of service records	Access to assistance, Legal	Yes	Medium/High
Jackson et al. 2012	Canada, children's hospital, legal assistance for low income families	Observational, Mixed methods. Retrospective review of service records, semi-structured interviews with healthcare providers, clients and lawyers	Health, Prevention, Healthcare support	No	Medium/High
Jones et al. 2017	Canada, primary care, income security intervention offering expert advice, advocacy and case management	Observational, Quantitative. Retrospective review of service records	Access to assistance, Legal	Yes	High
Justice Connect Seniors Law and cohealth 2016	Australia, community health service, legal assistance for older people experiencing elder abuse and other legal issues associated with ageing	Observational, Mixed methods. Before-and-after follow-up, surveys of health professionals pre- and post- introduction of intervention, interviews with healthcare professionals	Access to assistance, Legal, Care delivery	No	Low/Medium
Kite 2016	UK, primary care, welfare rights advice in general practices	Observational, Mixed methods. Cross-sectionals data collection, client survey, interviews with clients and advisors	Access to assistance, Legal	Yes	High
Klein et al. 2013	USA, pediatric primary care centers, legal services for low income patients	Observational, Quantitative. Retrospective review of service records	Legal, Care delivery	Yes	Low/Medium
Langley et al. 2004	UK, primary care and hospital settings, welfare benefits screening and advice for adults with arthritis	Observational, Quantitative. Prospective collection of service process and outcome data	Legal	Yes	Medium/High
Levy and Payne 2006	UK, end of life care hospice, welfare advice for palliative care patients, families and carers	Observational, Quantitative. Retrospective review of service records, prospective review of referrals	Legal, Healthcare support	Yes	Low/Medium
Lishman-Peat and Brown, undated	UK, primary care, welfare benefits assessment and assistance for patients in deprived areas	Observational, Mixed methods. Retrospective review of service records, cross-sectional survey of clients including qualitative sections	Access to assistance, Legal, Prevention	Yes	Low

Mackintosh et al. 2006	UK, primary care, welfare rights assessment and assistance delivered through general practices for patients aged 60 years and above	Experimental, Quantitative. Pilot randomised controlled trial. Self-reported surveys with intervention and control groups, collected in a structured, face-to-face interview at baseline, 6, 12 and 24 months.	Legal, Health	Yes	High
Macmillan Cancer Support 2010a	UK, cancer services, welfare rights advice and assistance for people affected by cancer	Observational, Mixed methods. Unspecified	Legal, Health, Prevention, Healthcare support	No	Low
Macmillan Cancer Support 2010b	UK, cancer services, assistance with benefits and financial issues for people affected by cancer	Observational, Mixed methods. Retrospective review of service records	Legal, Health, Healthcare support	No	Low
Martin et al. 2015	USA, general hospital, lawyer embedded in inter-professional care team, for patients with high service utilization	Observational, Mixed methods. Retrospective review of service records, illustrative patient case study	Legal, Care delivery	No	Low
Mcdaid et al. 2017	UK, primary care, debt advice delivered in general practices for working aged adults	Other, Quantitative. Literature review and cost-effectiveness modelling	Healthcare support	No	Medium/High
Moffatt and Mackintosh 2009	UK, primary care, welfare rights advice delivered through general practices for people aged over 60 years who were not English	Observational, Qualitative. Cross-sectional, semi-structured interviews with clients	Access to assistance, Legal, Health, Prevention	Yes	Medium/High
Moffatt and Scambler 2008	UK, primary care, welfare rights advice in general practices for patients aged 60+	Observational, Qualitative. Prospective, Semi-structured interviews with clients pre- and post-intervention	Legal, Health, Prevention	Yes	High
Moffatt et al. 2004	UK, primary care, welfare advice delivered in general practices	Observational, Qualitative. Cross-sectional, semi-structured interviews with clients	Access to assistance, Legal, Health, Prevention, Healthcare support	Yes	High
Moffatt et al 2006	UK, primary care, welfare benefits screening and assistance delivered through general practices	Observational, Qualitative. Nested within a randomised controlled trial, semi-structured interviews with individuals in intervention and control groups	Access to assistance, Legal, Health, Prevention	Yes	High

Moffatt et al. 2010	UK, cancer services, welfare benefits assistance for cancer patients and carers	Observational, Qualitative. Cross-sectional data collection, semistructured interviews with clients (patients and carers)	Access to assistance, Legal, Health, Prevention, Care delivery	Yes	High
Moffatt et al. 2012	UK, cancer services (primary care and hospital locations), financial and welfare benefits assistance for cancer patients and carers	Observational, Mixed methods. Retrospective review of service records, semi-structured interviews	Access to assistance, Legal, Health, Prevention	Yes	High
O'Sullivan et al. 2012	USA, hospital-based asthma clinic, legal assistance to improve housing environments for asthma patients in deteriorated housing	Observational, Quantitative. Before-and-after follow-up, review of service records before and after successful intervention	Health, Healthcare support	Yes	Medium/High
O'Toole et al. 2012	USA, children's hospital clinics, legal and social welfare support for patients	Observational, Quantitative. Cross-sectional survey of medical trainees	Care delivery	Yes	Medium/High
Ollerenshaw and Camilleri 2017	Australia, community health centre, legal services for young people aged up to 25	Observational, Mixed methods. Cross-sectional surveys with clients and staff	Care delivery	Yes	Low/Medium
Palmer et al. 2010	UK, primary care, welfare advice sessions delivered in general practices	Observational, Mixed methods. Review of service records pre- and post-intervention, interviews with managers, general practitioners and advisors	Access to assistance, Health, Prevention, Healthcare support, Care delivery	No	Low/Medium
Parsonage 2013	UK, mental health inpatient units, welfare advice for people with severe mental health problems	Observational, Mixed methods. Service case study, review of service records	Legal, Prevention, Healthcare support	No	Low/Medium
Pettignano et al. 2011	USA, children's healthcare, on-site legal assistance for patients with sickle cell disease and their guardians	Observational, Quantitative. Retrospective review of service records	Legal	Yes	Medium/High
Pettignano et al. 2012	USA, children's healthcare, lawyer integrated into healthcare team, providing legal assistance for families on low incomes	Observational, Quantitative. Retrospective review of service records, cross-sectional survey of healthcare providers	Legal, Healthcare support	Yes	Low/Medium
Pettignano et al. 2013	USA, children's hospitals, on-site legal assistance for families on low incomes	Observational, Quantitative. Retrospective review of service records	Legal	Yes	Medium/High

Powell et al. 2004	UK, primary care and hospital settings, welfare benefits screening and advice for adults with arthritis	Observational, Quantitative. Prospective collection of service process and outcome data	Access to assistance, Legal, Healthcare support	Yes	Medium/High
Reading et al. 2002	UK, primary care, welfare rights advice in general practices for families with infants	Observational, Mixed methods. Before-and-after follow-up, semi-structured interviews with eligible families	Access to assistance, Legal, Health	Yes	Medium/High
Redfern Legal Centre 2015.	Australia, hospital setting	Observational, Mixed methods. Post intervention client survey, pre-and-post staff surveys	Health, Care delivery	No	Low
Regenstein et al. 2017	USA, medical-legal partnerships across the country	Observational, Quantitative. Cross-sectional survey of healthcare and legal organisations	Access to assistance, Legal, Care delivery, Healthcare support	No	Medium/High
Release 2012	UK, drug and alcohol treatment centres, legal assistance for financial and housing issues for drug users	Observational, Mixed methods. Cross-sectional survey of service users and health centre staff	Access to assistance, Legal, Health, Prevention, Care delivery, Systemic change	No	Low/Medium
Rodabaugh et al. 2010	USA, cancer institute, Legal Services Program offering legal assistance on a range of welfare and end of life issues for low income patients	Observational, Mixed methods. Retrospective review of service records, two patient case descriptions	Legal	Yes	Medium/High
Rosen Valverde et al. 2018	USA, pediatric primary care clinic, legal assistance for low income children with disabilities and their families	Observational, Quantitative. Before-and-after follow-up survey with clients	Health	Yes	Medium/High
Ryan et al. 2012	USA, family medicine clinic, legal services for low-income patients	Observational, Quantitative. Before-and-after follow-up survey with clients	Legal, Health	Yes	Medium/High
Seligman et al. 2017	UK, major trauma centre, legal services relating to personal injury for major trauma patients	Observational, Quantitative. Retrospective review of service records	Legal	Yes	Low
Sherr et al. 2002	UK, primary care, practice-based welfare rights advice sessions	Observational, Mixed methods. Cross-sectional data collection, case audits, practice manager survey, interviews with advice providers, funders perspectives	Access to assistance, Care delivery,	No	Medium/High

Sherratt et al. 2000	UK, primary care, GP practice-based welfare rights advice sessions	Observational, Mixed methods. Retrospective review of service records, interviews and focus groups	Access to assistance, Legal	Yes	Medium/High
Sinclair 2017	UK, primary care, advice on financial and housing issues for patients in deprived areas	Observational, Mixed methods. Retrospective review of service records, semi-structured interviews with staff, advisory group consultations	Access to assistance, Legal, Care delivery	No	Medium/High
Taylor et al. 2015	USA, children's hospital, legal assistance to address utility shut-offs for low income families	Observational, Quantitative. Retrospective review of service records pre- and post-intervention	Legal	Yes	Medium/High
Teufel et al. 2009	USA, independent non-profit healthcare facility, legal assistance on public benefits, personal disability, family and employment issues	Observational, Quantitative. Retrospective review of service records	Legal, Healthcare support	Yes	Low/Medium
Teufel et al. 2012	USA, rural non-profit health system, legal assistance with a variety of welfare and end of life issues for people on low incomes	Observational, Quantitative. Retrospective review of service records, comparing two time periods	Legal, Healthcare support	Yes	Medium/High
Toeg et al. 2003	UK, primary care, welfare benefits screening and advice for patients aged over 80 years	Observational, Quantitative. Prospective collection of service process and outcome data	Legal, Care delivery	Yes	Low/Medium
Tsai et al. 2017	USA, veteran's healthcare, legal advice and representation for homeless and low income veterans with mental illness	Observational, Quantitative. Retrospective review of service records, before-and-after follow-up survey of clients	Legal, Health	Yes	Medium/High
Weintraub et al. 2010	USA, children's hospital, on-site legal services for uninsured families on low incomes	Observational, Mixed methods. Before-and-after follow-up survey of clients including qualitative sections	Access to assistance, Legal, Health, Prevention, Healthcare support	Yes	Medium/High
Woodhead et al. 2017a	UK, primary care, welfare rights advice in general practices	Observational, Qualitative. Cross-sectional data collection, semi-structured interviews with general practice staff, advisors and funders	Access to assistance, Health, Healthcare support	Yes	High
Woodhead et al. 2017b	UK, primary care, welfare advice delivered in general practices	Quasi-experimental, Quantitative. Before-and-after follow-up with comparison group via self-report survey	Access to assistance, Legal, Health, Healthcare support	Yes	High

Wright et al. 2015	UK, children's hospital, social welfare legal advice for parents and carers of children attending hospital	Observational, Mixed methods. Retrospective review of service records, post-intervention client survey, client case descriptions	Access to assistance, Legal, Health, Healthcare support, Systemic change	No	Low/Medium
Zisser and van Stone 2015	USA, health center for children with developmental disabilities, legal services assisting with access to education and resources for families and children	Observational, Mixed methods. Retrospective review of service records, cross-sectional clinician survey	Access to assistance, Legal, Systemic change, Care delivery	Yes	Low/Medium

APPENDIX 2 COMPARATIVE CASE STUDY MATERIALS

Appendix 2A Research proposal for stakeholder feedback

Implementing Health-Justice Partnerships:

Proposed PhD Research Questions

Background:

Partnerships between healthcare and legal advice services have emerged across the world as a means of addressing inter-linking health and social welfare issues in an integrated way. Evidence suggests that these partnerships can improve access to support for vulnerable people and are effective in resolving legal problems, leading to a range of other potential benefits for individuals, health services and communities.

The design and delivery of health-justice partnerships varies widely, reflecting the fact that their generation has been mainly bottom-up in response to local needs and priorities. Little research has explored this diversity or compared approaches in implementation. Collaboration between healthcare and non-health agencies has challenges, and research has begun to explore some of the factors that can influence the success of partnership working in health-justice settings; however, no studies have drawn on implementation theories to inform understanding or generate transferrable knowledge. Given the range of different service models being adopted, there is a need to understand the different approaches in more detail and what affects their successful implementation. Lessons from this research will inform the effective delivery of health-justice partnerships, enabling scale-up and adoption in different settings. It will also generate transferrable learnings that can apply more generally to health service collaborations with other non-health community services, a topic of increasing policy interest in the NHS.

Overarching question:

Implementing integrated health-justice partnerships: why, how, for which services and in what circumstances is collaboration successful?

Success is investigated at the organisational level, and defined in terms of:

- Sustainability
- Inter-agency collaboration
- Impact on services

Sub-questions:

1. What is the nature and origin of different models of existing partnerships, and what is the rationale for initiating such partnerships in different settings?

2. What underlying factors (contexts and mechanisms) influence differences in the 'success' of partnerships at an organisational level?

3. How does implementation of health and non-health collaborative partnerships compare with the evidence for implementation of other types of multi-agency working in health care?

4. What tools/resources would be most helpful to health and legal services to support the implementation and scaling up of collaborative partnerships?

Appendix 2B Recruitment documents

Information Sheet for Case Study Services

UCL Research Ethics Committee Approval ID Number: 16061/001

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of Study: Integrating legal advice and healthcare services

Department: UCL Department of Applied Health Research and UCL Faculty of Laws

Name and Contact Details of the Researcher(s): Sarah Beardon (sarah.beardon@ucl.ac.uk) 1-19 Torrington Place, University College London, WC1E 7HB

Name and Contact Details of the Principal Researcher: Professor Rosalind Raine (r.raine@ucl.ac.uk) 1-19 Torrington Place, University College London, WC1E 7HB

Invitation Paragraph

We invite you as someone who manages a service to take part in a research study that is part of a PhD project at UCL. Before you decide it is important for you to understand why the research is being done and what participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

What is the project's purpose?

Partnerships between healthcare services and legal advice services exist across the country to assist patients with social welfare problems. These partnerships work in many different ways. We want to understand how healthcare services and legal advice services work together and what the partnerships are achieving. This research will help to inform how services can best be delivered.

Why has my service been chosen?

Your service has been asked because it provides social welfare legal advice for patients, or works in partnership with healthcare services. We are seeking services to participate that present varied example of practice.

Does my service have to take part?

Participation is entirely voluntary. If you do decide to take part you will be asked to provide written confirmation of your decision. You can withdraw from the study at any time without giving a reason. If you decide to withdraw you will be asked what you wish to happen to the data you have provided up that point.

What will be involved in taking part?

We will ask you to provide details about the work your service is doing. This will include basic data on the activities of your service, such as referrals received and work undertaken. We will not ask for any personal data on individuals.

We will also ask you to provide any documents you have that describe how the service operates, which could include evaluation reports, service specifications, policies, business cases, funding arrangements or contracts.

We would ask for your help to identify staff who work in the service that could be invited to be interviewed for the study.

What are the possible disadvantages and risks of taking part?

Preparing the information to provide for the study will take some of your time. This should not be long, but we will work with you to understand what is possible.

What are the possible benefits of taking part?

There are no immediate benefits of participating in the project, but it is hoped that this work will help inform how services are delivered across the country for your patients/client groups. It is a chance for you to share your professional experiences and inform future practice.

What if something goes wrong?

If you wish to raise a complaint about the research you should contact the Principal Investigator Professor Rosalind Raine using the details provided above.

What about confidentiality?

All the information that we collect about your service during the course of the research will be kept strictly confidential. The service will not be identifiable in any ensuing reports or publications. Each service will be assigned a code to replace its name in all analysis and reporting.

Limits to confidentiality

Confidentiality will be respected subject to legal constraints and professional guidelines.

What will happen to the results of the research project?

Results will be published in articles and presented at conferences, as well as within the PhD thesis. You will receive written copies of the results when they are available. You are free to contact the research team at any time to ask more about the study findings.

All research data will be stored electronically in UCL secure IT systems. At the end of the project it will be transferred to the UCL Research Data Repository for longer-term storage (10 years, as specified in the UCL data retention schedule). Anonymised information may be shared with other researchers for future research.

Who is organising and funding the research?

The study is being organised by the UCL Department of Applied Health Research with the UCL Faculty of Laws. It is funded by the NIHR School for Public Health Research and the NIHR CLAHRC North Thames.

Contact for further information

Sarah Beardon
1-19 Torrington Place, University College London, WC1E 7HB
Tel: [redacted]
E-mail: sarah.beardon@ucl.ac.uk

Thank you for reading this information sheet and for considering to take part in this research study.

Participant Information Sheet for Interviewees

UCL Research Ethics Committee Approval ID Number: 16061/001

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of Study: Integrating legal advice and healthcare services

Department: UCL Department of Applied Health Research and UCL Faculty of Laws

Name and Contact Details of the Researcher(s): Sarah Beardon (sarah.beardon@ucl.ac.uk) 1-19 Torrington Place, University College London, WC1E 7HB

Name and Contact Details of the Principal Researcher: Professor Rosalind Raine (r.raine@ucl.ac.uk) 1-19 Torrington Place, University College London, WC1E 7HB

Invitation Paragraph

You are being invited to take part in a research study that is part of a PhD project at UCL. Before you decide it is important for you to understand why the research is being done and what participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

What is the project's purpose?

Partnerships between healthcare services and legal advice services exist across the country to assist patients with social welfare problems. These partnerships work in many different ways. We want to understand how healthcare services and legal advice services work together and what the partnerships are achieving. This research will help to inform how services can best be delivered.

Why have I been chosen?

It is important that we hear the perspectives of people working in different roles. You have been asked because you work in a service providing social welfare legal advice for patients, or as a healthcare professional who connects with advice services, or as a manager involved in service delivery or commissioning of legal advice in healthcare.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. You can withdraw at any time without giving a reason. If you decide to withdraw you will be asked what you wish to happen to the data you have provided up that point.

What will happen to me if I take part?

We will ask you to talk to the researcher in an audio-recorded interview, either in person or over the phone, which is likely to take 30-45 minutes (and will not go beyond 60 minutes). The interview will cover topics relevant to your professional role, including your experiences of collaborative working and your views on the value of the service.
You will also be invited to attend an optional participatory workshop with other professionals taking part in the study at a later stage in the project.

Will I be recorded and how will the recorded media be used?
The audio recordings of the interviews made during this research will be used only for analysis and for illustration in conference presentations and lectures. No other use will be made of them without your written permission, and no one outside the project will be allowed access to the original recordings.

What are the possible disadvantages and risks of taking part?
Giving an interview will require some of your time (between 30 and 60 minutes), but we will work to find a time that is convenient for you to meet or speak on the phone. We will not be asking about personal details other than regarding your professional role, and you may stop the interview at any time if you wish.

What are the possible benefits of taking part?
There are no immediate benefits of participating in the project, but it is hoped that this work will help inform how services are delivered across the country for your patients/client groups. It is a chance for you to share your professional experiences and inform future practice.

What if something goes wrong?
If you wish to raise a complaint about the research you should contact the Principal Investigator Professor Rosalind Raine using the details provided above.

Will my taking part in this project be kept confidential?
All the information that we collect about you during the course of the research will be kept strictly confidential. No details will be shared with anyone outside of the research team that could identify you as an individual and you will not be identifiable in any ensuing reports or publications. You will be assigned a code to replace any personal details about you in all analysis and reporting. Your personal details will be kept securely and separately from any information you provide. All data will be collected and stored in accordance with the General Data Protection Regulation (2016) and the Data Protection Act (2018).

Limits to confidentiality
Confidentiality will be respected unless there are compelling and legitimate reasons for this to be breached. If this was the case we would inform you of any decisions that might limit your confidentiality.

What will happen to the results of the research project?
Results will be published in articles and presented at conferences, as well as within the PhD thesis. You will receive written copies of the results when they are available. You are free to contact the research team at any time to ask more about the study findings.
All research data will be stored electronically in UCL secure IT systems. At the end of the project it will be transferred to the UCL Research Data Repository for longer-term storage (10 years, as specified in the UCL data retention schedule). Anonymised information may be shared with other researchers for future research.

Local Data Protection Privacy Notice
Notice:
The controller for this project will be University College London (UCL). The UCL Data Protection Officer provides oversight of UCL activities involving the processing of personal data, and can be contacted at data-protection@ucl.ac.uk

This ‘local’ privacy notice sets out the information that applies to this particular study. Further information on how UCL uses participant information can be found in our ‘general’ privacy notice: For participants in health and care research studies, click here.

The information that is required to be provided to participants under data protection legislation (GDPR and DPA 2018) is provided across both the ‘local’ and ‘general’ privacy notices.

The categories of personal data used will be as follows:

- Name of participant
- Contact details (email and telephone number)
- Signed consent form
- Interview recording

The lawful basis that would be used to process your *personal data* will be performance of a task in the public interest.

Your personal data will be processed so long as it is required for the research project. If we are able to anonymise or pseudonymise the personal data you provide we will undertake this, and will endeavour to minimise the processing of personal data wherever possible.

If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at data-protection@ucl.ac.uk.

Personal data will not be transferred to anyone outside the research team.

Who is organising and funding the research?
The study is being organised by the UCL Department of Applied Health Research with the UCL Faculty of Laws. It is funded by the NIHR School for Public Health Research and the NIHR CLAHRC North Thames.

Contact for further information
Sarah Beardon
1-19 Torrington Place, University College London, WC1E 7HB
E-mail: sarah.beardon@ucl.ac.uk
Tel (personal): [redacted]

You will be given a copy of the information sheet and a signed consent form to keep.

Thank you for reading this information sheet and for considering to take part in this research study.

CONSENT FORM FOR INTERVIEW PARTICIPANTS

Before you agree to take part, the researcher must explain the project to you. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you to decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research (tick as appropriate):

1. I confirm that I have read the information sheet (Version 4, 25/02/2020) for the above study. I have had the chance to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I agree to take part in the above study. ☐
3. I understand the interview will be audio-recorded and transcribed and that and references to personal identifiable information will be removed. ☐
4. I understand that if I decide at any time that I no longer wish to take part in this project, I can notify the researchers involved and withdraw immediately. If I withdraw the information already collected from me will be used in an anonymised format unless I ask for it to be destroyed. ☐
5. I consent to the processing of my personal information by the UCL research team for the purposes of this research study. This includes contacting me to inform me about the study findings. ☐
6. I understand that such information will be treated as strictly confidential and handled in accordance with the provisions of the General Data Protection Regulation (2016) and the Data Protection Act (2018). ☐
7. I understand that the information I provide may be used in an anonymised, non-identifiable format to support other research in the future, and may be shared anonymously with other researchers. ☐

____________________	____________________	____________________
Name of Participant	Date	Signature

Appendix 2C Topic guides

INTERVIEW TOPIC GUIDE – ADVICE SERVICE MANAGERS

I'd like to start by asking a bit about yourself and your work:

Could give me an overview of your current role? (check if advisory role as well as management)
What kind of team do you work within?
How long have you been working here?

DETAILS OF THE PROJECT & HOW YOU CONNECT WITH THE HEALTH SERVICE

History (*if there at the time*)	*When was the partnership set up originally?* *Do you know how it came about / how it got set up?* *Has it been running continuously? Check reasons for any breaks.*
Basic aspects of the project	*Confirm the health setting they're in* *What types of clients do you tend to see at the service?* *What type of advice service? Issues addressed & level of assistance*
Is the advice service based on site in the healthcare location?	*How often are they there?* *How easy is it to be accommodated on site?* *How useful is it to be on site / what difference does it make?*
What are the main routes you get referrals from?	*Could you talk me through how the referral process works?* - *Who makes referrals, how patients identified* - *Referral system (formal method / signposting)* - *Are there other routes in? e.g. self-referral* *How often are referrals made / how much it's being used by staff?*
Is there any information you share with the health service in your daily work?	*What kinds of information:* - *Individuals needs / care* - *Health information to support claims* - *Feedback on advice work / outcomes of claims* *Any difficulties around this?*
Do you ever have joint meetings?	*What kind of meetings are they? How often do they happen?* *What kind of things would you discuss / decide together?* *How useful is it to have these meetings?*
How much interaction would you generally have with health service staff on a day-to-day basis?	*Regular or only sometimes?* *How do you feel about the level of interaction you have? Is that sufficient / would more contact help?*
Are there any other ways you work together on day-to-day basis?	*Check what, how often, how useful*
Thinking about what you've just described, how easy do you find the system of working with the health service?	*Is it all quite clear and straightforward?* *Anything at all that's confusing about the system?*
Are there any particular challenges you find of working in a healthcare environment?	*Anything about your local service setting that can be difficult to fit in with? E.g. busyness, staffing, ways of working,* *Is there anything that might make things easier?*
Within the health service team, how aware do you feel people are of the advice service?	*Does everyone know it's there / how to use it?* *Is it ever advertised / promoted to the staff?* *Do you ever provide training sessions on welfare issues?*

On a personal level, how well do you feel you know the staff in the health service?	*How do those relationships feel? Positive / constructive?* *Anything difficult about working together?* *What difference do these relationships make in your work with them?*
Generally, how close does the link feel between the two services?	*Do you work quite closely together, or is it mostly quite separate?*

MANAGEMENT

Who is responsible for overseeing the project?	*Where does the management come from - Advice? Health? Joint?* *What is their / your role in managing the project?* *Is there anyone championing it on the ground? (promoting, encouraging)*
Are there any formal agreements / contracts between the services?	*If so what are they? What do they contain?* *If not, what is the relationship based on? Informal understanding?*
How is the project funded?	*Check source and length of funding.* *How secure is future funding?*
Do you feel you have all the resources you need to deliver the project?	*Anything else that might help you?* *E.g. Guidance, practical support, training*

YOUR OWN THOUGHTS AND PERSPECTIVES ON THE PARTNERSHIP

How worthwhile do you feel it is to have this partnership with the health service?	*Is it serving an important purpose from your perspective?*
From your perspective, what is the purpose of the partnership with the health service?	*What would you say are the main aims are / reasons for working in a health setting?* *Particular needs it's designed to address for clients?*
How do you feel about working with the health service?	*Are you happy to have that as part of your role?* *Is that something that feels appropriate / acceptable to you?*
Within your own team (Welfare rights advisors), what are the general attitudes towards it?	*Do they seem positive about working with the health service / HCPs?* *Any negative attitudes towards it at all?*

THE DIFFERENCE YOU FEEL THE PARTNERSHIP IS MAKING

Firstly for yourself and your advice team – are there any ways it helps you in your own work?	*Effectiveness? Reach? Job satisfaction?*
Are there any impacts your notice for patients?	*Improved circumstances?* *Care / patient experience?* *Health/wellbeing?*
Do you get any feedback from HCPs about the difference it might be making for them?	*Do you get a sense of whether they value it?* *Time / Workload?* *Addressing needs of patients?*

That brings me to the end of the questions I wanted to ask.

Is there anything you would like to add that you did not get a chance to discuss fully?

INTERVIEW TOPIC GUIDE – WELFARE RIGHTS ADVISORS

I'd like to start by asking a bit about yourself and your work:

Could give me an overview of your current role?
What kind of team do you work within?
How long have you been working here?

DETAILS OF THE PROJECT & HOW YOU CONNECT WITH THE HEALTH SERVICE

Basic aspects of project	*Confirm the health setting they're in* *What types of clients do you tend to see at the service?* *What type of advice service? Issues addressed & level of assistance*
Is the advice service based on site in the healthcare location?	*How often are they there?* *How easy is it to be accommodated on site?* *How useful is it to be on site / what difference does it make?*
What are the main routes you get referrals from?	*Could you talk me through how the referral process works?* - *Who makes referrals, how patients identified* - *Referral system (formal method / signposting)* - *Are there other routes in? e.g. self-referral* *How often are referrals made / how much it's being used by staff?*
Is there any information you share with the health service in your daily work?	*What kinds of information:* - *Individuals needs / care* - *Health information to support claims* - *Feedback on advice work / outcomes of claims* *Any difficulties around this?*
Do you ever have joint meetings?	*What kind of meetings are they? How often do they happen?* *What kind of things would you discuss / decide together?* *How useful is it to have these meetings?*
How much interaction would you generally have with health service staff on a day-to-day basis?	*Regular or only sometimes?* *How do you feel about the level of interaction you have? Is that sufficient / would more contact help?*
Are there any other ways you work together on day-to-day basis?	*Check what, how often, how useful*
Thinking about what you've just described, how easy do you find the system of working with the health service?	*Is it all quite clear and straightforward?* *Anything at all that's confusing about the system?*
Are there any particular challenges you find of working in a healthcare environment?	*Anything about your local service setting that can be difficult to fit in with? E.g. busyness, staffing, ways of working,* *Is there anything that might make things easier?*
Within the health service team, how aware do you feel people are of the advice service?	*Does everyone know it's there / how to use it?* *Is it ever advertised / promoted to the staff?* *Do you ever provide training sessions on welfare issues?*
On a personal level, how well do you feel you know the staff in the health service?	*How do those relationships feel? Positive / constructive?* *Anything difficult about working together?* *What difference do these relationships make in your work with them?*

Generally, how close does the link feel between the two services?	*Do you work quite closely together, or is it mostly quite separate?*

YOUR OWN THOUGHTS AND PERSPECTIVES ON THE PARTNERSHIP

How worthwhile do you feel it is to have this partnership with the health service?	*Is it serving an important purpose from your perspective?*
From your perspective, what is the purpose of the partnership with the health service?	*What would you say are the main aims are / reasons for working in a health setting?* *Particular needs it's designed to address for clients?*
How do you feel about working with the health service?	*Are you happy to have that as part of your role?* *Is that something that feels appropriate / acceptable to you?*
Within your own team (Welfare rights advisors), what are the general attitudes towards it?	*Do they seem positive about working with the health service / HCPs?* *Any negative attitudes towards it at all?*
How supportive do you feel the managers are of the project?	*What's the vibe you get from them?* *Is there anyone championing it? Encouraging / leading?*

THE DIFFERENCE YOU FEEL THE PARTNERSHIP IS MAKING

Firstly for yourself – are there any ways it helps you in your own work as an advisor?	*Effectiveness? Reach? Job satisfaction?*
Are there any impacts your notice for patients?	*Improved circumstances? / needs met* *Care / patient experience?* *Health/wellbeing?*
Do you get any feedback from HCPs about the difference it might be making for them?	*Do you get a sense of whether they value it?* *Time / Workload?* *Addressing needs of patients?*

That brings me to the end of the questions I wanted to ask.

Is there anything you would like to add that you did not get a chance to discuss fully?

INTERVIEW TOPIC GUIDE – HEALTH SERVICE MANAGERS

I'd like to start by asking a bit about yourself and your work:

Could give me an overview of your current role? (check if care-giving role as well as management)
What kind of team do you work within?
How long have you been working here?

DETAILS OF THE PROJECT & HOW YOU CONNECT WITH THE ADVICE SERVICE

History (*if there at the time*)	*When was the partnership set up originally?* *Do you know how it came about / how it got set up?* *Has it been running continuously? Check reasons for any breaks.*
Basic aspects of the project	*Confirm: the healthcare setting they're in* *What types of patients do you tend to see at the service?* *How often do you come across welfare rights issues among patients?*
Is the advice service based on site in the healthcare location?	*How often are they there?* *How easy is it to be accommodated on site?* *How useful is it to be on site / what difference does it make?*
Do you make referrals to the advice service?	*Could you talk me through how the referral process works?* - *Who makes referrals, how patients identified* - *Referral system (formal method / signposting)* *How often do you make referrals / how much do you use it?*
Do you share any information with the advice service as part of your work with them?	*What kinds of information:* - *Individuals needs / care* - *Health information to support claims* - *Feedback on advice work / outcomes of claims* *Any difficulties around this?*
Do you ever have joint meetings?	*What kind of meetings are they? How often do they happen?* *What kind of things would you discuss / decide together?* *How useful is it to have these meetings?*
How much interaction would you generally have with advice service staff on a day-to-day basis?	*Regular or only sometimes?* *How do you feel about the level of interaction you have? Is that sufficient / would more contact help?*
Are there any other ways you work together on day-to-day basis?	*Check what, how often, how useful*
Thinking about what you've just described, how easy do you find the system of working with the advice service?	*Is it all quite clear and straightforward?* *Anything at all that's confusing about the system?*
Are there any particular challenges you find of working with the advice service?	*Is there anything about it that's difficult or awkward for you?* *Any extra time / work involved?* *Is there anything that might make things easier?*
Within your team (HCPs & admin), how aware do you feel people are of the advice service?	*Does everyone know it's there / how to use it?* *Is it ever advertised / promoted to the staff?* *Do you ever receive information / training on welfare issues?*
On a personal level, how well do you feel you know the staff in the advice service?	*How do those relationships feel? Positive / constructive?* *Anything difficult about working together?* *What difference do these relationships make in your work with them?*

Generally, how close does the link feel between the two services?	*Do you work quite closely together, or is it mostly quite separate?*

MANAGEMENT

Who is responsible for overseeing the project?	*Where does the management come from - Advice? Health? Joint?* *What is their / your role in managing the project?* *Is there anyone championing it on the ground? (promoting, encouraging)*
Are there any formal agreements / contracts between the services?	*If so what are they? What do they contain?* *If not, what is the relationship based on? Informal understanding?*
How is the project funded?	*Check source and length of funding* *How secure is future funding?*
Do you feel you have all the resources you need to deliver the project?	*Anything else that might help you?* *E.g. Guidance, practical support, training*

YOUR OWN THOUGHTS AND PERSPECTIVES ON THE PARTNERSHIP

How worthwhile do you feel it is to have this partnership with the advice service?	*Is it serving an important purpose from your perspective?*
From your perspective, what is the purpose of the partnership with the advice service?	*What would you say are the main aims / reasons for working with the advice service?* *Particular needs it's designed to address for patients?*
How do you feel about working with the advice service?	*Are you happy to have that referral role? Should that responsibility lie elsewhere?* *Does it feel like a trustworthy service to you?*
Within your own team (HCPs), what are the general attitudes towards it?	*Do they seem positive about working with the advice service?* *Any negative attitudes towards it at all?*

THE DIFFERENCE YOU FEEL THE PARTNERSHIP IS MAKING

Firstly for yourself as a HCP – are there any ways it helps you in your own work?	*Is it something you value? Does it support you?* *What would be the impact on you if the service was discontinued?* *Time / Workload?* *Addressing needs of patients?*
Are there any impacts your notice for patients?	*Improved circumstances?* *Care / patient experience?* *Health/wellbeing?*

That brings me to the end of the questions I wanted to ask.

Is there anything you would like to add that you did not get a chance to discuss fully?

INTERVIEW TOPIC GUIDE – HEALTHCARE PROFESSIONALS

I'd like to start by asking a bit about yourself and your work:

Could give me an overview of your current role?
What kind of team do you work within?
How long have you been working here?

DETAILS OF THE PROJECT & HOW YOU CONNECT WITH THE ADVICE SERVICE

Basic aspects of the project	*Confirm: the healthcare setting they're in* *What types of patients do you tend to see at the service?* *How much time do you get to spend with each patient?* *How often do you come across welfare rights issues among patients?*
Is the advice service based on site in the healthcare location?	*How often are they there?* *How useful is it to have them on site / what difference does it make?*
Do you make referrals to the advice service?	*Could you talk me through how the referral process works?* - *Who makes referrals, how patients identified* - *Referral system (formal method / signposting)* *How often do you make referrals / how much do you use it?*
Do you share any information with the advice service as part of your work with them?	*What kinds of information:* - *Individuals needs / care* - *Health information to support claims* - *Feedback on advice work / outcomes of claims* *Any difficulties around this?*
Do you ever have joint meetings?	*What kind of meetings are they? How often do they happen?* *What kind of things would you discuss / decide together?* *How useful is it to have these meetings?*
How much interaction would you generally have with advice service staff on a day-to-day basis?	*Regular or only sometimes?* *How do you feel about the level of interaction you have? Is that sufficient / would more contact help?*
Are there any other ways you work together on day-to-day basis?	*Check what, how often, how useful*
Thinking about what you've just described, how easy do you find the system of working with the advice service?	*Is it all quite clear and straightforward?* *Anything at all that's confusing about the system?*
Are there any particular challenges you find of working with the advice service?	*Is there anything about it that's difficult or awkward for you?* *Any extra time / work involved?* *Is there anything that might make things easier?*
Within your team (HCPs & managers), how aware do you feel people are of the advice service?	*Does everyone know it's there / how to use it?* *Is it ever advertised / promoted to the staff?* *Do you ever receive information / training on welfare issues?*
On a personal level, how well do you feel you know the staff in the advice service?	*How do those relationships feel? Positive / constructive?* *Anything difficult about working together?* *What difference do these relationships make in your work with them?*

Generally, how close does the link feel between the two services?	*Do you work quite closely together, or is it mostly quite separate?*

YOUR OWN THOUGHTS AND PERSPECTIVES ON THE PARTNERSHIP

How worthwhile do you feel it is to have this partnership with the advice service?	*Is it serving an important purpose from your perspective?*
From your perspective, what is the purpose of the partnership with the advice service?	*What would you say are the main aims / reasons for working with the advice service?* *Particular needs it's designed to address for patients?*
How do you feel about working with the advice service?	*Are you happy to have that referral role? Should that responsibility lie elsewhere?* *Does it feel like a trustworthy service to you?*
Within your own team (HCPs), what are the general attitudes towards it?	*Do they seem positive about working with the advice service?* *Any negative attitudes towards it at all?*
How supportive do you feel the managers are of the project?	*What's the vibe you get from them?* *Is there anyone championing it? Encouraging / leading?*

THE DIFFERENCE YOU FEEL THE PARTNERSHIP IS MAKING

Firstly for yourself as a HCP – are there any ways it helps you in your own work?	*Is it something you value? Does it support you?* *What would be the impact on you if the service was discontinued?* *Time / Workload?* *Addressing needs of patients?*
Are there any impacts your notice for patients?	*Improved circumstances?* *Care / patient experience?* *Health/wellbeing?*

That brings me to the end of the questions I wanted to ask.

Is there anything you would like to add that you did not get a chance to discuss fully?

INTERVIEW TOPIC GUIDE – FUNDERS/COMMISSIONERS

I'd like to start by asking a bit about yourself and your work:

Could give me an overview of your current role?
What organisation / team do you sit within?
What types of services do you commission (medical and non-medical?)

ABOUT THE PROJECT

Confirm basic details of the partnership	*Healthcare setting* *Type of advice service and issues addressed* *Patient group the service is targeted towards* *How the services connect / System for linking them up (co-location / referral)*
Is the service commissioned under a wider programme of work?	*Organisational strategies / initiatives / service models*
What was the main purpose of commissioning the advice service to work with healthcare?	*Any particular priorities it's designed to address? Overarching aims?*

MANAGEMENT

Could you tell me a bit about how the project is managed?	*Which organisations are responsible for doing what?* - *Where funding comes from* - *Who is responsible for delivering the advice service* - *Who is the advice service accountable to? report to?* - *Who oversees the project? E.g. steering group?* - *Who does the planning and monitoring of the service?*
Are there any formal contracts or agreements in place?	*If so what are they / what do they contain?* *If not, what is the relationship based on? Informal understanding?*
What systems are in place to assure the quality of the advice service?	*Does the advice service need to hold an accreditation (AQS)* *Are there also policies that need to be in place to allow the advice service to work with patients? E.g safeguarding* *Is the service evaluated? How / by whom? Fed back to whom?*

PERFORMANCE / OUTCOMES

What kind of outcomes are you looking for from the service?	*What are the important things you want to see?* - *Work being done / patient needs addressed* - *Patient feedback / experience* - *Staff feedback / support for staff* - *Health improvement* - *Costs savings / return on investment? Reduced HS use?*
According to the information you have, how well do you feel the advice service is performing?	*Are you happy with what it's achieving?* *Is it well used / valued?*
More generally, is there any more evidence you would want to see as a CO about the impacts of financial/legal services?	*Academic evidence – would it be useful?* *Interested in what you value most in your health setting?*

RESOURCING

How is the project funded?	*Source of funding? Length of funding?* *What does the funding cover?* *How expensive is it compared with other services you commission?*
How secure is future funding for the project?	*What does future funding depend on?*
Are there any other resources you need to deliver the service?	*Space / equipment / admin support / training* *Check where those come from and if they have enough*

CHALLENGES

Have there been any obstacles / challenges in delivering this partnership with the advice service?	*For example:* - *Differences in organisational policies / goals* - *Differences in organisation culture / ways of working*
How have those challenges been overcome?	*What has helped?*
Do you get a sense of how things go on the ground, with the services working in partnership?	*How smoothly do you feel that goes?* *How closely do they work together?*

PERSPECTIVES

I'm interested in your perspectives as a commissioner, on commissioning non-health services like this one

How do you feel about that?	*Is it something that you feel is worthwhile? / Is it serving an important purpose in your local health service?* *Is it something you'd want to keep funding in future? How high on the list of priorities?*
What are your thoughts on social prescribing?	*Any benefit of having an in-house service rather than navigating people out?*
If you could summarize, what would you say are the main positives of this partnership?	*Anything you feel is particularly good / works particularly well*

That brings me to the end of the questions I wanted to ask.

Is there anything you would like to add that you did not get a chance to discuss fully?

Appendix 2D Thematic coding framework

	Theme	Description	Sub-theme	Coded content
CONTEXT THEMES - Delivery level	Service features	Characteristics and activities of the services that participate in the partnership	Characteristics of health service	Descriptions of the health service setting, including the type of service (e.g. primary/secondary care), type of team (e.g. MDTs or multi-agency partnerships) and impacts of welfare issues on the health service locally.
			Characteristics of legal service	Descriptions of the legal service, including the type of provider organisation, type of welfare issues addressed (e.g. benefits, housing), staffing arrangements and capacity.
			Work of legal service	Descriptions of the activities of the legal service, including the type of legal assistance provided (e.g. casework, representation), other assistance (e.g. assessment and onward referral), and additional activities within and outside the partnership.
			Characteristics of patients/clients	Descriptions of the patient/client group, including demographic characteristics, welfare needs, health needs and other vulnerabilities, impacts of both health and welfare problems on their personal situations.
	Partnership features	Details of service design and activities of the partnership	Aims of partnership	Descriptions of the aims of the partnership in relation to the immediate outcomes for patients/clients, e.g. improving access to advice and welfare circumstances, addressing social determinants of health, supporting health and wellbeing, improving patient experience.
			Partnership design	Descriptions of how the partnership is designed, including co-location or remote delivery arrangements, geographical area coverage, referral sources and patient/client eligibility.
			Partnership working processes	Descriptions of service delivery details, such as referral mechanisms and appointment booking, data protection processes and integration of IT systems.
	Delivery issues	Issues affecting the operation of the	Service design issues	Descriptions of issues experienced in relation to service design, such as accessibility for patients, efficiency of delivery, and the appropriateness of a given design for the health setting.

		partnership on the ground	Resources	Descriptions of the resource availability for frontline operations, including availability of physical space, capacity to meet demand, staff turnover, learning opportunities and stability of funding.
			Patient engagement	Descriptions of patients' engagement with the legal service, including trust in the service, awareness and help-seeking behaviour, and experience of the delivery mode (face-to-face and remote).
CONTEXT THEMES - Management level	Management structures	The local systems and policies within which the partnership operates	Partnership formalisation	Descriptions of the formal structures supporting the resourcing and oversight of the partnership, e.g. contracts and other agreements, steering groups and other leadership arrangements, funding sources.
			Strategic aims	Descriptions of the aims of the partnership in relation to organisational goals, e.g. supporting health service functioning, reducing costs, adopting collaborative approaches, health promotion and prevention.
			Local health frameworks	Descriptions of the wider local healthcare context, including links with social prescribing schemes and other initiatives, shifting policies and structures.
	Management functions	The management-level activities involved in delivering the partnership	Commissioning activities	Descriptions of how the partnership was commissioned and the role of commissioners, e.g. in designing and developing the partnership, setting goals, procuring services and monitoring contracts.
			Leadership activities	Descriptions of the roles of leaders in delivering the partnership, including promoting and championing the service, brokering relationships, engaging with commissioners and health services.
			Evaluation activities	Descriptions of the evaluation activities being undertaken to look at the performance of the partnership, including the approaches taken, evaluation challenges and outcomes measured.
MECHANISM THEMES - Delivery level	Willingness	Staff attitudes towards partnership and the preparedness to participate in joint working	Sentiment towards partnership	Expressions and behaviours demonstrating attitudes towards the partnership (both positive and negative) and perceived responsibility to engage.
			Perceived value of partnership	Perceptions of the value of the partnership, including the need for the legal service (among patients and staff), the quality of the service provision and the importance of non-medical interventions.
			Alignment with purpose	Judgements of how and whether the partnership was important to the staff in participating services, e.g. alignment with core roles and values.

	Confidence	Staff members' certainty in their own actions and faith in the actions of others	Trust in service	Health and social care professionals' faith in the legitimacy, competence, reliability and quality of the legal service, any doubts in relation to that.
			Quality of relationships	How positive the relationships were between health and legal teams, whether advisors were accepted as colleagues or any difficult working relationships.
			Habits & norms	How familiar, routine, natural or automatic the ways of engaging were for staff members, any uncertainty around new ways of working or confidence in doing the right thing.
	Ability	Staff members' possession of the means and skills to participate in joint working	Knowledge levels	Levels of understanding in relation to the partnership, including awareness of its existence, understanding of the service offer and knowledge of legal needs and processes.
			Opportunities to interact	The opportunities available to team members to come together and communicate, including in formal meetings and day-to-day interactions.
			Workability of systems	The practical feasibility of joint working, including the ease of routine processes, challenges in daily work, time constraints and administrative approvals required for inter-agency collaboration.
MECHANISM THEMES - Management level	Willingness	Funders' and managers' attitudes towards partnership and preparedness to support and fund the initiative.	Sentiment towards partnership	Feelings and attitudes towards the partnership among managers and funders (both supportive and unsupportive) and funders' perceived responsibility to support the service.
			Perceived value of partnership	Perceptions of the value of the partnership, including the need for the legal service, quality of the service provision, importance of non-medical interventions and value for money.
			Alignment with purpose	Judgements of how and whether the partnership was contributing to funders' goals and local policy aims.
	Confidence	Sources of information and evidence contributing to decision-makers' views on the partnership.	Use of evidence	How evidence was used to inform strategic decisions around service delivery, the role and importance of evidence, any unfulfilled wishes for evidence.
			Service profile	The prominence and reputation of the service in the local area and nationally, levels of exposure and recognition.
			Funder-provider relationships	The levels of communication, interaction and familiarity between the Welfare rights advice service managers and their funders, quality of those relationships.
	Ability	The resources available to funders	Funding sufficiency	The levels of funds available and whether these were adequate to support and sustain the partnership.

		and managers to make service delivery possible	Support in kind	Non-financial resources made available to the partnership from the participating organisations, e.g. physical space, equipment, training, administrative support, staff time.
OUTCOMES THEMES	Engagement	Staff members' participation in joint working with the partner service	Collaborative working activities	Actions by staff members to join up provision of health and legal services, including identifying needs (both health and welfare), making referrals, exchanging personal information, contributing jointly to case work, consulting each other and providing feedback.
			Interaction between teams	The levels of interaction between teams, including engagement in communication and dialogue between staff members and extent of personal familiarity.
			Resistant actions	Actions that inhibited collaborative working, obstructive and hostile behaviour, refusal to participate or cooperate.
	Sustainability	The trajectory of the partnership, how long it has continued and whether or not is has survived	Longevity	Records of the project's start date and length of existence.
			Continuity	Records of how the project has continued, whether it has persisted, expanded, contracted or come to an end.
	Impact	The difference that partnership makes to patients, staff and participating organisations	Impacts for patients/clients	The difference the partnership makes for individual patients/clients, including in relation to accessing services, experience of services and changes in personal circumstances (both welfare and health).
			Impacts for staff	The difference the partnership makes for participating members of staff, including in relation to knowledge and expertise, job satisfaction and ability to perform role effectively.
			Impacts for service functioning	The difference the partnership makes for participating organisations, including in relation to reduced service utilisation, return on investment, increased resources, cross-organisational learning and support.

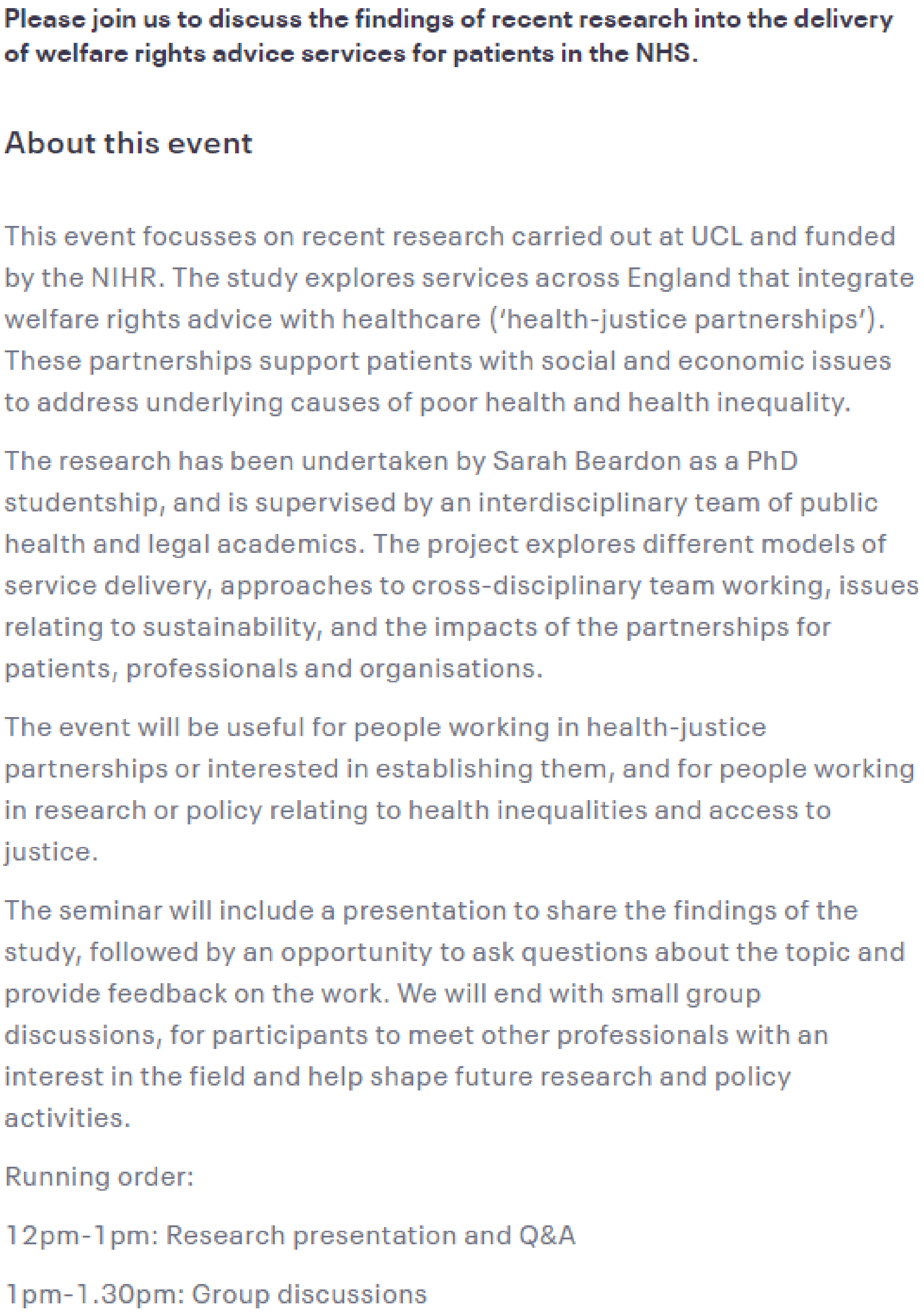
Appendix 2E QCA raw data matrices

CaseID	Collaboration	Communication	Leadership	Commitment
1	0	0	0	0
2	0	0	0	0
3	0	0	1	0
4	0	0	0	0
5	1	1	0	1
6	1	1	1	1
7	1	1	1	1
8	1	1	1	1
9	0	0	1	0

CaseID	Continuity	Leadership	Resources	Commitment
1	1	1	1	1
2	0	0	0	0
3	1	1	1	1
4	0	1	0	0
5	1	1	1	1
6	1	1	1	1
7	1	1	1	1
8	0	1	0	1
9	1	1	1	1

APPENDIX 3 STAKEHOLDER CONSULTATION MATERIALS

Appendix 3A Eventbrite invitation



Please join us to discuss the findings of recent research into the delivery of welfare rights advice services for patients in the NHS.

About this event

This event focusses on recent research carried out at UCL and funded by the NIHR. The study explores services across England that integrate welfare rights advice with healthcare ('health-justice partnerships'). These partnerships support patients with social and economic issues to address underlying causes of poor health and health inequality.

The research has been undertaken by Sarah Beardon as a PhD studentship, and is supervised by an interdisciplinary team of public health and legal academics. The project explores different models of service delivery, approaches to cross-disciplinary team working, issues relating to sustainability, and the impacts of the partnerships for patients, professionals and organisations.

The event will be useful for people working in health-justice partnerships or interested in establishing them, and for people working in research or policy relating to health inequalities and access to justice.

The seminar will include a presentation to share the findings of the study, followed by an opportunity to ask questions about the topic and provide feedback on the work. We will end with small group discussions, for participants to meet other professionals with an interest in the field and help shape future research and policy activities.

Running order:

12pm-1pm: Research presentation and Q&A

1pm-1.30pm: Group discussions

Appendix 3B Talking points for group discussions

<u>Introduction</u>

Thank you for joining us for the discussion.

We would like to hear your thoughts on the issues raised today. This will help us to plan future projects to support people working in the field.

We have two main talking points for the discussion session:

3. How do the results reflect your own experiences?
4. What would you like to see happen in future, to support your work in this area?

We will split the time between those topics and would like to hear from everyone in the room.

As we go around, please introduce yourselves say your role / interest in health-justice partnerships.

<u>Topic guide for facilitators</u>

Please take notes of the responses!

1. <u>How do the results reflect your own experiences?</u>

Prompts if you need to encourage discussion:

Any surprises / agreements / disagreements?

Any remaining questions / issues you feel should be explored further?

What do you see as key issues/ challenges for health-justice partnerships?

5. <u>What would you like to see happen in future, to support your work in this area?</u>

Prompts if you need to encourage discussion:

Is there anything that would help <u>personally</u>? E.g.

- *Peer learning networks*
- *Training*
- *Information resources*

Is there anything that would help <u>locally</u>? E.g.

- *Tools / guidance on service design/ implementation*
- *Tools / guidance on evaluation*
- *More research evidence on a topic*

Is there anything that would help <u>nationally</u>? E.g.

- *Greater awareness*
- *Campaigns for recognition and support*