Ministry of Justice

Evaluation of Integrated Advice Hubs in Primary Healthcare Settings

Progress report

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IFF Research & York Health Economics Consortium

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Glossary of terms

Term	Definition
Advice	In the context of this evaluation, advice refers to a broad range of topics relating to legal or civil issues. This includes first-line advice to in-depth casework, legal representation and consultancy; with support ranging from filling in application forms for benefits, representing people at tribunals, and taking direct action on behalf of individuals.
Advisors	Individuals working for advice organisations (such as Citizen's Advice) delivering advice on a range of topics to the public, usually via one-to-one sessions.
Citizen's Advice	The UK's largest advice giving charity, providing independent advice on topics including benefits, work, debt, housing and immigration. Comprised of a national charity and a network of local charities.
Cost-benefit analysis	Cost-benefit analysis is a comparison of interventions and their consequences in which both costs and resulting benefits (health outcomes and others) are expressed in monetary terms. This approach allows costs and benefits to be appraised consistently.
Counterfactual group	The counterfactual group acts a proxy for what would have happened to beneficiaries in the absence of the intervention, in order to estimate the impact of a specific intervention.
Health-justice partnerships (HJPs)	Partnerships between social welfare legal services and healthcare aim to support individuals with issues affecting physical and mental health, whilst assisting healthcare professionals in managing non-clinical demand. They seek to improve access to legal advice for people most in need, and address underlying causes of ill health and inequalities.

Term	Definition
HJP leads	Individuals who lead or manage the operation of HJPs.
Incremental effect	The difference in a chosen measure of health outcome or effect.
Integrated Care Team	Integrated Care Systems (ICSs) are partnerships of organisations that come together to plan and deliver joined up health and care services, and to improve the lives of people who live and work in their area. The team that delivers this work is often referred to as an Integrated care team (ICT).
Propensity score matching	Propensity score matching is a quasi-experimental method in which the researcher uses statistical techniques to construct an artificial control group by matching the intervention unit with a control group unit of similar characteristics. For further detail please see Appendix B.
Statistical significance	Statistical significance helps to quantify whether a result is likely due to chance. A high degree of statistical significance indicates that the relationship is unlikely to be due to chance.

1. Executive summary

This progress report provides an update on Ministry of Justice's (MoJ) commissioned evaluation of integrated advice in primary healthcare settings from January 2022 to June 2024. Building on the feasibility study published on 15 June 2023,[1] this report provides a progress update on the implementation phase of the evaluation, including interim findings from the research undertaken to date (between June 2022 and May 2023).

1.1 Evaluating integrated advice in primary healthcare settings

The MoJ Legal Support Action Plan[2] outlines a commitment to delivering smarter, better forms of legal support and initiatives. To achieve this, co-locating[3] legal and health support services are identified as one strategy as part of a holistic approach. There is evidence to suggest that 'Health-Justice Partnerships (HJPs)'[4] can "improve access to legal assistance for people at risk of social and health disadvantage; positively influence material and social circumstances through resolution of legal problems; and improve mental wellbeing".[5] To further test and evaluate the provision of HJPs in England and Wales, an external evaluation was commissioned by the MoJ in two stages:

Stage One: A feasibility study, to explore and finalise a suitable methodology for conducting an impact, process and economic evaluation. This phase has been completed and the feasibility study was published online.

Stage Two: An implementation phase, to apply the recommended methodology from the feasibility study. The evaluation is currently in this stage and due to end in summer 2024.

1 Evaluation of Integrated Advice Hubs in Primary Healthcare Settings - GOV.UK (www.gov.uk)

2 Legal Support Action Plan - GOV.UK (www.gov.uk)

3 References to 'co-location' have been changed from the Invitation To Tender to 'Health-Justice Partnerships' and 'Integrated Advice Hubs', reflecting the fact that not all the models explored have advice services sharing physical space with healthcare services.

4 The evaluation uses the broad definition of 'health-justice partnerships' provided by Beardon et al (2021) as the provision of legal assistance for social welfare issues in healthcare settings.

5 Murphy C. Making the case for medical-legal partnerships: An updated review of the evidence, 2013-2020. National Center for Medical-Legal Partnership. 2020

The final report containing the findings from full evaluation will be produced after the implementation phase is completed.

1.2 Recommendations from the feasibility study

The feasibility study (which ran from January to March 2022) recommended the following:

- Explore the implementation and delivery of HJPs through a detailed **process evaluation** which would involve interviews and/or focus groups with HJP leads, frontline advisors, healthcare professionals and clients.
- For the **impact evaluation**, conduct 'before' and 'after' surveys with HJP clients who have received legal advice and a comparison group identified as having similar legal needs. To reduce the bias due to confounding variables, the two groups can be matched using propensity score matching techniques. Qualitative data collected from client interviews for the process evaluation will also be used to validate the impacts observed.
- To conduct the **economic evaluation**, assess the financial and economic costs and benefits of HJPs through a cost-benefit analysis. Qualitative data from the process evaluation will also be used to shape costs and resources interviews with HJP leads, and be triangulated with findings from the economic evaluation to understand how the design of services affects costs.

Further details on the evidence base around HJPs and the primary research (i.e. literature review and interviews) conducted to inform the recommended methodologies can be found in the full feasibility study.[6] Similarly, technical details on the methodological design and risk considerations are outlined in a technical appendix.[7]

[6] Evaluation of Integrated Advice Hubs in Primary Healthcare Settings - Feasibility Study (publishing.service.gov.uk)

[7] Evaluation of Integrated Advice Hubs in Primary Healthcare Settings - Technical Appendix (publishing.service.gov.uk)

Key progress findings

- Intuitive and direct booking systems between Health-Justice Partners were key to the successful referral of patients/clients and the delivery of advice.
- Clients of HJPs tended to be aged 45 or older (65%), female (64%), white (92%), tended to be from E socio-economic grade[8] (55%) and have a long-term health condition (71%).
- Clients most commonly presented with issues to do with government payments (35%) and treatment for mental health issues (31%).
- There is considerable variation in the scale of the service models meaning that the incremental annual running costs range between £7,000 per annum to £225,000 per annum.

The **final evaluation report** will expand on and verify the initial findings outlined above and will be published once this full research is completed.

[8] Socio-economic grade is based on the occupation of the chief income earner within a household. For A this is higher managerial roles, administrative or professional; B is intermediate managerial roles, administrative or professional; C1 is supervisory or clerical and junior managerial roles, administrative or professional; C2 is skilled manual workers; D is semi-skilled and unskilled manual workers; and E is state pensioners, casual and lowest grade workers, unemployed with state benefits only.

2. Introduction

In 2019, the MoJ published the Legal Support Action Plan (the 'Action Plan'),[9] which outlines the department's vision for legal support. The Action Plan commits to delivering smarter, better forms of legal support that prioritise the needs of the person seeking help and are built upon the evidence of what works, in order to support people to resolve their legal problems at the earliest opportunity in the most accessible and effective ways possible.

In the Action Plan, the MoJ committed to test and evaluate the provision of holistic legal support via HJPs, to generate evidence on how this approach can more effectively support earlier resolution of a person's legal problems.

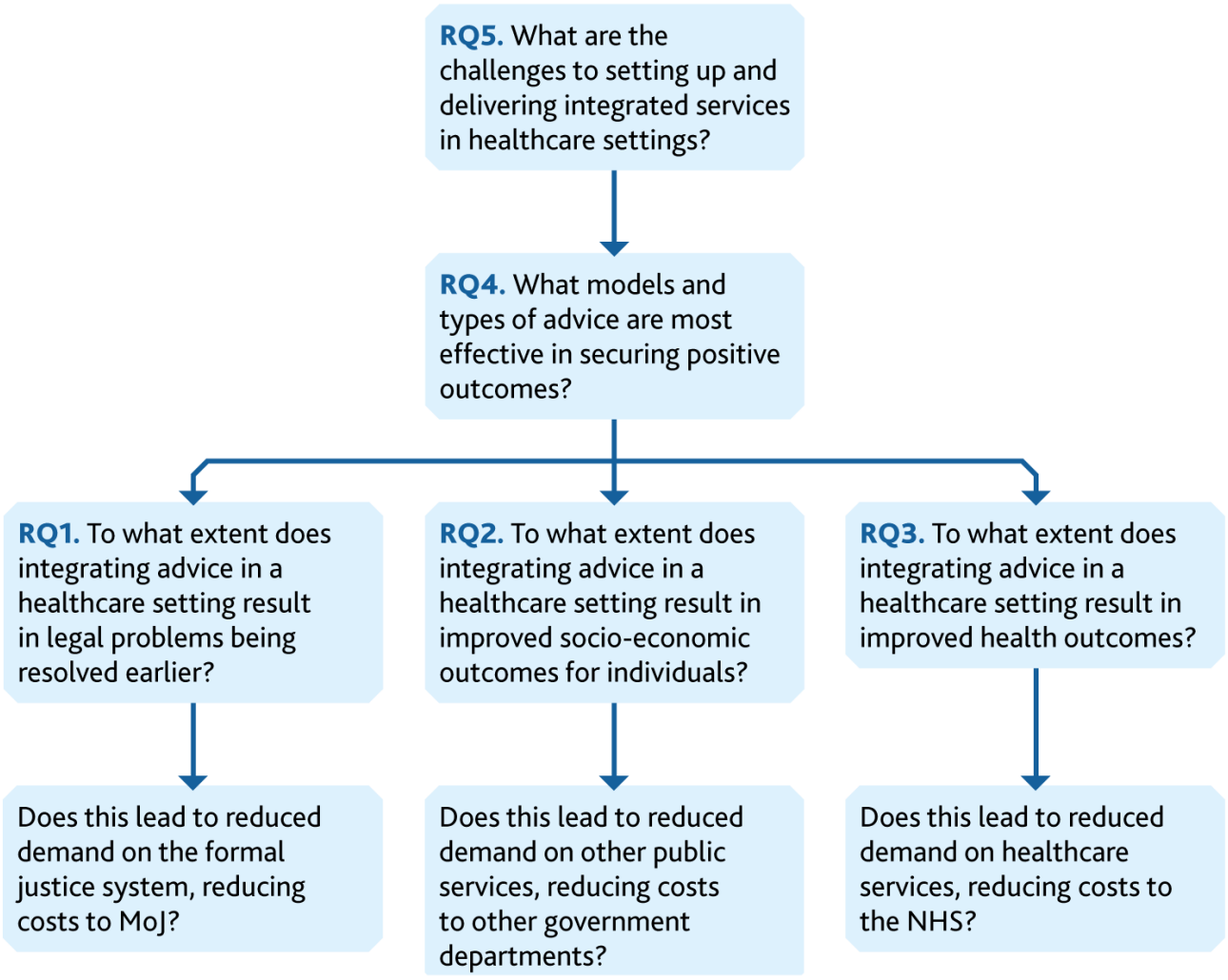
There are various initiatives underway across England and Wales that creatively deliver legal support alongside other services, including legal advice delivered with healthcare, education and criminal justice services. MoJ' is looking to test and evaluate legal support services integrated with primary healthcare settings (e.g. GP practices), referred to as 'Heath-Justice Partnerships' (HJPs) as there are strong links between rights based and health problems. More detail on the nature of health-justice partnerships and the rationale behind them can be found in this evaluation's Feasibility Study.[10]

As the MoJ does not operate these initiatives it wants to understand more about their operation and impact. This is with a view to identifying how to best support such initiatives and to influence policy and practice by gathering learning and best practice on the space they operate in. To achieve this, the evaluation is looking to answer five key research questions, which are presented graphically below.

9 Legal Support Action Plan - GOV.UK (www.gov.uk)

10 Evaluation of Integrated Advice Hubs in Primary Healthcare Settings - Feasibility Study (publishing.service.gov.uk)

Figure 1. MoJ research questions and evaluation objectives



To answer these research questions, the MoJ has commissioned an independent evaluation from January 2022 to June 2024 to meet three specific objectives:

- **Objective one:** Explore implementation and delivery of advice integrated with primary healthcare settings (process evaluation, to address RQ5).
- **Objective two:** Collect evidence and conduct analysis to understand any change in outcomes and, if possible, to what extent are they attributable to the HJPs (impact evaluation, to address RQ1, RQ2, RQ3, RQ4).
- **Objective three:** Use the evidence related to the change in outcomes to determine the financial and economic benefits, including potential economic benefits to Government and wider society (economic evaluation, to address RQ1, RQ2, RQ3).

The evaluation uses mixed method approaches, including qualitative interviews and quantitative survey data, to meet these objectives and answer the research questions. 16 HJPs have kindly volunteered to participate in the evaluation, including 14 Citizens Advice, 1 Law Centre and 1 City Council.

3. The process evaluation

The process evaluation aims to explore the implementation and delivery of advice integrated with primary healthcare settings through qualitative research.

3.1 Key findings

Set-up of HJPs

- The physical presence of advisors in healthcare settings has had a positive impact on working relationships with healthcare professionals and volume of referrals.
- Some HJPs have faced practical barriers to co-location, including issues around a lack of (sufficient funding for) space in healthcare settings, and advisors not being allowed to use the staff facilities.

Referral process

- Intuitive and direct booking systems between Health-Justice Partners were key to the successful referral of patients/clients and the delivery of advice.

Delivery of advice

- Co-location in healthcare settings was seen as key to successful delivery.
- However, being able to deliver advice remotely when required (e.g. during the pandemic, due to lack of available space in GP practices or if preferred by clients) helps maximise the reach of services.

3.2 Methodology

The feasibility study recommended that to gain insight at a high level, the evaluator conducts:

- Two to three depth interviews with **strategic staff** in umbrella body organisations (e.g., the central Citizens Advice office and academics specialising in HJPs)

Then within each of the 3 model types, the evaluator conducts:

- Three depth interviews with **HJP leads or managers** (e.g., local advice clinic CEO)
- Three mini-groups with four to five **frontline advisors** working in HJPs
- 6 depth interviews with **healthcare professionals**
- 20 depth interviews with **HJP clients** soon after they have been had their first meeting with the advisor and then 10 follow up interviews with these participants six months after their first appointment (the smaller follow-up sample size accounts for the expected attrition between interviews).

The feasibility study recommended to conduct the interview / focus group recruitment and analyses by three model types[11] based on whether advisors were co-located on-site in the healthcare setting, and by the nature of their referral process from the healthcare setting to the advisory team. However, the process evaluation findings were not analysed against the three models as the depth interviews found more nuance and variation in operational structures than initially envisaged, as advice services tailor their services to their clients. As such, analysis has **focused on the key barriers and enablers of successful delivery.** See Appendix A for further detail and case studies that illustrate the variety of operational structures among the participating HJPs.

Note that outcomes and impacts of HJPs will mainly be assessed through the baseline and follow-up surveys which are being conducted as part of the impact evaluation. Appendix C outlines some qualitative evidence identified on outcomes for clients, healthcare professionals and the wider Health-Justice systems.

[11] These were identified as: 1) A co-located HJP that uses a structured consultation booking system and shares information 2) A co-located HJP that uses a consultation booking system and 3) A HJP that is not co-located but does use a structured consultation booking system and shares information.

3.3 Progress to date

As the process evaluation analysis is no longer structured by model type, it has become less pertinent to complete interviews with all audience groups within each HJP. Whilst the overall targets have remained the same, fieldwork has not been divided by model type. There were also challenges around availability, which were most apparent in HJPs that involve a minimal number of advisors and GP practices.

The targets for each of the professional audience groups have either been met or are close to being met. Fieldwork with clients has been slower than anticipated, due to a smaller number of survey completes (from which participants for the qualitative interviews are recruited). See chapter 4 for more information.

Given that participants are somewhat self-selecting, there is the possibility that the views expressed by participants are particularly positive or negative. However, given the number of interviews achieved, the impact of this is likely be minimal.

The table below outlines the number of interviews and focus groups achieved to date against the targets. The analysis in this report is based on a smaller number of conversations, due to fieldwork progress at the time of writing. These figures are also included in the table below.

Table 1. Number of completed interviews and focus groups across 13 HJPs

	Strategic staff in umbrella organisations	HJP lead interviews	Advisor interviews or mini-focus groups	Healthcare professional interviews	Client interviews
Total completed by 28th June 2023	3	9	9 (20 participants in total)	16	36
Total included in the analysis for this report	3	9	9 (20 participants in total)	10	21
Target	3	9	9	18	60 baseline interviews[12]

[12] The aim is to complete 60 baseline interviews with clients, and 30 follow-up interviews from the same sample roughly three months after the first interview. The follow-up interviews will explore longer-term

3.4 The set–up of HJPs

This section covers the key barriers and enablers to the successful set up of HJPs, as described by stakeholders, HJP leads, advisors and healthcare professionals.

Advocates within healthcare are key to enabling patient referrals

In many cases, the set-up of HJPs has involved considerable time and effort from individuals who believe in the value of HJPs, and who have the professional skills and local connections to drive projects forward. For example, in Solihull, the idea behind one of the projects initially developed from informal conversations between a local Citizens Advice advisor and GP who were both professionally interested in the social determinants of health and were inspired by another local project in which legal advice was available to patients in a GP practice.

> "[The set-up requires] someone to constantly push."
>
> **Strategic staff – HJP trustee**

One stakeholder described a similar process, having set up a HJP in their area. She personally championed the project and faced challenges around access to space and lack of buy in from influential healthcare professionals. However, when the service was eventually up and running, other local GP practices saw its success and wanted to get involved or set up similar services themselves.

Connecting with the local community and wider Health-Justice system facilitates trust and utilisation of legal advice services

Citizens Advice's reputation and position in the justice system enables them to build, maintain and utilise relationships with actors in the wider Health-Justice system, such as

impacts for clients' who have received support from a HJP. The findings from these interviews will be included in the final report due to be published in June 2024.

with Primary Care Networks (PCNs), Clinical Commissioning Groups, Local Authorities and voluntary sector organisations.

> "CA is unique. It is known and trusted."
>
> **Strategic staff – HJP trustee**

This was also felt by HJP leads to be important in securing funding (which in many cases is awarded by PCNs), facilitating productive conversations with colleagues in the wider system to share knowledge and ideas, and to ensure awareness of local services and organisations that they can signpost clients to. Healthcare professionals also mentioned the need to build relationships with local organisations and services so that together they can ensure patients receive the help they need in their community.

> "You can see what the local need is and then you can have a service that meets that local need."
>
> **Healthcare professional**

Varying contracts and funding arrangements impact service efficiency and continuity

Several HJP leads reported that funding for their HJP had changed several times since implementation. They felt that this resulted in their services being rolled out in a 'piecemeal' way over time, which negatively impacted the efficiency and continuity of service delivery.

One of the HJP leads observed that a lot of the funding they have received has been in response to political crises rather than due to a long-term governmental policy, which has made planning strategically for future delivery of services very difficult. There was a clear demand for more investment into the longevity and financial sustainability of HJP services.

Several stakeholders and HJP leads mentioned the difficulties with securing funding in a constantly evolving health system, where new statutory boards are established with different roles, responsibilities and ways of working (e.g. Integrated Care Boards which

succeeded Sustainability Transformation Partnerships were introduced in July 2022 to take over the NHS commissioning functions of Clinical Commissioning Groups).

3.5 The referral process

This section covers the key barriers and enablers the successful referral of clients from the health partner to the justice partner, as described by stakeholders, HJP leads, advisors, healthcare professionals and clients.

Co-location

All of the HJPs had some physical presence in healthcare settings before the Covid-19 pandemic. HJP leads and advisors generally agreed that the presence of advisors in healthcare settings has had a positive impact on working relationships with healthcare professionals, and as a result, on the volume of referrals.

Co-location enables higher volume of referrals

Several HJP leads and advisors described co-location as a visual reminder to healthcare professionals and patients of the service they provide. During periods of co-location, the physical presence of an advisor in the healthcare setting anecdotally translated into higher numbers of referrals.

In one HJP, a coffee kiosk next to the advisors' office within the healthcare setting encouraged patients to seek legal advice before or after a medical appointment.

> "Particularly for elderly people, [they] would come in there, have a coffee and by conversation they would know that I'm sitting around the corner. And they can pop in if they've got a letter they don't understand or whatever."
>
> **Advisor**

During the various lockdowns in the Covid-19 pandemic, many of the advisors worked from central offices or at home and supported clients virtually. HJP leads suggested that referral volumes decreased during this time due to the advisors' lack of visibility in the healthcare settings. A misconception that Citizens Advice was closed due to the

pandemic, and the increased pressure on healthcare staff, also contributed to decreased referrals during this time.

In initial interviews conducted for the feasibility study in 2022, many advisors explained that despite healthcare settings having returned to some level of normality since the various Covid-19 lockdowns, they had not returned to GP practices. This was largely due to continued concerns about Covid, which made it difficult for many patients to see a doctor face-to-face or to physically visit a healthcare setting.

In addition, some reported GP practices no longer having space available for them due to rooms being rented to other organisations and services at a higher fee. This suggests that some ties between the Health-Justice partners were negatively impacted by the lack of co-location during the pandemic and that these needed to be re-built to facilitate more integrated ways of working.

> "We've not been seen in centres for two years now which makes it very difficult… still trying to get those referrals… we need to effectively re-establish partnerships [post covid]."
>
> **HJP lead**

In the interviews conducted for the process evaluation in 2023, these issues did not feature as prominently, with many advisors having returned to co-location, or operating a hybrid service with similar referral processes and volumes to pre-pandemic.

Co-location enables ease of access to legal advisors

HJP leads explained that co-location enables advisors to reach clients that they otherwise would not be able to. This was attributed to the lack of stigma around going to a GP practice in comparison to a legal advisor's office.

> "No one attended CAB sessions in village halls because there is a stigma. There is no stigma around GP surgeries."
>
> **Strategic staff – HJP trustee**

GP practices are generally localised and embedded in communities, which makes them easy to access for everyone. In addition, many clients will already be attending the GP practice as patients. This enables people in rural areas where public transport is often poor to access advice easily as well as those who do not have personal transport (e.g., older people). This was felt to be particularly important now, during the cost of living situation, as many cannot afford additional trips via public transport or taxis.

> "We reach people in surgery who we wouldn't ever get to if we just relied on our office… it's about being where people need us to be… people cannot afford taxis to go to things. They struggle to get taxis for GP appointments."

HJP lead

Healthcare professionals echoed this view, suggesting that patients find the provision of legal help in the healthcare setting most accessible. One stakeholder highlighted that the ease of access and continuity of care enabled by co-location encourages patients to attend appointments and, in some cases, can prevent them from needing to repeat their story to multiple professionals.

> "Place matters... half the time people don't show up for referrals. You need to bring services to them in the same place and you need the consistency of agency to facilitate the handover. So people really don't need to tell the story again… the whole thing just becomes more efficient, more integrated."

Strategic staff – national body for law centres

Referrals from healthcare professionals enables ease of access to legal advisors, even when advisors are not co-located

Many clients spoke positively about the ease of access to advisors that are co-located in healthcare settings. Notably, in many cases, clients suggested that it was the referral from primary care that really enabled their access to legal support. This is because for many people, a GP is the first person they consider contacting when they need support, and because GPs are considered trusted sources of support.

> "My GP is my first point of contact. I speak to my GP every week, because she [helps to] support my mental health. Talking to her was much easier than anyone else."
>
> **Client**

This was particularly significant for those least able or likely to seek support in other ways (e.g., people with severe mental or physical health issues, people with poor digital literacy, and people who are geographically isolated). Some clients suggested they would not have accessed the necessary and beneficial support if they had not been referred or signposted by a healthcare professional.

> “If I didn’t ask my GP questions, I would have not got this link. It was very good that [the GP practice and advice organisation] were linked together so that people that need help can be [referred to the advice organisation] and can get the necessary help they need.”
>
> **Client**

Signposting materials can enable access to legal advisors during periods when advisors are not co-located in healthcare settings

During periods of time that advisors have not been physically present in healthcare settings (e.g., due to the Covid-19 pandemic), the materials used to signpost patients to legal support services, such as posters and short videos, successfully enabled patients to seek support from advisors.

Although the CA branding is viewed by many as a trusted source of impartial advice, CA advisors also suggested that it can negatively impact the volume of referrals, as there are some misconceptions and mistrust among patients and the public around the delivery (and therefore quality) of advice by volunteers, and the organisation’s perceived lack of independence from government. However, this sentiment was not shared by the clients who were interviewed.

Requirement for advisors to travel can be a barrier to successful co-location

HJP leads also mentioned the burden on advisors who are required to travel to multiple sites a week and maintain relationships with many different individuals and teams. As such, the role was described by some as being transient.

Collaborative working

A key enabler of success, as described by all parties involved in the set-up and delivery of HJPs, is the ability to foster and maintain a collaborative way of working between the legal and health partners, as well as with other professionals in the local community and wider Health-Justice system.

Co-location enables relationship building between Health-Justice partners

The physical presence of advisors in healthcare settings was described by all parties as an opportunity to foster and maintain effective relationships by enabling individuals to get to know one another in person and become familiar with each other's ways of working, including systems for referral.

Multidisciplinary meetings support effective referrals

Some HJPs reported hosting regular multidisciplinary meetings to discuss patients' needs in a holistic way and organise their care plans. Representatives from a range of organisations are often in attendance, including social workers, occupational therapists, link workers and Citizen Advice advisors.

These meetings offer an opportunity to share information about patients and make 'warm' referrals to multiple organisations at the same time. In this way, many healthcare professionals and advisors described feeling that they support efficient referrals. They also explained that these meetings provide forums for ongoing discussions about the impact of referrals and patient outcomes. However, not all advisors or HJP leads felt that

multidisciplinary meetings are needed. In these cases, they felt that referrals could effectively be made via shared booking systems or secure email.

Advocates within healthcare are key to enabling referrals

Support from the practice manager and/or GPs and admin staff, was felt to be particularly necessary to enable referrals. HJP leads and advisors reported that the majority of referrals come from GP practices in which the practice manager and/or other senior individuals are outspoken in their support for the project. For example, in one HJP, the lead and advisor manager explained that around 90% of referrals are received from one of the three practices involved with the project, and they attributed this to their good working relationship with the practice manager there.

> “[The implementation of the service] is an uphill struggle if [healthcare professionals] aren't on board.”
>
> **HJP lead**

Lack of awareness of the HJP services prevents referrals

A lack of awareness or knowledge among healthcare professionals of the services provided by advisors was felt to be detrimental to the volume of referrals. Some healthcare professionals attributed their lack of awareness to a lack of signposting and/or communication about the services in their workplace. In some HJPs, this lack of awareness among individual healthcare professionals has translated into a lack of awareness among patients.

> “It’s not really advertised… I didn’t have a clue anything like that was available.”
>
> **Healthcare professional**

This emphasises the value of advisors being physically present in healthcare settings to make clear their role and how they can help both staff and patients, something which was felt by several HJP leads to be crucial in increasing referral numbers and achieving the desired outcomes for patients/clients and the wider Health-Justice system.

> "Our service could save [healthcare professionals and PCNs] substantial amounts of money… [but it is] not on their radar."
>
> **HJP lead**

One stakeholder suggested that advisors can raise awareness among healthcare professionals by running training sessions with them to explain what the advice organisations can help patients with and how healthcare professionals can refer patients to them. Healthcare professionals expressed an interest in this, as they felt it would help ensure they refer the right types of clients and are utilising the advice organisations' services as much as possible.

> "There could be better training. It could be more publicised rather than just the one-off training that we've received."
>
> **Healthcare professional**

However, in practice, training healthcare professionals around their role within the HJPs largely depended on the HJP leads' personality, connections, and proactivity. One lead reported they had not provided any training for healthcare staff in over 14 years, while another reported being heavily involved in the registrars' regular training curriculum, and in a programme for recently qualified GPs.

Booking systems

All professional groups suggested that intuitive and direct booking systems between the Health-Justice Partners are a key enabler of successful referrals. Many felt that sharing basic information about the patient at the referral stage is sufficient, whilst some felt that receiving more information would better enable them to support clients.

Simple and direct systems enable efficient referrals

In some HJPs, where an advisor is most commonly physically present in the healthcare setting, the healthcare professionals can view an advisor's calendar and book in an appointment for a patient directly. In some cases, GPs or nurses book the appointments for patients, but in other settings, this process was managed by GP receptionists, freeing up GP time.

> "It's really easy, I don't really even have to make a referral, I just tell the patient to ask the receptionist for an appointment."
>
> **Healthcare professional**

Several healthcare professionals suggested that these direct booking systems are particularly helpful in that they give authority to the referrals: meetings are booked and treated the same as medical appointments. In addition, this system prevents the onus being on patients to make their own appointments. Reminder messages from the surgery have also helped to prevent non-attendance.

> "It feels joined up and there is authority behind the referrals both ways."
>
> **Healthcare professional**

In other HJPs, healthcare professionals send the necessary information about a referral via secure email to the advice organisations' administrator or an advisor who then arranges the appointment with the client. This was felt to work well because it provides an opportunity to 'triage' clients and prioritise urgent cases, book appointments in line with clients' needs and preference (e.g., location, mode and length of appointment), as well as give time to advisors to prepare for appointments in advance.

In one HJP, clients are required to call a specified number to make an appointment with an advisor. Importantly, if a prospective client found the advisors' number through word of mouth (as opposed to through a referral from a healthcare professional), the designated admin support worker would redirect them to the main CA advice line. This is to ringfence the HJP service for those who are least able to access support in the standard ways.

> "I see people who otherwise wouldn't access support - they are reluctant or wouldn't have thought of it or are too ill to think of it. For people who are likely to seek help, there are lots of ways - like the internet… [The people referred to me tend to be] people who can't stay on the phone long enough or are not digitally literate. They are at the end of their tether and don't think anyone is going to help. I see a lot of very vulnerable people - more vulnerable than those who can wait in a waiting room at CAB [head office]."
>
> **Advisor**

Automated referral systems were described as helpful in that they reduce the administrative burden on healthcare professionals but also challenging in that they increase the demand for appointments, which advisors are not always able to meet. Referral processes with many steps (which were mostly mentioned in relation to other referral pathways within the health service or onwards referral processes) were felt to work less well.

Importance of data sharing and consent for the referral process

In all HJPs, some information about the client is shared (with consent) between partners when a referral is made. This usually includes basic contact details, and in some cases a brief description of the issues faced. In many cases, this is felt to be sufficient because clients' issues and needs are explored fully in advice sessions.

Medical information is often not provided because it is classified data and therefore requires some form of data protection agreement (varying by location and local rules) to be in place between health and legal partners. Some HJPs suggested that the need for, or lack of, data sharing agreements is a barrier to fully integrating services, as professionals are unable to discuss patients' needs with staff from other services. Where data sharing agreements are in place, advisors can access patient information directly without needing additional support from surgery staff.

Some healthcare professionals working in Integrated Care Teams (ICTs) that refer patients to Citizens Advice, reported wanting more information about patients' needs from

the original referrers (who are most often GPs). They felt that this would improve the efficiency of onwards referrals and minimise the need for back and forth between parties. However, information sharing between parties may also be dictated by legal and client privilege, and the role this plays in data sharing will be reflected on in the final report.

> “I have to read between the lines [on the referral notes] and it makes it difficult [as I have] to go back and ask questions if something is missing.”
>
> **Healthcare professional**

Clients had mixed preferences about the type and amount of information shared between organisations. Some favoured advisors not knowing their personal circumstances prior to meeting as this meant they could explain their situation in their own words, which helped to build trust. Others felt that it may have been beneficial for advisors to know some background information about them prior to meeting as this avoided the need for them to repeat their story, which may include disclosing sensitive issues.

> "When they called back and we started going through the information, the fact that they knew my name, they knew why I was calling, and they knew why I had a problem, made me much more at ease, [and felt better] than [them] saying ‘I've been given your name, what's the problem?’”
>
> **Client**

Staff capacity

A lack of capacity among staff was felt by many to be a key barrier to the effective referral of patients from health partners to legal partners.

Reduced capacity in the wider health system due to the pandemic and cost of living situation is a barrier to referrals

Healthcare professionals reported a lack of capacity to facilitate referrals during the pandemic due to pressures on the health system overall. More recently, they spoke of limited capacity due to facing a backlog of patients since the pandemic. They mentioned needing to go above and beyond their role description and/or rostered hours in order to

facilitate the effective referral of patients to legal partners. This includes the time needed to develop and maintain collaborative working relationships with advisors.

While HJP leads and advisors acknowledged that healthcare professionals require sufficient time to make referrals within appointments, they also felt strongly that their services could help to take some of the pressure off healthcare professionals. For example, advisors provide time for non-medical issues to be discussed outside of GP appointment time, and when resolved, have the potential to positively impact a clients' medical issues and reduce their need for GP support. This sentiment was also shared by healthcare professionals who described being able to spend more time on medical issues with patients as a result of the support offered by advisors.

> "With my agenda I should be thinking about mental health and offering counselling but I can't get to that because I'm talking [to patients] about disputes with neighbours... now I can pass that on to someone else who can help… I have fewer consultations and they are quicker."
>
> **Healthcare professional**

3.6 The delivery of advice

This section first describes the types of issues and advice clients received from HJPs. It then covers the key barriers and enablers to successful delivery of advice, as described by stakeholders, HJP leads, advisors, healthcare professionals and clients.

Types of issues and advice

HJPs reported providing advice and support for a wide variety of issues. However, the main types of advice offered by HJPs tended to be the same across the board: issues to do with benefits, housing and rent, and debt and finances.

Most HJPs provide advice around issues to do with benefits, housing and rent, and debt/finances, with a recent increase in the need for support around food and fuel

All advisors who took part in the research said they commonly signposted or referred clients on to other services. One HJP lead explained that if the client was capable, they

just signposted them to other services; if they were in a more vulnerable situation, they acted on their behalf, reaching out to the appropriate organisations themselves.

Onward referrals/signposting enables advisors to provide effectively support the diversity of clients' needs

Signposting and referring onwards from advisors may happen internally or externally. Internally, many CA advisors refer clients on to in-house qualified debt case workers and energy specialists. In addition, they often refer clients to the general CA advice service for further issues once the issue they originally presented with has been resolved. Externally, advisors may signpost clients on to specialised local charities, national charities, or further government support and advice.

Only one HJP had a formalised approach to referring clients to other organisations through a secure online portal, however this was not always used due to the time required to make the referral this way and given frustrations that the portal does not save client details.

One HJP lead explained that their advisors only make 'warm' referrals (as opposed to signposting) to avoid clients feeling as though they are simply being sent from one organisation to another, often without efficient problem resolution.

> "We never just say 'sorry that's not us'… [We want to avoid] sending the most vulnerable from pillar to post."
>
> **HJP lead**

Delivering advice in co-located settings

Most HJPs were at least partially co-located in GP practices or healthcare centres. This co-location is felt to support the continuity of care for patients. However, space within GP practices continues to be limited since the Covid-19 pandemic, with some HJPs struggling to return full time (or at all) to a co-located service.

Most HJPs were at least partially co-located in GP practices or healthcare centres. Co-location was seen by staff as key to successful delivery (as described above).

Some healthcare professionals and advisors described feeling that co-location supports the continuity of care for patients. They suggested that the referral from a healthcare professional, alongside the co-location of the advisor, encourages clients to treat advisor appointments as medical appointments. In this way, some patients are more open to receiving help from advisors (and financial support) because the appointment is viewed as a means to support their overall health.

> “[The benefit of being co-located is that] people feel as though [seeing an advisor] is part of an improvement to their health... they don’t feel they have gone somewhere with a begging bowl, they feel its ok to [seek help] because the doctor has said it’s what they need and they respect a doctor... it becomes part of the health service, so it's more acceptable to a lot of people.”
>
> **Advisor**

Some clients echoed this view:

> "[The advice appointment was in a location] that I associate with positively, in that [it is where] I'm being looked after for my illness."
>
> **Client**

Limited space in GP premises is a barrier to advice delivery in co-located settings

GP premises have become places for delivering a great variety of services and treatments, meaning finding available space within them has proved more and more difficult. Several HJP leads explained this was made worse by the pandemic, as available space is now used for vaccination rooms and Covid patients’ rooms. This issue featured less prominently in interviews conducted in 2023 compared to in 2022. However, a couple of HJP leads pointed to the rise of the social prescriber role being linked to a lack of room in GP practices for advisors, as available space is now often reserved for social prescribers belonging to the practice.

Further practical co-location issues experienced by one of the HJPs were around accessing staff toilets, securing IT support, and using Wi-Fi and printers. These issues

have been compounded somewhat by the cost of living situation, as GP practices are required to further minimise outgoing costs.

One of the leads perceived such difficulties in finding physical space within healthcare settings as being directly linked to a lack of awareness/buy-in around the service.

> "I think the key thing really is if GP surgeries could understand the value of advice and how it can influence health outcomes, I think they'd be more willing to give up space for it."

HJP lead

Delivering advice remotely

Given the limitations on space in GP practices, many HJPs are operating a telephone-based advice service. An advantage of this, is that it can be more cost effective and reach more clients than solely co-located services. However, many clients still prefer face-to-face communications. Advisors suggested that the appropriateness of a specific mode of delivery is largely dependent on the nature of the conversation and the issues clients need help with.

Telephone-based advice services can be cost effective and reach more clients

Delivering advice remotely was felt by some stakeholders and HJP leads to be a cost-efficient way to assist as many patients as possible, especially across large geographical areas. One advisor explained that clients appreciate the fact that the service is provided through telephone as they often are not well enough to attend a face-to-face appointment.

> "It [becoming a telephone service] allowed us to open it to every practice in the county and there are now about 120 practices and branches who actively refer in."

HJP lead

Being able to deliver advice remotely when needed was seen as positive by hybrid HJPs, too. One HJP lead commented that this allowed for more flexibility in terms of triaging calls and only having face-to-face appointments when required, which led to less busy waiting

rooms. This is particularly important given that for many patients, it is still difficult to make a face-to-face appointment with a GP since the Covid-19 pandemic.

Clients' have varied preferences about the delivery of advice

Clients were generally very positive about their experiences of receiving advice, both face-to-face and remotely. They found the advisors to be friendly, supportive and knowledgeable. This was particularly reassuring for some clients who mentioned feelings of shame around accessing support.

> "[CA] is a fantastic service they offer and they're friendly, want to listen to you and help…it's absolutely amazing."
>
> **Client**

> "Their knowledge is just amazing. They knew instantly…'you can get this help and we can signpost you to here.'"
>
> **Client**

Some patients, particularly those with mental health issues, or with concerns about anonymity, reported preferring remote advice sessions. Others felt that face-to-face sessions enabled them to open up to advisors more easily. Some clients acknowledged that the appropriateness of a specific mode of delivery depended on the nature of the conversation and the issue they needed help with.

> "I think for the initial bit, just explaining my circumstances, it was absolutely fine over the phone, [especially] considering I don't really like leaving the house, and I don't like being in new different environments… After about a month or so, I did physically go and see CA to [get] help with forms, as I don't think this is something they could have helped with over the phone."
>
> **Client**

Staff training

Most commonly, CA advisors only undertake standard CA training. Many reported feeling content with the standard of this training. In HJPs that are funded through social prescribing funds, advisors also undertake NHS compulsory training.

Standard CA training supports frontline advisors to deliver advice effectively

CA advisors generally reported being trained to the same level as all CA advisors working at “standard” CA settings. Specific topics that advisors were trained on varied across HJPs, but included safeguarding training, shadowing colleagues, and basic training around debt, housing, welfare benefits, completing forms, and how to challenge decisions. One HJP lead said their advisors received some external training on housing issues.

Advisors generally reported feeling content with the standard of training they received.

> "As generalist advisors we go through a fair bit of rigorous training beforehand."
>
> **Advisor**

Changes in training requirements for social prescribers contribute to inefficient service delivery

In a couple of the HJPs, specific projects are funded through social prescribing (SP) grants. In these cases, CA advisors deliver information and advice in a slightly different way to usual. They listen to all the needs of a client and discuss options for seeking support in their local community. They can signpost or refer clients to organisations or activities nearby and within CA e.g. a specialist debt advisor.

Advisors in these roles undertake NHS compulsory training, including training on motivational interviewing, personalised care agenda, and support plans. Such training was described as being significantly different from the standard CA training. However, they also reported some duplication between the compulsory training modules.

One HJP lead explained that training requirements for SPs change frequently as new guidance develops, which makes it difficult and time consuming to ensure advisors have completed the required training.

> "Every time the government changes the contract, there is more and more training that needs to be done. The challenge is knowing what training needs to be done. It could be clearer and laid out at the beginning."
>
> **HJP lead**

Staff capacity

Many HJPs reported issues around staff capacity, such as the reduction of volunteers since the Covid-19 pandemic, and the negative impact this has on delivering advice to clients, including longer wait times.

Lack of staff is a barrier to delivering advice across HJPs

Issues around staff capacity were common across HJPs. In some cases, these appeared to have been compounded by the pandemic and the cost of living situation , with HJPs experiencing high levels of staff turnover and a lack of volunteers at the same time as a steep rise in demand. One HJP reported a 75% drop in the number of volunteers following the pandemic. They attributed this drop to people having to give up volunteering to take up part-time jobs due to the cost of living and insufficient pension funds, and/or re-evaluating their priorities in life (e.g. relocating to be able to spend more time with family).

These issues have resulted in longer waiting times for clients, the majority of whom waited between one and two weeks for their first appointment with an advisor after their referral. This is longer than the target wait time of two to five days suggested by many HJPs. Some HJPs felt they were unable to help people in a timely way and that they were struggling to keep up with demand.

> "So what's happened is we've had a massive backlog in our advice giving and we have found it difficult to help people in a timely way that will have an impact on our referrals and our reputation with the referrals with the health providers."
>
> **HJP lead**

However, it is worth noting that clients interviewed did not perceive wait time to be an issue and only a few had to wait longer than two weeks for their first appointment.

Some HJP leads highlighted that newly developed social prescriber roles have also led to an increased volume of referrals to their HJP. They commented that they struggle to manage this increase in demand given that their funding (and therefore their staff capacity) has not increased proportionately.

Staff capacity can also be affected by requirements to attend NHS meetings and to produce quarterly reports to their Clinical Commissioning Group (CCG). A couple of HJP leads saw these as a waste of time and resources.

> “It's just a waste of resource, a waste of time, valuable time. So that's the challenge that we faced. You know… we're not the NHS, we're a service. We've been brought in to do it. Just let us do that bit… We don't want our caseworker spending hours a week in a meeting. We want them in with the patients... that's *where* the value is.”
>
> **HJP lead**

One of the HJPs commented that a lack of resource negatively affected their HJP’s ability to pre-empt problems and to strategically plan for the long-term future of the service.

Funding

Inadequate long-term funding was mentioned by many HJP leads as being a key barrier to the successful delivery of their services.

Lack of (long-term) funding is a barrier to delivering advice across HJPs

A lack of funding was mentioned by most HJPs as being a major barrier to successful delivery of advice services. One HJP lead admitted their projects were operating at a loss, with another complaining that funding had not increased in line with the cost of providing services.

> "Costs have gone up but our grant has remained the same and we are expected to deliver the same service."
>
> **HJP lead**

Funding was in some cases felt to be inadequate. For example, one HJP lead explained that while social prescribing services are directly funded by the NHS, this only covers the salary of the actual employee, not all other related expenses, such as ensuring adequate supervisor support and admin support.

In one case, CA advisors found it difficult to refer clients on to other local organisations, due to the latter being severely underfunded.

> "Social prescribing is about linking a patient to an organisation. There isn't any funding where we are linking them to. No funding provided to give advice to patients. Social prescribing is absolutely wonderful and there is a need, but it doesn’t seem to be onward funding for referrals."
>
> **HJP lead**

4. The impact evaluation

The impact evaluation aims to collect quantitative evidence and conduct analysis to understand **any change in** outcomes and (if possible) to what extent they are attributable to the HJPs. It will also draw on qualitative data from the client interviews conducted during the process evaluation to validate any observed changes in outcomes.

4.1 Key points

Findings on HJP client profiles

- Clients of HJPs tended to be aged 45 or older (65%), female (64%), white (92%), and tended to be from E socio-economic grade (55%), meaning the chief income earner of the household was unemployed, retired, a casual worker, or a full-time carer or homemaker. By comparison, the counterfactual group tended to be aged 44 or younger (65%), and were slightly less likely to be female (54%) or white (78%). They counterfactual group were more evenly spread across socio-economic grades.
- Health issues were common among both groups – 94% of clients and 84% of counterfactual respondents indicating some kind of poor mental or physical health. However, clients were more likely to have a long-term health condition (71% vs 47% among the counterfactual). Health problems also tended to be more severe among clients, reflecting the increased prevalence of ill health and long-term conditions compared to the counterfactual.
- Clients most commonly presented with issues to do with government payments[13] (35%) and treatment for mental health issues (31%). This compares to 13% and 19% within the counterfactual group respectively.

[13] In this context, issues with government payments refers to disputes concerning entitlement to, the amount of, suspension of or registration for government payments having to do with, for example, welfare, tax benefits, state pension or student loans.

- Debt (41%), personal finance (29%) and issues to do with employment (20%) were the issues commonly faced in the counterfactual group.
- Propensity score matching techniques will allow comparisons across individuals in the HJP client group with individuals in the control group that have similar profiles i.e. similar likelihood of using an HJP service.

4.2 Methodology

The feasibility study recommended the following impact evaluation methodology:

- **Conduct 'before' and 'after' surveys with HJP clients** and **a counterfactual group** who are also experiencing legal needs but who have not had access to the HJPs.
- Hone the counterfactual to match the profile of HJP clients more closely, including through the use of **propensity score matching (PSM) techniques**.

The PSM process will allow comparisons across individuals in the intervention group with individuals in the control group that have similar likelihood of using an HJP service, balancing out their observable characteristics (covariates). For example, individuals could be matched based on covariates such as age, type of legal problem, Indices of Multiple Deprivation (IMD), presence of physical and/or mental health conditions. The covariates will be agreed for the final evaluation when all of the outcome data are available, and it is possible to make a judgement on which characteristics are most relevant to the use of HJP services. See Appendix E on the steps that will be followed to conduct the PSM.

4.3 Progress to date

Following the recommendation from the feasibility study, the impact evaluation involves surveys with two groups: clients of HJPs and a counterfactual group of people facing a legal issue who did not access support from a HJP. Both groups will be surveyed twice: once as a baseline and then as a follow up, three months later. A £10 Amazon e-voucher or a physical Love2Shop voucher will be provided for each survey completion. For more detail on the impact survey methodology and recruitment method see Appendix E.

Based on sample size considerations detailed in the technical appendix from the feasibility stage,[14] the implementation phase aimed to collect **600 baseline and 200 follow-up responses from the HJP client group** and **1,200 baseline and 400 follow-up responses from the counterfactual group**. Since implementation, there have been challenges related to duplicate completes and low response for the HJP client group. Details on the mitigation measures taken are provided in Appendix F.

As of 28th June 2023, 109 baseline clients completes and 902 baseline counterfactual completes have been received. The interim quantitative data in this report consists of fewer responses as it was drawn for analysis in May 2023. The data in this report consists of:[15]

- 83 client completes
- 602 counterfactual completes (300 during wave one and 302 in wave two).

The follow up surveys for both clients and the counterfactual group have launched. As of 28th June, 15 clients and 238 counterfactual follow up survey completes have been received. However due to low responses to date, a robust comparison of baseline and follow up is not possible in this report. This analysis will be included in the final report.

4.4 The profile of HJP clients

This section outlines the profile of HJP clients alongside the profile of the counterfactual group. Examining these alongside each other offers insight into the types of people accessing legal advice via this route, compared with the wider population of individuals facing a legal issue that do not access support via this route.

Note that at this interim stage, some variation in the profiles of the clients and counterfactual is to be expected. The counterfactual group has been designed to consist of a wide pool of people with a legal need, that final analysis can draw on. The final reporting will use this large sample of individuals with a legal issue to include comparison of respondents that more closely match the client group, such as those who had a legal issue

[14] See section 2 of Evaluation of Integrated Advice Hubs in Primary Healthcare Settings - Technical Appendix (publishing.service.gov.uk)

[15] The wave three baseline counterfactual interviews (n=300) were completed after the analysis for this report was conducted and therefore do not feature in this report.

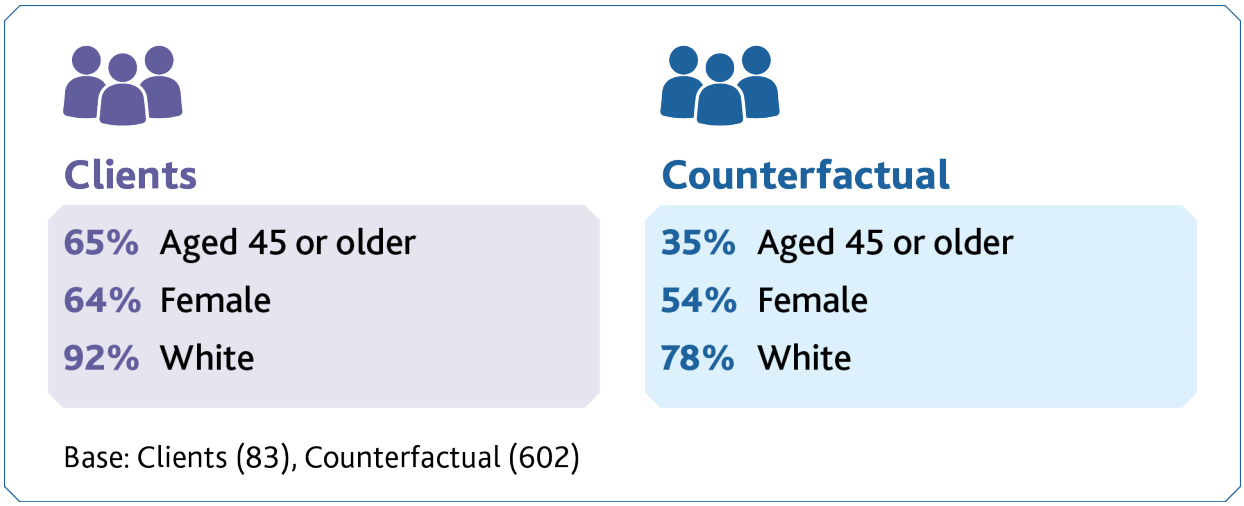
which had a slight or significant impact on their physical or mental health. The propensity score matching will further enhance this process of like comparison by matching respondents in the clients to like respondents in the counterfactual.

Moreover, when reading this section it is important to remember that this is based on interim data and is potentially subject to change. This is particularly true of clients where respondent numbers are low.

Demographic profiles

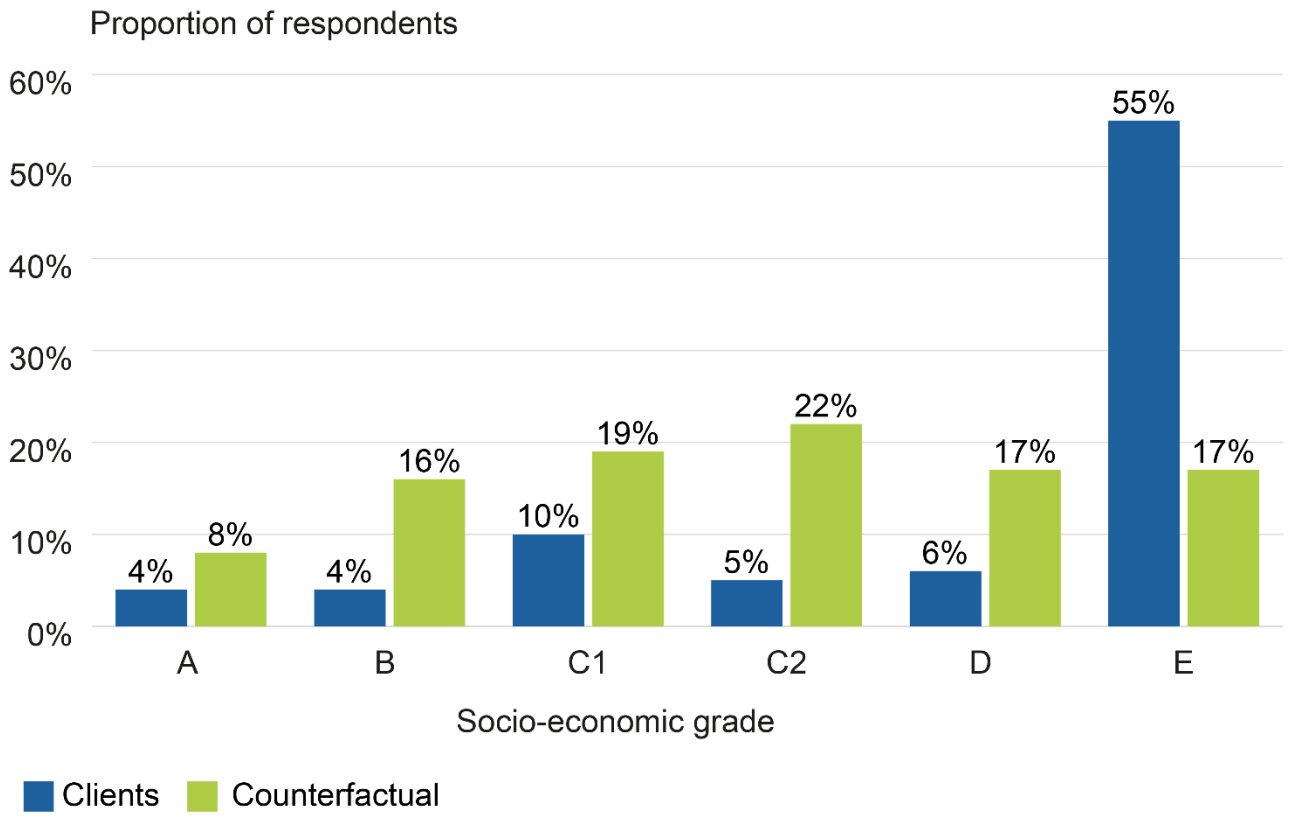
As shown in Figure 2, clients were most commonly female. Both groups were more likely be white, although this was more pronounced among clients. There was some difference by age, with clients tending to be older than those in the counterfactual group. This likely reflects the increased use of primary care services among older people, making this group more likely to come into contact with HJP referrers.

Figure 2. Age, gender and ethnicity of respondents



Base: clients (83), counterfactual (602).

Figure 3. Socio economic[16] grade of respondents



Base: clients (83), counterfactual (602).

As shown in Figure 3 the majority of clients (55%) came from E socio-economic grade (the chief income earner of the household being unemployed (35%), retired (13%), a casual worker (5%), a full-time carer or homemaker (1%)). The counterfactual group, in contrast, presented a more even split across the socio-economic grades. Underpinning these differences is a higher number of unemployed (35% vs 6% among the counterfactual) and retired clients (13% vs 5% among the counterfactual).

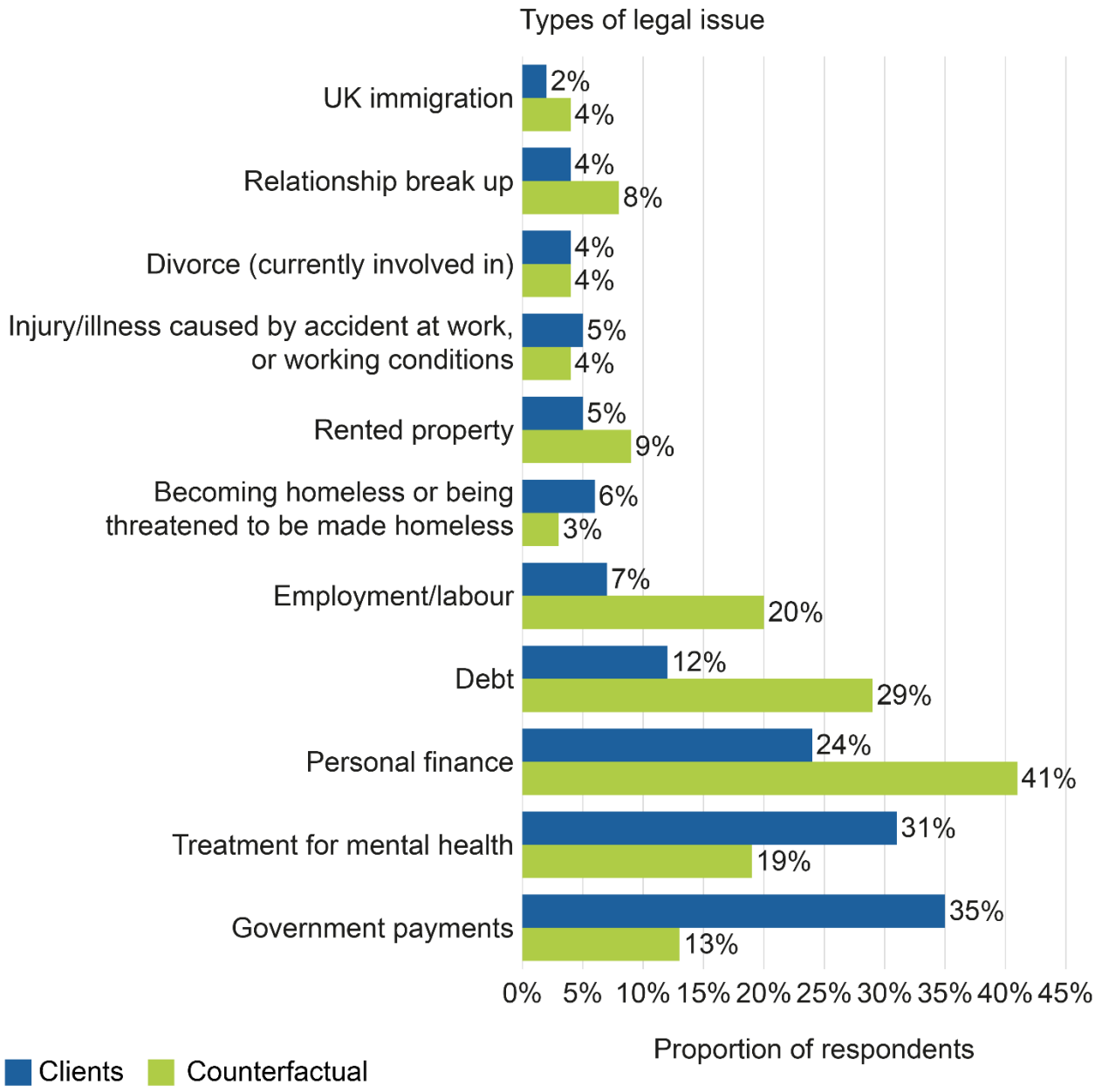
Legal issues

As shown in Figure 4, government payments (35%) and treatment for mental health issues (31%) were the issues most clients needed support with. Around a quarter (24%) presented with an issue to do with personal finance and 12% an issue around debt.

[16] Socio-economic grade is based on the occupation of the chief income earner within a household. For A this is higher managerial roles, administrative or professional; B is intermediate managerial roles, administrative or professional; C1 is supervisory or clerical and junior managerial roles, administrative or professional; C2 is skilled manual workers; D is semi-skilled and unskilled manual workers; and E is state pensioners, casual and lowest grade workers, unemployed with state benefits only.

Personal finance (41%), debt (29%) and issues to with employment / labour (20%) were the issues most commonly faced in the counterfactual group.

Figure 1. Types of legal issue faced by respondents



Base: clients (83), counterfactual (602).

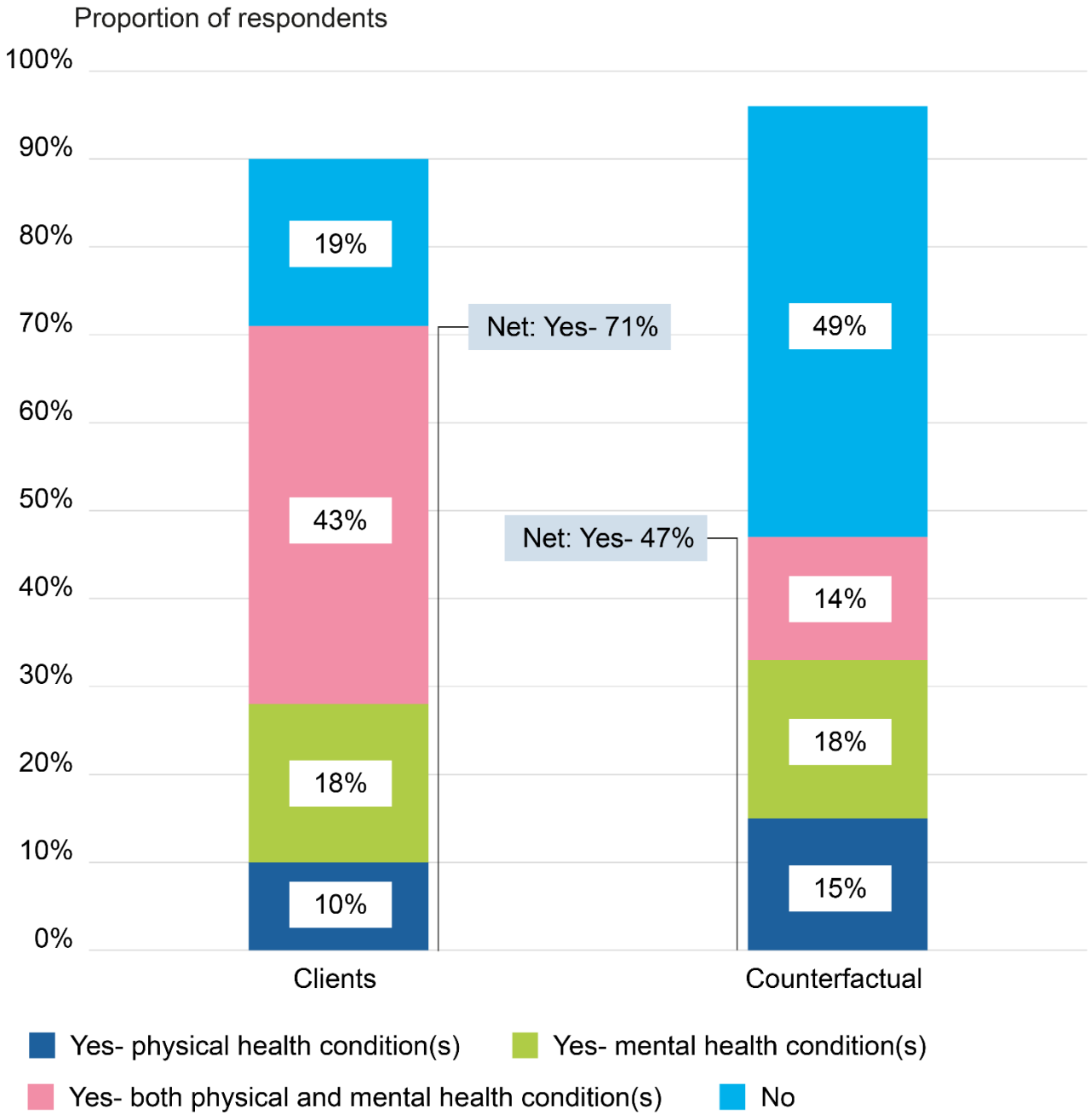
Clients being more likely to need support with government payments than the counterfactual group likely reflects the high rate of unemployment among clients. Similarly,

the increased need for support with treatment for mental health is likely a reflection of the fact that these are people referred to support from a primary healthcare setting.

Health issues

Health issues were common among both groups – 94% of clients and 84% of counterfactual respondents indicating some kind of poor mental or physical health. However, clients were more likely to have a long-term health condition (71% vs 47% among the counterfactual), as shown in Figure 5.

Figure 5. Health conditions expected to last 12 months or more



Base: clients (83), counterfactual (602).

Health problems tended to be more severe among clients, reflecting the increased prevalence of ill health and long-term conditions compared to the counterfactual. On the day of being surveyed, clients were more likely to report: severe or extreme anxiety or depression (46% vs 25% among the counterfactual); experiencing at least some pain or

discomfort (87% vs 61% among the counterfactual) and to describe this as severe (10% vs 4% among the counterfactual); experiencing problems with completing their usual activities (e.g. work, study, housework, family or leisure activities) (71% vs 45% among the counterfactual group); facing issues with mobility (69% vs 40% among the counterfactual); and facing problems with self-care (54% vs 29% among the counterfactual).

4.5 Analytical implications

Low response rates and detection of statistically significant effects

As discussed, the client impact survey responses collected are lower than the target sample size (i.e. 600 baseline and 200 follow-up) recommended in the feasibility study for detection of statistically significant effects. As of 28 June 2023, 109 baseline clients' responses have been received. Based on the response rate seen in the 12 weeks up to this point, an additional 36 responses would be collected giving a final sample of 145 baseline clients completes. This would result in 58 follow up completes, based on the current numbers of baseline respondents opting into the survey, and the rate at which these are converted into follow up completes.

Considering the projected final sample sizes, the sample size will likely be too small to detect significant differences within the client group. In this scenario, the evaluation would look to report on indicative findings, complemented by the qualitative interviews. The PSM would still be performed, so that the descriptive analysis can be based on a control group which is similar to the treatment group.

This approach would report on differences that were not statistically significant as indicative only, acknowledging that they should be treated with caution and complemented by qualitative findings where possible.

Matching the intervention and counterfactual groups for analysis

Initial comparisons of the client group subjects to the counterfactual group subjects show that there are differences in age, IMD, type of legal problem presenting to HJP and the presence of physical or mental health conditions. In order to prevent the analysis being biased towards any particular observable characteristics in the study subjects, PSM techniques will be used to create comparable respondents from the intervention and counterfactual groups, to be used in both the impact and economic evaluation.

5. The economic evaluation

The economic evaluation aims to determine the **financial and economic benefits** of HJPs, including potential economic benefits to Government and wider society.

5.1 Key points

Cost and resources

- The bulk of the HJP set-up costs relate to project management, the development of relationships with stakeholders and staff training.
- There is considerable variation in the scale of the service models meaning that the incremental annual running costs range between £7,000 per annum to £225,000 per annum.
- When unit costs are considered, there is a four-fold variation in costs between £9 per hour of casework, up to £40 per hour of casework.
- Costs per client vary even more, with a ten-fold difference between the lowest cost of £45 per client to the highest cost of £465 per client.
- This is reflected in the range of average time spent with clients, from between one hour to 19 hours.
- As a next step, further exploration will be conducted to understand the extent to which differences in service delivery models impact on the unit costs.

5.2 Methodology

The feasibility study recommended to quantify in economic terms:

- Costs associated with setting up and running HJP services;
- Changes in resource use in the justice and health and social care systems, as well as any other relevant government departments
- Impacts on individuals relating to improved access to justice and resulting health benefits;

- Wider societal benefits, such as the 'spill over' effects of the creation of additional employment or getting people back to work

A cost-benefit analysis (CBA) approach was recommended to compare the monetary value of costs associated with HJP services and the benefits generated by them, either directly or indirectly.

5.3 Progress to date

Since the feasibility study, the economic evaluation framework setting out the cost and benefit elements being considered and the source of data that will be used has been further developed and can be found in Appendix G.

To monetise changes in resource use related to setting up and running HJP services, data has been collected directly from each HJP participating in the economic evaluation. The survey questions (see Appendix H) were developed in conjunction with stakeholders. Of the 16 participating HJPs, the survey was sent to the 10 HJPs which initially expressed a willingness to participate in the economic strand of the evaluation. Completed surveys have been received from seven HJPs, with the outstanding three unable to return the survey due to resource constraints at this time. While seven surveys were returned, not all parts of the survey were fully completed in all cases. The summarised findings from the information provided for the cost and resources analysis are presented below.

5.4 Costs and resources

The seven HJPs which have returned data via the costs and resources survey are Broxtowe, County Durham, Derbyshire, Solihull, Pembrokeshire, (all Citizens Advice), Central England Law Centre (CELC), and Salford Council.

What are the incremental costs involved in setting up and running HJPs?

The costs reported by the seven HJPs can be categorised into:

- One off set-up costs: staff and non-staff resources required e.g. project management, training staff, setting up new systems and infrastructure for referrals
- Annual running costs: staffing and non-staffing

The survey also collected data on funding received to run the HJP. The costs provided are annual so have a one-year time horizon.

One-off set-up costs

One off set-up costs were categorised into project management/meetings; stakeholder involvement/building relationships; staff training; setting up IT/referral systems; community engagement; and other costs. Only two reported any costs in the main categories, with one reporting an overall cost, as shown in Table 2. The bulk of the set-up costs relate to project management, the development of relationships with stakeholders and staff training.

Table 2. HJP-reported set up costs

HJP (anonymised)	Project management/ meetings	Stakeholder involvement/building relationships	Staff training	IT/referral system set up	Community engagement	Other	Total
A	NR	NR	NR	NR	NR	NR	£19,771*
D	£936	£457	£94	NR	£130	NR	£1,616
E	£1,913	£2,303	£1,442	£850	£236	£2,340	£9,083

NR: indicates no costs were reported for these items

* Only total costs reported by this HJP

Annual running costs

Staff costs included advice support by caseworkers; administrative tasks; ongoing project management costs; line management of staff; and other staff costs, including overheads and travel costs. Advice support makes up around two-thirds of the total staff cost across all HJPs.

Non-staff related costs include a range of resource costs such as room rental; licence costs; and advertising and publicity. These costs are relatively small and make up less than a tenth of the overall annual running cost alongside staff costs. All seven HJPs reported their annual running cost as per Table 3.

Table 3. HJP-reported annual running costs

HJP	Staff costs	Non-staff costs	Total
A	£6,846	NR	£6,846
B	£10,361	£797	£11,158
C	£148,500	NR	£148,500
D	£127,947	£29,500	£157,447
E	£92,633	£3,508	£96,141
F	£22,206	£13,170	£35,376
G	£221,873	£2,700	£224,573

NR: indicates no costs were reported for these items

There is large variation in the reported running costs of the HJPs so it is important to consider these costs in relation to the activity undertaken by each HJP. This can be measured using data provided in the survey from two sources: the number of hours of casework delivered per year, and the number of clients served per year. Tables 4 and 5 show the unit costs of the provision of services at the HJPs based on annual running costs.

Table 4. Unit costs of casework hours by HJPs

HJP	Total annual running costs	Hours of casework delivered	Cost per hour of casework
A	£6,846	NR	NR
B	£11,158	455	£24.52
C	£148,500	15,600	£9.52
D	£157,447	9,880	£15.93
E	£96,141	5,720	£16.81
F	£35,376	2,002	£17.67
G	£224,573	5,616	£39.99

NR: not reported

Table 5. Unit costs of clients served by HJPs

HJP	Total annual running costs	Clients served	Cost per client
A	£6,846	362	£18.91
B	£11,158	24	£464.92
C	£148,500	2,061	£72,05
D	£157,447	2,030	£77.56
E	£96,141	1,150	£83.60
F	£35,376	218	£162.28
G	£224,573	5,000	£44.91

Aside from one HJP, which did not provide data on the number of casework hours delivered, the cost per hour of casework ranged from £9.52 to £39.99. The unit cost per client ranged from £18.91 to £464.92.

Further work will be done to consider the factors that affect unit costs included in this report, including the possibility that there is some under-reporting of costs. It is interesting to note that the two hubs with the lowest unit cost per client have not reported non-staff costs, so there may be elements of under-reporting in the information obtained via the survey.

The extent to which the different modes of service delivery impact on the unit costs will be considered by further contact with the HJPs, such as differences in the mode of client

contact (e.g. fully remote vs face-to-face) and the extent of any costs associated with co-location, drawing out common themes across HJPs. For example, from the process evaluation so far, we understand the type of activity and the administrative approach to organising client appointments may influence the time and costs associated with client contact (e.g. form filling is time consuming and usually done face-to-face), telephone appointments can be slotted in around other appointments so time can be used efficiently, allocation of appointment time according to need allows advisors to utilise time effectively.

Furthermore, services which are either partially or fully or telephone based, will have no costs associated with co-location (this is noted to be the service model for HJPs A and C, which operate telephone-based projects and show lower unit costs). This additional information will be combined with insights from the process and impact evaluations to contextualise the findings from the economic evaluation. The additional analysis will be included in the final evaluation report.

Table 6 shows the variation in the average number of casework hours delivered per client, demonstrating the heterogeneity of the different HJPs.

Table 6. Average number of casework hours per client

HJP	Hours of casework delivered	Clients served	Hours per client
A	NR	362	NR
B	455	24	18.96
C	15,600	2,061	7.57
D	9,880	2,030	4.87
E	5,720	1,150	4.97
F	2,002	218	9.18
G	5,616	5,000	1.12

The average number of hours delivered per client ranged from just over one hour to nearly 19 hours. The reported average length of each advice appointment is between 45 minutes and one hour. It is anticipated that the amount of support provided per client is influenced by the profile of the clients and their needs, leading to different types and extent of advice and help provided. For example, form filling is reported as requiring the most time, so the extent of this in a caseload could be expected to influence the average amount of time

spent per client. There is an observation that the lower the number of clients in the service overall, the higher the number of hours of support provided per client. The extent of any relationship between these will be further explored in the next phase of the work.

Cost-benefit analysis

The cost data from the seven HJPs provides the incremental cost of the advice services in different ways. When outcome data are available from the impact evaluation, this will be used to assess the benefits provided by the services. This will include any costs offset from other parts of the public sector, for example, reductions in costs to the justice or health and social care system. Data from the impact survey questionnaire will also be used to understand the value of any changes in health gained by people using the services. Appendix I provides detail on items in the impact evaluation survey that will be used for the economic analysis.

6. Next steps

The final evaluation report will be published after the full research is completed in 2024. Before then, the focus will be on the below activities.

6.1 Process evaluation

- Continuing recruiting and interviewing healthcare professionals on a rolling basis.
- Continuing recruiting and interviewing clients on a rolling basis. This will include conducting follow-up interviews with clients to explore longer term impacts of receiving support through an HJP.

6.2 Impact evaluation

- Continuing to collect baseline survey responses from the HJP clients and the counterfactual group.
- Continuing to collect follow-up survey responses from the HJP clients and the counterfactual group.
- Agreeing the covariates for matching and intervention and counterfactual groups and conducting the PSM analysis as outlined in Section 4.6.

6.3 Economic evaluation

- Further investigate variation in costs by reviewing qualitative findings from the process evaluation and clarifying data with respondents.
- Analysing the relevant data items collected by the baseline and follow up client surveys (from the impact evaluation) to help quantify the benefits.
- Collecting any additional management information required, including follow-up data from HJP systems on client outcomes (e.g. income gained, housing situation stabilised, employment sustained).
- Further interrogating the evidence identified in the literature review to develop values for improved outcomes in terms of justice and health, where data are unavailable.

- Conducting statistical analysis (e.g. generalised linear model) to estimate the benefits i.e. effect size of HJPs where treatment status (i.e. use of an HJP) is the independent variable and outcomes such as health/well-being are dependent variables. Summarising and aggregating the outcomes of HJPs, describing in monetary terms where appropriate, and comparing for the intervention and counterfactual groups.
- Comparing the unit costs with the value of benefits generated for individual HJPs.
- Conducting sensitivity analysis to test the impact on the results where there is uncertainty or assumptions have been needed in the analysis e.g. reported use of GP services, range of unit costs.

Appendix A
Approach to qualitative data collection and analysis

HJP clients were mainly identified for qualitative interviews via the impact survey, which was sent to them – with their consent – soon after a meeting with an advisor. At the end of the impact survey, responding HJP clients were asked if they would be willing to be contacted about a longer follow-up interview. 4 clients were the exception to this as they were referred directly to IFF Research by CA Liverpool advisers. All those opting in were then contacted soon after this to arrange a convenient time for the interview. Interviews were conducted by trained qualitative researchers at IFF Research, and were carried out via telephone or online depending on the respondent's preference.

Below is a simplified version of the discussion guide used to shape interviews:

Pre-advice experience

- Can you briefly give me a bit of context about the issue that led to you being in contact with [insert name of hub]? You don't need to go into a lot of detail or talk about anything that you don't want to.
- How did you first hear about [insert name of hub]? Were you referred/sign-posted or self-referred?
- What did you understand the service to be able to help you with?
- *For those referred/signposted:* What would you have done without the referral / signposting?
- *For those who self-referred:* Would you have come across the hub if it had not been linked to a healthcare setting?
- What happened in the period between finding out about the service and accessing legal advice?

Advice experience

- Can you tell me about your interactions with the hub? (e.g., what support was received, over what timeframe, and how this was delivered)
- When you first spoke to the legal adviser, did they already know your name, the issue you needed help with, anything about your health, anything about your GP appointment history?
- *If yes:* Did you feel there were any benefits to this?
- *If no:* How did this feel?
- *If advice service co-located with primary care:* Did you feel there were benefits to receiving the legal advice in the same place as healthcare?
- *If advice service not co-located:* How did you feel about receiving the support/ advice in a different place to your healthcare?
- Did you feel there were any (other) benefits of [refer to healthcare setting that led to them seeking legal advice] being linked to legal advice or the other way around?
- Thinking about your overall experience, what did [insert name of hub] do particularly well?

Post-advice experience

- What, if any, steps did you take following the advice you were given? How easy/difficult was this?
- What was the outcome of your issue(s)?
- To what extent did the advice, information or support you received help you solve the issue?
- What, if any, impact has it had on how you feel in your day-to-day life?
- If you encountered a similar issue in the future, how do you think you would tackle it?
- Do you feel that receiving help/advice/support has changed your knowledge / understanding of your rights?

Our approach to the analysis of the qualitative data to date has been iterative and inductive – building upwards from the views of participants.

All interviews were written up in detail, including verbatim quotes, in an analytical framework in Excel. The framework was structured around the logic model and research questions, with a research question per column, and detail from each qualitative interview entered individually per row. The framework also included key sample data, to allow for comparison of findings by different characteristics.

The data was analysed to search for themes and trends, both present and absent. To date, we have held two internal director-led analysis sessions (on 31st October 2022 and 4th May 2023) to bring the team's thinking together, encourage challenge of assumptions and identify areas for further, targeted analysis.

Appendix B
Operational structure of HJPs

In the feasibility report we categorised HJPs into model types based on whether advisors were co-located on-site in the healthcare setting, and by the nature of their referral process from the healthcare setting to the advisory team.

The decision to group HJPs into models based on their co-location and their referral process aligns with the main distinguishing factors identified in the definitions of HJPs, integrated services and co-located services used in the literature:

- **Health-Justice Partnerships:** HJPs or Medical-Legal Partnerships (MLP) can be generally understood to include services in which legal and social services are provided in a healthcare setting. To note some definitions from included papers, an evaluation of MLPs in the US from Nerlinger et al (2021) [4] described MLPs as “a prime example of a health system–community partnership that incorporates legal assistance as an integral component of medical care.” An Australian paper evaluating HJPs in various Melbourne hospitals stated that “HJPs integrate legal assistance into a healthcare setting.” Beardon et al (2021) defined “Health-Justice Partnership” broadly as the provision of legal assistance for social welfare issues in healthcare settings.

  We have adopted Beardon et al’s broad definition of HJPs to refer to all 13 models of Health-Justice initiatives included in this study.

- **Integrated services** (within the context of Health-Justice initiatives): Integration of services can follow various models. A report on the Health-Justice landscape in England and Wales noted that, rather than following a single model, most were unique local arrangements developed independently and could include co-located services, referral pathways and integrated multidisciplinary teams.

The degree of integration between the services when the health partner refers the client to the justice partner influenced how the HJPs were originally allocated to a particular HJP model.

- **Co-location** (within the context of Health-Justice initiatives): Co-location refers to the physical presence of legal services within a healthcare setting. An international systematic review of HJPs defined co-location as health and legal services as these "being physically located together." (Beardon et al 2021). A report on the Health- Justice landscape in England and Wales found that the most common healthcare settings in which service partnerships were found were GP practices (49%), followed by mental health services (34%) and hospitals (34%) (Beardon et al 2018).

  Co-location, or the lack of physical co-location, also influenced how the HJPs were allocated into models.

The three models suggested to include in the process evaluation were those where the healthcare and legal advice services are fairly integrated:

- Model one: A co-located HJP that uses a structured consultation booking system and shares information
- Model two. A co-located HJP that uses a consultation booking system
- Model three. A HJP that is not co-located but does use a structured consultation booking system and shares information

During the implementation of the evaluation, this categorisation helped to establish the selection criteria for HJPs to include. That is, to capture variation in models, HJPs that are co-located versus not co-located, as well as HJPs that use more structured booking systems versus less structured booking systems were included. However, the process evaluation findings were not analysed against the three model types as the in depth interviews found more variation in operational structures than initially envisaged. In more detail, several HJPs run multiple HJP services, which have different operational structures from each other and therefore do not map neatly onto the models identified for each HJP in the feasibility study.

While specific approaches varied extensively by HJP, most HJPs provide advice both within a healthcare setting ('co-located') and remotely (via telephone or online). In the case of HJPs offering both in person and remote advice, the choice of mode seemed to be based on the client's needs and requirements.

The case studies below illustrate the variety of operational structures among the participating HJPs and demonstrate why the analysis by model type has been abandoned in the process evaluation. For example, CA Liverpool would not fit neatly into one of the three model types because HCPs can refer patients in multiple ways (including via the Integrated Care Team), all of which utilise different booking systems and levels of information sharing.

Figure 6. HJP case study 1: Citizens Advice Solihull

Case Study 1: Citizens Advice Solihull

CA Solihull's GP Project has been running for nearly 14 years. It has predominantly received funding from the local Clinical Commissioning Group/Primary Care Network.

The referral process

Most clients are signposted to the online referral form by their GP or through seeing physical materials (e.g. leaflets) in the GP offices. Once a form is completed it goes to the main hub office, where an admin staff member calls the clinic to book them an appointment with the advisor at their healthcare clinic. **Sometimes GPs and medical administration staff fill in the online referral form** for clients.

Data sharing

Varying amounts of information is shared at referral stage. Generally, just the name and type of issue is shared – but the form has an open text box, so the amount of information shared varies. There is **very limited collaboration** between healthcare professionals and advisors after the referral. A client can request for the advisor to talk with the GP and share information if needed (and with consent) – but this rarely happens.

The delivery of advice

Pre COVID, advisors were **physically located** in 17 GP practices, visiting each practice weekly or fortnightly. With COVID this moved to **remote working**, but now advisors are beginning to go back to physical co-location in some healthcare clinics and are running a **hybrid service**.

Figure 7. HJP case study 2: Central England Law Centre

Case Study 2: Central England Law Centre

Central England Law Centre's GP Project has been running for nearly 10 years and is funded directly by the GP practice partner.

The referral process

Central England Law Centre HJP has **no shared booking system**. **HCPs signpost patients to the receptionist who books appointments** with the advisor for them using an onsite diary. The advisor will then call the receptionist the day before their visit to check which clients they will be seeing the next day.

Data sharing

A limited amount of information is shared at the referral stage, usually the advisor is only told the name and the type of issue they need assistance with. **Healthcare professionals and advisors collaborate** on an ad hoc basis. No formal meetings are planned but occasionally they might meet to ensure the correct and required information is provided for the clients' legal work (e.g. fit note covers the essentials for DWP application).

The delivery of advice

An advisor visits the healthcare clinic for ½ day per fortnight. **The first meeting with a client is face-to-face**, when the advisor is physically located at the clinic. For ongoing casework, the advisor usually has a mix of face-to-face, telephone and email communication with clients.

Figure 8. HJP case study 3: Citizens Advice Pembrokeshire

Case Study 3: Citizens Advice Pembrokeshire

CA Pembrokeshire's health project called 'Community Advice' has been running for 18 years (previously known as 'Better Advice, Better Lives'). Currently, the project is predominantly funded by the Welsh government.

The referral process

CA Pembrokeshire's HJP has **no shared booking system**. Patients who are referred by a healthcare professional are instructed to collect the advisor's business card from the GP receptionist and call the number. A dedicated admin support worker receives the call and arranges the appointment for the patient and advisor. **Healthcare professionals can also refer at regular multidisciplinary meetings** at which the advisor (or the Community Connector) is present.

Data sharing

No information is shared between the healthcare professionals and the advisor. However, the **dedicated admin support** worker gathers necessary information from patients during the initial call to ensure their needs can be met (e.g. type of issue, which dictates length of appointment, and any documents they need to bring on the day). There is **little ongoing collaboration** between the advisor and the healthcare professionals.

The delivery of advice

The delivery of advice depends on the clients' needs (e.g. whether their mental or physical health enables them to travel to the healthcare setting). The advisor tends to delivery advice **face-to-face**, either at the healthcare setting (often an available room in the hospital next to the GP practice) or sometimes in peoples' homes. Otherwise, advice is delivered **over the phone**.

Figure 9. HJP case study 4: Citizens Advice Liverpool

Case Study 4: Citizens Advice Liverpool

CA Liverpool's health project called 'Advice on Prescription' has been running for seven years (first piloted 10 years ago). The project has been funded by the local Clinical Commissioning Group/Primary Care Network.

The referral process

Healthcare professionals can refer patients via secure **NHS email, completing an online web form, a dedicated phone line or the 'integrated front door'** (intranet system). A dedicated team of admin support workers pick up the referrals and then contacts the patients to arrange the meetings with advisors. In addition, healthcare professionals can refer patients at **regular multidisciplinary meetings** at which CA advisors are present.

Data sharing

Healthcare professionals working in GP practices tend to provide only **basic information** about patients at the referral (e.g. name and contact details). Those working in Integrated Care Teams tend to provide more detail (e.g. type of issue). The admin support workers **gather additional information from patients during the initial call** to ensure their needs can be met (e.g. home address, which dictates the location of the appointment). There is some **ongoing dialogue about patients'** care plans between healthcare professionals and advisors.

The delivery of advice

The delivery of advice depends on the clients' needs (e.g. whether their mental or physical health enables them to travel to the healthcare setting). Advisor/s tend to deliver advice **face-to-face** at the healthcare settings. Otherwise, advice is delivered **over the phone**.

Appendix C
Qualitative findings on outcomes

Outcomes and impacts of HJPs will largely be assessed through the baseline and follow-up surveys which are being conducted as part of the impact evaluation. Quantitative data on outcomes will be reported on in the final report.

The below briefly highlights the qualitative evidence gathered to date in relation to the outcomes for clients, healthcare professionals and the wider Health-Justice systems.

Outcomes for clients

Increased income

One of the most commonly cited outcomes for clients was an increase in their income. This was mentioned by all frontline advisers interviewed and the majority of the HJP leads. This usually was achieved through increased benefits and reduced debt.

> "Income maximisation so people have more income for their basics…[is our] main focus."
>
> **HJP lead**

Mental and physical health improvements

It is important to note that the majority of clients were referred to an advisor from a healthcare professional, and therefore, the majority of clients presented with mental or physical health issues to begin with. Most HJP staff considered it an obvious consequence to see health improvements in this particular group.

All HJP advisors interviewed reported improvements in their clients' mental health, usually due to a reduction in stress and anxiety, related to receiving advice from a trusted source and the resolution of issues.

> "I felt I could trust them. They were confident in what they were doing, [and when the issue was resolved], the relief was unbelievable."
>
> **Client**

According to advisors, even just having someone listen to them and support them with their issues in a non-judgemental way could have a significant impact on clients' anxiety levels and improve their general wellbeing and confidence levels.

> "Not just material stuff. They appreciate the empathy."
>
> **Advisor**

The impact of receiving advice on clients' health seemed to be further supported by evidence collected by the HJPs. One of the leads cited figures collected internally by their HJP following the delivery of advice. These showed that their clients felt significantly less isolated, better able to cope with their problems, and more positive about dealing with things following the sessions.

However, advisors explained that for some clients, improvements to their mental or physical health only materialise when the tangible issues (e.g., disputes with energy suppliers) have been resolved. For example, an increase in a person's income can help with costs of heating, thus having a direct impact on their health; or improving a person's housing situation (e.g., to reduce contact with mould) can have a positive impact on their wellbeing as well as physical health.

> "A person is a whole being not just their medical history – mental health improved when finance improved because of less worry, can go into community start seeing people, pay carers and heat their home."
>
> **Advisor**

Employment issues resolved

Another outcome achieved for some clients was the resolution of employment issues. For example, disputes with employers and unions that impact a client's mental health.

> "[CA] were brilliant. [The advice made me] look at things outside the box… they gave me concise advice and I made my decision [to move departments at work] based on what they said."

Client

Improved ability to manage finances

Some advisors reported that clients are better able to manage their finances after receiving advice. For example, in cases when advisors supported clients to communicate with their banks or secure a debt repayment plan. One client suggested that they were better able to manage their finances as a result of the advice they received about debt reduction.

> "[CA] gave me the steps to improve the issue…the advice definitely helped me quite a bit… I'm not worried about my finances any more".

Client

Better able to recognise a legal problem in the future and seek appropriate support

Some clients suggested they would feel more confident addressing problems in the future because of the skills gained from speaking with advice organisations previously (e.g., around form filling).

> "[The advice from CA will] make me think about [an issue] a lot clearer in the future, and address things quicker."

Client

However, many clients said that they would immediately seek advice from CA again in the future if they encountered a similar problem.

> "Any issue at all that I needed support with, I would still go to CA."
>
> **Client**

Others explained they would only do so if they couldn't resolve it by themselves first.

Increased faith in the justice system

Another outcome mentioned by one of the advisors included some degree of improved faith in the justice system.

> "Possibly a little bit of faith restored but also a lot of scepticism because of how much of a fight it takes."
>
> **Advisor**

Outcomes for the wider Health-Justice systems

There was some evidence of positive impact of HJPs on the wider Health-Justice system.

Reduced demand on the healthcare system

HJP leads, advisors and healthcare professionals all mentioned the benefit of a dedicated service to support patients with non-medical issues that could be impacting their health. This was described as saving healthcare professionals time, both in the short term (with more time in appointments to discuss medical issues) and in the longer term (with patients anecdotally requesting fewer GP appointments once they received support from an advisor).

> "Now I can pass [non-medical issues] on to someone else who can help. It clears the waters for me to talk about mental health."
>
> **Healthcare professional**

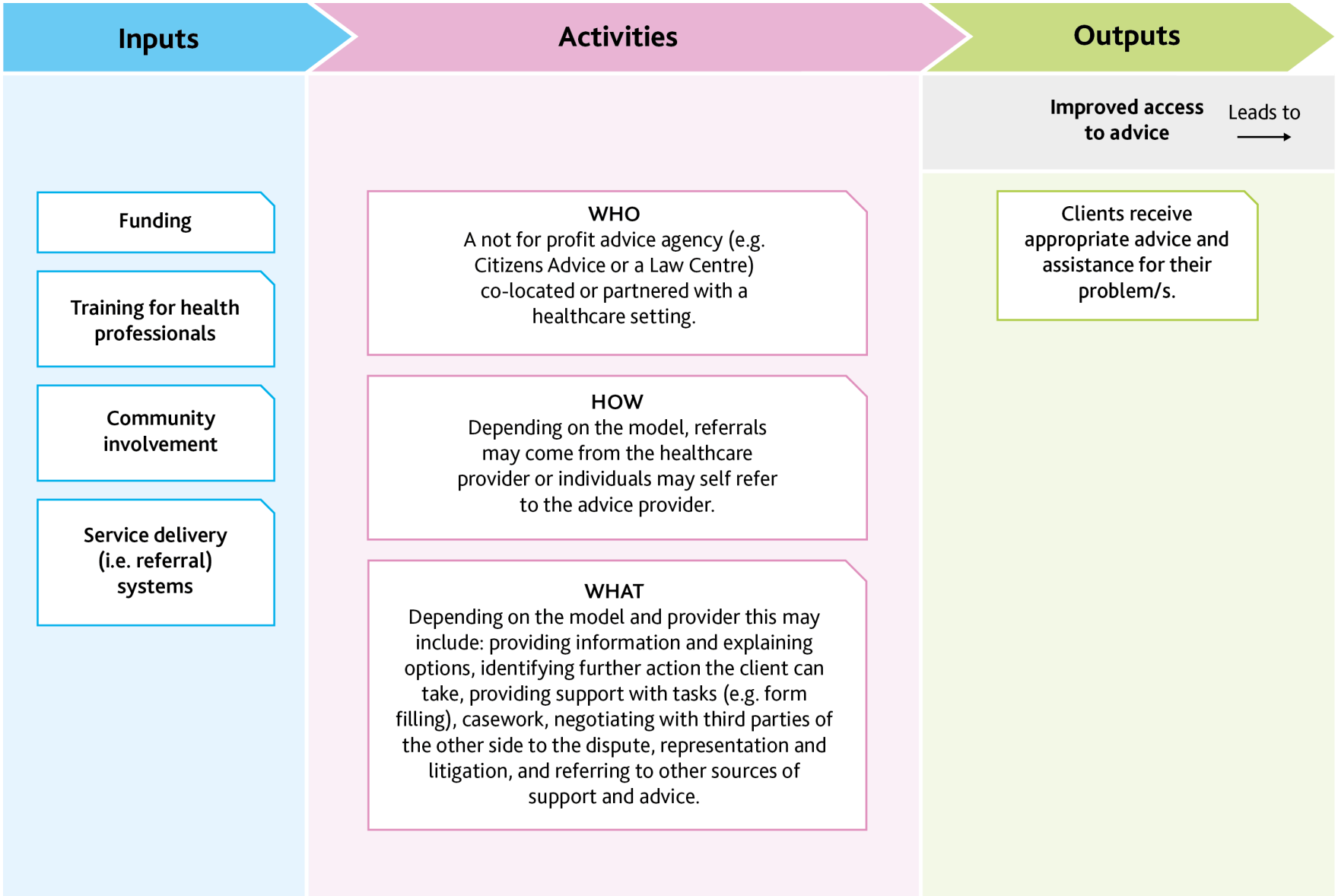
Reduced demand on the formal justice system (courts and tribunals)

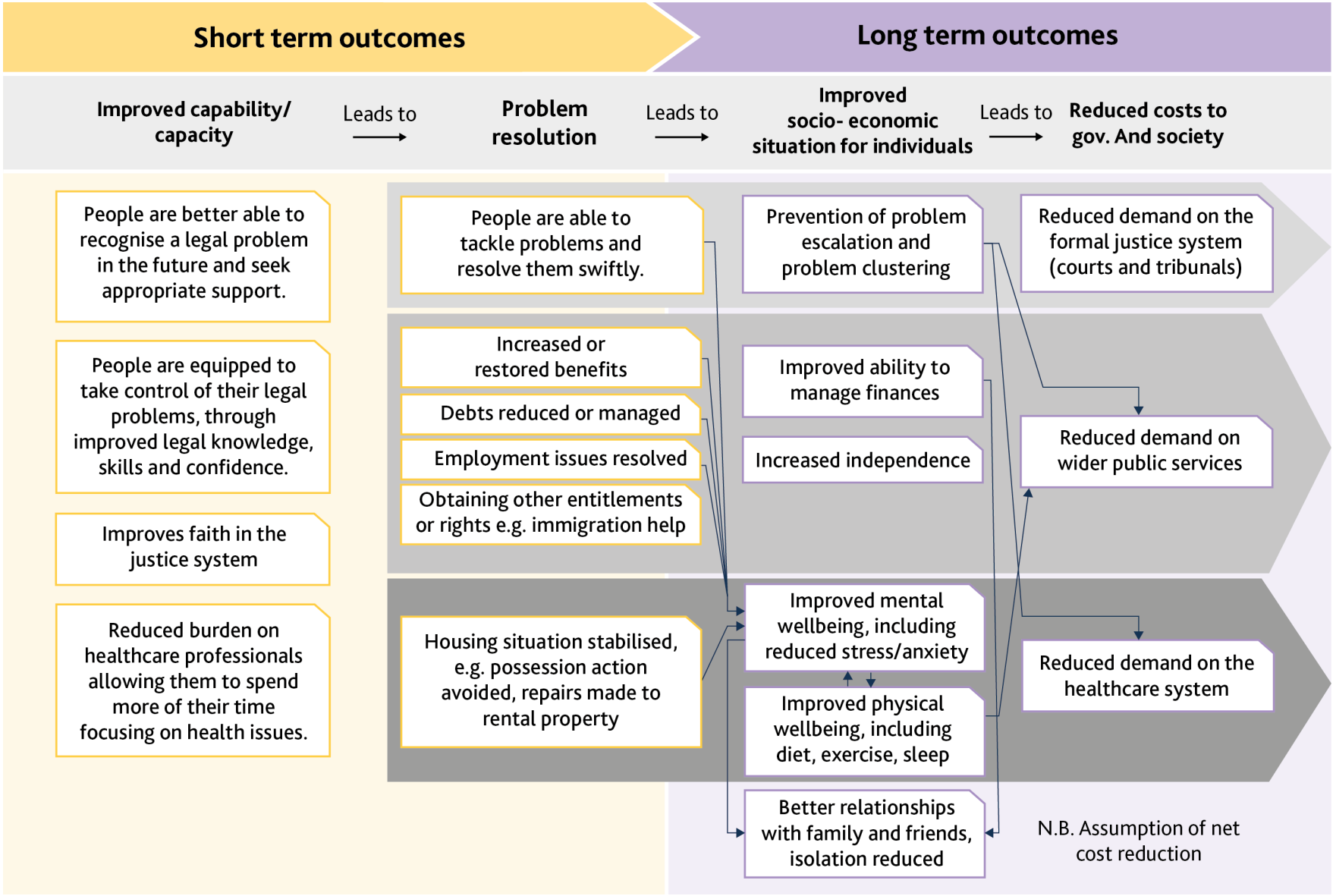
Stakeholders and HJP leads proposed that HJPs may also reduce demands on the formal justice system – for example, clients being able to apply for benefits in the correct way thanks to advisors, may lead to fewer benefit appeals and therefore to time savings for judges. They also suggested that HJPs may lead to reduced demand on the healthcare system and a reduction in time wasted by clients contacting incorrect organisations.

These findings seemed to be supported by the evidence collected by one of the HJPs which showed significant improvements in the clients' self-reported knowledge of where to get help following the advice sessions.[17]

[17] This data was collected as part of an annual impact survey on cost effectiveness.

Appendix D
Theory of Change




Short term outcomes
Long term outcomes
Improved capability/ capacity
Leads to
Problem resolution
Leads to
Improved socio- economic situation for individuals
Leads to
Reduced costs to gov. And society
People are better able to recognise a legal problem in the future and seek appropriate support.
People are equipped to take control of their legal problems, through improved legal knowledge, skills and confidence.
Improves faith in the justice system
Reduced burden on healthcare professionals allowing them to spend more of their time focusing on health issues.
People are able to tackle problems and resolve them swiftly.
Increased or restored benefits
Debts reduced or managed
Employment issues resolved
Obtaining other entitlements or rights e.g. immigration help
Housing situation stabilised, e.g. possession action avoided, repairs made to rental property
Prevention of problem escalation and problem clustering
Improved ability to manage finances
Increased independence
Improved mental wellbeing, including reduced stress/anxiety
Improved physical wellbeing, including diet, exercise, sleep
Better relationships with family and friends, isolation reduced
Reduced demand on the formal justice system (courts and tribunals)
Reduced demand on wider public services
Reduced demand on the healthcare system
N.B. Assumption of net cost reduction

Appendix E
Impact survey approach

The impact study sought to measure the impact that HJPs have on their clients. Particular areas of focus were:

- Understanding of legal problems
- Resilience when faced with a legal problem (e.g. knowing how to tackle it, where to find support)
- impact on socio-economic outcomes
- impact on health outcomes.

Surveys were broadly consistent in terms of content. This allows for an accurate 'before and after' picture of how things have changed for the clients and counterfactual groups.

To measure this baseline and follow up surveys were used. Clients completed the baseline immediately following their first advice session and, those who consented to be recontacted, were invited to complete the follow up survey three months later. Client consent for the baseline survey was taken during their first advice session by their advice service advisor. Counterfactual sample was secured using an online panel company.

Clients are recruited to the impact study during their first advice session. Where clients consent to participate, their email address is inputted by the advisor into an online portal. This automatically generates a link to the survey which is emailed to the client so that they can take part. Each link generated is unique so that each client can only complete the survey once.

A leaflet is handed to clients without digital access, which contains a telephone number they can call to complete the survey over the phone. Initially the leaflet also contained an 'open' link to the survey that clients could type into their web browser to complete. Such links are designed to be quick and simple to type in and are used to make it as easy as possible for people to access the survey. However, an open link can allow multiple people

to complete the survey through the same link. More recent versions of the leaflet do not contain an open link to the survey for this reason (see further information on duplicate completes below).

Alongside the clients, a counterfactual group of people who were facing a legal issue but had not received legal advice through a HJP were surveyed. This group acts as a comparison to control for the effects of clients contact with HJPs.

The impact study aimed to conduct 600 baseline surveys for clients and 1200 baseline counterfactual surveys. For the follow up survey the target was 200 clients completes and 400 counterfactual completes.

The counterfactual is conducted in four waves for both baseline and follow up spread across the same fieldwork period that clients are recruited to the survey.

The surveys lasted around five-15 minutes. The counterfactual group also completed a five minute screening survey to establish whether they were facing a legal issue and whether they were receiving support from a HJP for this.

Propensity score matching

Once further baseline and follow-up survey completes are received, an exploratory analysis will be performed to observe the feasibility of matching the HJP client and counterfactual group based on observable characteristics (covariates). These covariates would be factors that might influence the likelihood of an individual being an HJP service user. For example, age, type of legal problem, Indices of Multiple Deprivation (IMD), presence of physical or mental health conditions. Other potential covariates could be sex, ethnicity and employment status.

Once the matching covariates are agreed, there are four steps to the PSM:

- Estimate the propensity score – regression models are used to control for all of the covariates in the intervention group, to derive a likelihood (propensity score) that an individual received the HJP service.
- Match – an algorithm uses the propensity score to find individuals in the counterfactual population with a similar likelihood (or propensity) of using the HJP

service, if it had been available. The Nearest Neighbour (NN) propensity score matching method is commonly used in pharmacoepidemiology when using observational data. This method selects an individual in the control group which has the smallest distance in terms of characteristics from each individual in the treatment group.

- Evaluate the quality of matching – statistical tests (e.g. comparing means (t-test); percent bias reduction, graphical comparisons) are used to test how similar the intervention group and matched group are.
- Evaluate outcomes – compare means of samples, run a regression on the matched controlling unbalanced covariates.

While PSM seeks to reduce the bias due to confounding variables, it can only account for observed (and observable) covariates. Any hidden bias due to latent variables (e.g. quality of life, morale) may remain after matching, so awareness will be shown in final reporting that there may be some hidden bias due to such latent unobserved variables.

Appendix F
Impact survey challenges and mitigations

Two key issues faced on the impact study are noted – duplicate completes and low response.

Duplicate completes

In the first three months of fieldwork, duplicate completes were detected. These were from clients who had used the open link to the survey from the leaflet.

Initially these duplicates were individual respondents completing the survey using multiple different email accounts all under variations of the same name (e.g. johndoe@hotmail, jdoe@hotmail, jd@hotmail). This suggested that a small number of people were completing the survey multiple times in order to receive multiple incentives (£10 is offered to those who complete the baseline survey, to encourage participation). To counter this issue, an internet protocol (IP) address check was added to the survey. This meant that anyone attempting to complete from the same device more than once would be unable to enter the survey.

A few weeks later a new batch of duplicate completes were detected, again, initially due to the use of suspicious email addresses inputted for receipt of the incentive. It was found that these completes were coming in batches, with many completed in quick succession, very quickly (typically less than five minutes) and from IP addresses outside of the UK. These completes appeared to be logged using a virtual private network (VPN), which would have allowed a single respondent to change their IP address after each complete.

At this stage, the leaflets were re-printed without the survey link on. This was not a concern given that the leaflet was always primarily intended to be for those without digital access, who would need to complete by phone in any case. All responses that completed in less than five minutes or that were identifiable as duplicates by the use of a VPN, were removed from the sample. Incentives were not paid for those responses that were identified as fraudulent.

Low response

As described above, the main method of recruitment to the survey is through advisors collecting clients' email addresses and entering these into an online portal, which automatically sends clients a link to take part.

As of 19th April 2023, when the most recent survey complete included in this report was received, advisors had taken down the email addresses of clients interested in participating in the survey 101 times. A total of 54 of the responses included in this report came via portal referrals, with the remainder coming from the open link originally included on the information leaflet or respondents completing over the phone.

Portal referrals, however slowed down as the survey progressed, especially between October and November 2022. This suggests advisors became less engaged with the process as time progressed and that some advisors and leads were not fully aware of the process to establish client consent and input their details into the portal.

To counter this decrease, IFF Research have:

- Maintained regular email engagement with HJP leads, emphasising the importance of the survey and the process for completing it. This included monthly email check ins and follow-up calls;
- Liaised with the Citizens Advice head office to send out a reminder email to HJP leads on behalf of MoJ and IFF;
- Included prompts in the advisors' qualitative topic guide to explore their understanding of the process for referring clients to the survey and the importance of the impact study;
- Conducted face-to-face visits to HJPs to explore how they are finding the process of engaging with the impact study and to offer any guidance or support for doing so;
- Included a pop-up question on Citizens Advice's case management system, reminding advisors to secure client consent for the survey.

The impact of these steps can be seen in the increasing number of referrals and survey completes in March and April 2023.

Appendix G
Costs and benefits framework

Element	Stakeholder	Green Book classification	Monetisable?	Order of effect	Data required	Source of data
COSTS						
Incremental costs of setting up and running HJPs, including average cost per HJP service user per year	Funders	Direct public costs (capital and revenue)	Yes	First	Information on: • Staff time required (e.g. advice workers, GP practice time) training new and existing staff • Setting up new systems and infrastructure for referrals and booking, time per task • Community engagement to support service development, promotional materials • Project management time	Costs and resource survey – findings presented in the June 2023 interim report. Findings to be updated in subsequent report with further responses received, using information from the process evaluation to supplement and interpret the quantitative cost data.
Source of funding used to run HJPs	Funders	Direct public costs (capital and revenue)	Yes	First	Funding allocations	Costs and resource survey
HJP service capacity provided by volunteers	Non-statutory services	Wider benefits to UK society	Yes	Second	Tasks provided by volunteers Average number of volunteers per HJP Average number of hours volunteered per HJP	Costs and resource survey

Element	Stakeholder	Green Book classification	Monetisable?	Order of effect	Data required	Source of data
BENEFITS						
HJPs impact on users' reported health status	Individuals	Wider benefits to UK society	Yes	First	Reported health status before and after contact with HJPs, measured using EQ-5D scores on extent of problems with: mobility, self-care, usual activities, pain/discomfort, anxiety/depression. Physical or mental health conditions or illnesses experienced by people using HJPs which are lasting or expected to last 12 months or more Conditions or illnesses experienced by people using HJPs which reduced their ability to carry-out day-to-day activities Utility values for health conditions QALY value to be used in calculations (to be agreed)	Client baseline and follow-up survey Literature evidence National Institute for Health and Care Excellence

Element	Stakeholder	Green Book classification	Monetisable?	Order of effect	Data required	Source of data
HJPs impact on use of other services by people experiencing the problems presenting to HJPs	Public sector services	Indirect public sector benefits	Yes	Second	Types of problems being experienced by people using HJPs (employment, debt, mental health, relationships etc) Use of the following services before and after contact with HJPs: • Legal services e.g. courts and tribunals • Healthcare services e.g. GP, hospital • Social care services (adult and children's services), carer support • Housing services Unit costs of different types of service (listed above) use by users of HJPs	Client baseline and follow-up survey HJP data systems Literature evidence Expert elicitation Reputable unit costs from recognised sources: • NHS 2021/22 National Cost Collection data • Unit Costs of Health and Social Care 2022 Manual (Jones *et al* 2022) • Greater Manchester Combined Authority Unit Cost Database
HJPs impact on ability to remain in or stay in employment and to the value of benefits claimed by service users	Public sector services	Indirect public sector benefits	Yes	Second order	Number of people facing issues with employment and/or benefits claims before and after use of HJPs Unit costs of different types of service use by users of HJPs	Client baseline and follow-up survey Literature evidence Reputable unit costs from recognised sources (as above)

Element	Stakeholder	Green Book classification	Monetisable?	Order of effect	Data required	Source of data
Value of outcomes needed for the HJPs to be cost neutral	Funders	Direct public sector	Yes	NA	Incremental costs associated with HJPs (as above). Unit costs of different types of service use by users of HJPs	Costs and resource survey Client baseline and follow-up survey Reputable unit costs from recognised sources (as above)

Appendix H
Costs and resources survey questions

Below is a summary of the costs and resources questions asked to all participating HJPs.

1. One off set-up costs

What are the staff resources required to set up Health-Justice Partnerships?

e.g. project management, training staff, setting up new systems and infrastructure for referrals, community engagement to support service development.

2. Annual running costs: staffing

What staff are involved in running/delivering Health-Justice Partnerships?

This should include any additional staff (or staff hours) to enable the HJP to serve clients referred via a healthcare route, and also the time of existing staff who contribute to this work.

3. Annual running costs: non-staffing

What resources are needed to facilitate the work of the Health-Justice Partnership?

Not having these resources would prevent the services being delivered to clients referred via a healthcare route.

4. Budget and funding

What funding has been provided for the Health-Justice Partnership? Where has this come from? This could include contributions 'in-kind'.

5. Outcomes for service users

As part of the evaluation, we would also like to talk with the 'HJPs' about the data available to evaluate the outcomes for service users referred via a healthcare route. For example, income gained, other services used, employment sustained, mental health improved. This will supplement the data collected by the client surveys.

Appendix I
Impact survey data items for economic analysis

The economic evaluation expects to use the responses to the survey questions in the baseline and follow-up surveys being conducted for the impact evaluation, as shown below. These metrics will be use to estimate benefits as described in the Costs and Benefits Framework, applying reputable unit costs from recognised sources to estimate the value of any benefits observed Type of problems being experienced (employment, debt, mental health, relationships etc)

- Use of other organisations for support with their problem
- How much of an effect, if any, would you say that this issue is having on your physical and mental health?
- How many times have you been to your GP surgery for a consultation or treatment in the last three months?
- How often, if at all, have you received support from the following types of government social care services in the last three months?
- Social worker support for an adult (adult services)
- Social worker support for a child (children's services)
- EQ-5D scores: extent of problems with – mobility, self-care, usual activities, pain/discomfort, anxiety/depression
- EQ-5D VAS scores
- Do you have any physical or mental health conditions or illnesses lasting or expected to last 12 months or more?
- Do any of your conditions or illnesses reduce your ability to carry-out day-to-day activities?

Appendix J
Ethical considerations

During the feasibility study, the project team took advice from the Chair of the University of York Health Sciences' Research Governance Committee (HSRGC), with regard to requirements for ethical approval, given this project does include some methods (e.g., surveys and interviews with advice HJP clients) where there is the potential for interviews to create ethical issues or other risks for participants (e.g., identifying sensitive data or creating distress). Furthermore, if there is a possibility of wishing to publish results in the future, journals might require some form of ethics review/approval. As such, the project team concluded that the evaluation plans should be submitted to the HSRGC for consideration in the first meeting of 2022. Ethical approval was granted by the HSRGC in May 2022, giving assurance that our research methods align with the principles of research ethics, as set out by the Government Social Research (GSR) unit and the Social Research Association's (SRA) Ethical Guidelines.[18] After careful consideration, IFF Research and YHEC concluded that the proposed evaluation did not require further ethical approval from the Health Research Authority (HRA), as it indicated that service evaluations do not require HRA or NHS ethical approval.

This research has engaged individuals who are experiencing complex, stressful and upsetting problems, and so will we were careful to design our research approach to be sensitive to such issues. Key ethical concerns and mitigations are covered as follows:

1. **Informed consent:** Participants must understand who is doing the research, its purpose, what data are being collected, whether and how the session is being recorded or observed, and how the results and their personal data will be used. They must also understand their participation is voluntary, and that they can stop or withdraw at any time. For the impact survey, this information was given both by advisers who asked for initial consent to share a survey link with the participant, and was reinforced immediately prior to participation in the introductory text to the

[18] GSR professional guidance for ethics: 2021-GSR_Ethics_Guidance_v3.pdf (publishing.service.gov.uk) and SRA 2021 ethics guidance SRA Research Ethics guidance 2021.pdf (the-sra.org.uk)

survey. For HJP client interviews, this was covered both during recruitment (after they had participated in the survey) and at the beginning of each interview.

2. **Ensuring accessibility of participation:** Participation must be accessible to all those that the research is relevant for, and that the interview experience is a positive one. To ensure this, research materials were designed to ensure a logical flow of questions, with minimal complex language. All online surveys were digitally formatted so they can be accessed and read easily on a mobile phone and the option to opt for a telephone survey was made available for advice hub clients. In a small number of cases, IFF researchers travelled to the HJP to conduct client interviews face-to-face with particularly vulnerable clients where an online or telephone interview would have been inappropriate. It, however, was not possible to source the counterfactual group through a an RDD telephone sample, and an online panel only approach was used.

3. **Avoiding personal and social harm**: The feasibility study found that advice hub clients are likely to be experiencing sensitive and stressful situations, particularly given the dual components of legal and health concerns that they are dealing with. Guides and surveys were therefore designed to avoid antagonising their situation, ensuring that topics covered by the research are only as sensitive as absolutely necessary in order to meet the objectives. Qualitative discussion guides used open lines of questioning which empowered HJP clients to talk about their advice experiences in their own terms, with follow-up probes used to gather further detail in line with the research objectives. Researchers also stressed in advance, and during the interview or survey, IFF Researcher's independence from the HJPs and Ministry of Justice, and that taking part is entirely voluntary and that no answer is mandatory. All researchers and interviewers were trained to carry out interviews with vulnerable interviews, and in the process for escalating any concerns about participant wellbeing. To reflect gratitude for the time that advice hub clients contribute towards this evaluation, thank you payments in the form of Amazon or Love2Shop vouchers were offered for both the survey and interviews to acknowledge the valuable contribution these vulnerable participants are making. Respondents in the counterfactual group were identified as not having accessed a

HJP despite having a legal issue, but the majority had accessed some other form of advice (23% had not) and were not precluded from doing so by participating in the study. These respondents were also incentivised via the online panel provider.