Submission to the Health and Social Care Committee

Associate Professor Dr Liz Curran SFHIE and Solicitor (non-practicing)

27 January 2023

Background Information from Inquiry Web Page

The nature of the issue that the Committee should explore, why it deserves attention from the Committee now, and how Government policy in this area could be developed or improved.

The deadline for submitting a proposal is 8 February 2023. Unfortunately for this stage of the inquiry late submissions cannot be accepted. The Committee is not able to take up individual cases or complaints.

Proposals will be considered on the basis of merit, including:

- why the Health and Social Care Committee should consider this issue as part of its Prevention inquiry,
- why the Committee should look at it now: in particular, whether there is an opportunity for it to add value to existing research and evidence;
- why this area would benefit from scrutiny; and
- why the Government needs to take action in this area.

Please submit your proposal using the online portal here. If you have any difficulties, or questions, please email hsccom@parliament.uk

Summary

My submission is that through on the ground information that localised organisations can identify and by building on, developing, and creating trust in communities and delivering services in a coordinated and varied multi-pronged way presents a wonderful opportunity full prevention of poor health outcomes, is empowering not only for clients, patients, and community but also for the professionals that worked together in the services being proposed. The evidence is that by working together in an interdisciplinary way practitioners learn from each other, learn new ways of doing things, build reflection into their practise and combined they can make creative, innovative, and preventative solutions materialise and longer term can be an effective use of public funding.

Please note that the views expressed in this submission are the views of Dr Liz Curran and are informed by her research and practise experience. This includes working in a community health setting for 10 years as a community lawyer. Any views submitted here are not necessarily the views of Nottingham Trent University.

In the current climate, where people are under extreme pressure because of the recent pandemic, years of austerity and recent cost of living pressures many of the most disadvantaged in the community in the United Kingdom are finding it difficult to deal with the causes of their problem. Living with these problems and pressures places huge stress on individuals and family. Unresolved problems can lead to poor health outcomes an exacerbation of existing health and mental health conditions. There is a body of research that supports this conclusion including my own (Pleasence et al 2004-2017; Curran 2016-2022).

My research has shown that there are innovations which can be made, which although not easy because of different professional cultures, can lead to significant at lasting inroads that prevent poor health outcomes and present opportunities to support people in social care beyond those that are currently available (Curran 2022).

It is my submission, that a fundamental re-examination of how services in the United Kingdom are funded is needed. This includes an acknowledgment that the social determinant of health outcomes will never be improved with the current siloed, sporadic, and difficult funding regimes in which frontline service delivery agencies tend to operate. Public health for many years has looked at the important role of health promotion and the use of primary healthcare including allied health services in preventing problems as well as ensuring earlier intervention. Many people in poverty an experiencing discrimination for multiple reasons in the United Kingdom and are only likely to get help at the ambulatory end and when they are in crisis, rather than providing holistic, client centred support at the earliest possible stages to assist in problem solving an active and effective referral.

Currently, and rightly, a lot of funding of services occurs at a bureaucratic and accountability level. Although this is critical for ensuring client care and accountability sometimes the expenditure of public funds happens at the top levels and in administration and in unnecessary bureaucracy and contract management. This top-heavy administration diverts much needed limited funding from the frontline. It is my submission that this money could be better spent if it were redirected to early intervention and proper support for members of the community. Early intervention programmes would involve not only better funding of different disciplines in health and social care but an acknowledgement that many of people's problems and stressors arise from poor housing, inhumane and degrading conditions in housing such as mould and damp, a lack of income support to enable people to have food and heating, all of this has implications on children and educational attainment and health.

My research shows that the development of 'one stop shops' which incorporate community lawyers (namely law centres) who worked alongside and with other professions such as doctors, nurses, psychologists, mental health professionals, family counsellors, use workers, community support workers can make significant inroads into a social determinant of health.

This, however, cannot be imposed from the top down but must be organic and based on a range of organisations that come together with similar values and similar expectations, who have built trusted relationships across and between grassroots agencies and with the community and a long held commitment to support community members. However, currently these agencies do so without the adequate resources and funding and with overly

cumbersome reporting and accountability requirements that cause barriers. These factors impede the effective navigation of services, assessment, and effective triage so that people's problems can be dealt with or in one location and with the necessary supports being put in place in a holistic way rather than the current patchy, splintered, and reactive response that results from the barriers noted above. This means that patients and clients and patience currently must navigate a siloed, fragmented and complicated service system (Curran 2019, 2020, 2022).

Referral fatigue is a common phenomenon in the United Kingdom (Genn, 1999). We also know that there are barriers that prevent people from being able to seek advice and that often advice services can only provide very minimal service because of limitations in their contracts. This can be confounding, overwhelming and often people just give up. This is counterproductive to ensuring prevention and early intervention in people's health and social care needs.

Health justice partnerships (HJP) exist in the United Kingdom in some pockets as an attempted work around to go to where the people are likely to turn to for help and feel trust and confidence that often they do not feel with lawyers in traditional private legal practises or in other settings. This submission is not focusing on the ambulatory or hospital end but rather why is in which prevention an early intervention can occur through community organisations in local communities to avert peoples a necessary needing to go to hospital. People are going to hospital where there is significant illness that has escalated due to poor interventions earlier. The network of Citizens Advice Bureaus across the United Kingdom (whilst an important aspect in advice) do not provide the depth and level of support for prevention and early intervention in their often-one-off sessions with community members that I envisage would be necessary to make inroads into poor health and mental health and lead to prevention an improved access to legal support. timely legal support and secondary consultation with an ability to examine documentations and take detailed and full instructions from clients or patients can lead to reductions in date, the placement of people on pensions they are entitled to and earlier negotiation with authorities so that improved outcomes can occur, for instance in correct support and averting children being placed in institutional care. These some of the outcomes that has been proven in recent evidence to flow from the development of health justice partnerships (Curran 2022; Gyorki 2017, Tobin-Tyler 2016, 2022; Forsdike et al 2017). Such interventions enable inroads to be made into inequality through multiple professionals combining to shape and inform policy improvements based on repeating problems or trends that have been identified through analysis of casework. This also leads to downstream savings at departmental level across health and other government departments

Currently, by funding a range of different services to do different things in different places may not always be appropriate and can be incredibly expensive for the actual inroads that they make because the services are often one off, splintered, uncoordinated and so do not necessarily have an impact or provide an effective service model.

What I am recommending to this inquiry needs to go beyond patchwork and Band-Aid treatment too deep and entrenched problems. This includes funding a service model that

targeting and works with communities experiencing poverty and socio economic and cultural disadvantage. The service would not only provide multiple layers of service to members of the community but understand the complexity of peoples social, cultural, and economic position in the way in which it responds to their problems which can lead to poor health outcomes. In this model funding would be provided to not only give one off advice which can have limited utility for such entrenched problems, but rather enable services to do the following:

- Community based placement of models utilising existing organisations with a track record of being local, trusted, and responsive. In building this model this is essential, rather than funding new services and entrants who may be large scale and monopolistic. This approach means that local knowledge and understandings, established trusted relationships and knowledge of local community can be utilised as these are absolutely critical to bringing into these services clients who are often reticent, frightened or unaware that their situations could be capable of help and solutions.
- Co locates different services together which have shared values and specifically work with different groups that include health, allied health social and justice services (specifically law centres which have the non-hierarchical modes of private practise and approachability and interpersonal skills in dealing with vulnerable groups that often are lacking in traditional law firm models. My research indicates that this traditional model can be alienating both too different professionals and clients.
- Funding that recognises that time spent on building trust between professionals and developing relationships of trust which are precursors to effective assessment, referral and follow up can have long term benefits and payoffs in making inroads into client and patient problems and save downstream costs of problem escalation because they can intervene earlier.
- ‘No wrong door’ policy, once people have passed a realistic means test effective trained intake, assessment and triage can occur within the one stop co-located service. International experience shows that professional obligations and ethics can be effectively managed through good information technology systems, consents, and protocols.
- The services be able to involve themselves in providing holistic multiple layered services that can shape an inform each other to develop responsive and good practise and strategies for earlier intervention and prevention.:
    i. Localised community engagement and strategies that include working with community members and taking their advice on how to develop sophisticated strategies to reach people who would otherwise not feel comfortable seeking help
    ii. harneses the borrowed trust between the different professionals that might mean a more holistic response to multiple and varied problems that intersect

and cascade across different disciplines such as law, health, cultural, social, and economic.

iii. providing information,

iv. advice,

v. treatment,

vi. health promotion,

vii. community development,

viii. the development of peer-to-peer groups to enable connection, reduce social isolation and enable members of the community to build on the learning that they have through the community developed model mentioned above

ix. professional development training,

x. advocacy,

xi. representation before tribunals and courts e.g., housing, pensions, debt etc

xii. strategic policy advice by identifying problematic trends in casework with each of the different disciplines involved in this multidisciplinary practise being able to proffer different perspectives on a problem (because by working together and seeing more community members these can easily be identified in a systematic way) that indicate how causes of problems can be resolved.

xiii. shared staff meetings, team meetings where the different disciplines can come together to discuss problems, common barriers. and challenges to discover innovative work arounds and strategies utilising structures that exists within the service to minimise conflicts of interests or breach of client confidentiality.

Below are a list of existing services including ones that specifically target not only health but social care in their models that showcase the models that are being advocated in this submission. It also includes some links to YouTube clips that briefly convey the sort of model that is being suggested here.

https://www.youtube.com/watch?v=fWSzWulro4U

https://www.lawgazette.co.uk/practice-points/early-access-to-legal-support-can-make-a-real-difference/5114516.article

https://ohrh.law.ox.ac.uk/the-partnership-between-health-and-law-to-ensure-human-rights/

https://justiceconnect.org.au/our-services/seniors-law/about-hjps/

https://openresearch-repository.anu.edu.au/handle/1885/107085

https://www.ssph-journal.org/articles/10.3389/phrs.2021.1603976/full

https://justiceconnect.org.au/wp-content/uploads/2018/11/HJPs_Toolkit_final_new_brand_20181023.pdf

https://maternityaction.org.uk/wp-content/uploads/Evaluating-HJPs_challenges-and-opportunities_FINAL.pdf

https://imcl.org.au/our-services/health-justice-partnerships/

https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3076407

https://journals.sagepub.com/doi/10.1177/1037969X19843624

https://journals.sagepub.com/doi/full/10.1177/1035719X19832688

I am happy to talk further with the committee about what this might look like and how it could be rolled out in the United Kingdom. (Liz.Curran02@ntu.ac.uk)

I am already aware of the great work that is done by the Great Ormond Children's Hospital in London and by University College London in its Access to Justice Centre Model with clinical students working in GP clinics. However, the model I am advocating here is different and would require a wholesale re -examination of the policy settings, current funding models which in my view often currently inhibit and exclude innovative thinking, progressive models that are responsive and tailored to what the community needs. These can be siloed, cumbersome, and developed through a 'top down' response by people who have limited exposure to the sorts of problems and barriers that currently exist in the United Kingdom across diverse communities. This has been highlighted in numerous research studies in the United Kingdom (LSRC 2001-2013).

Opportunities to intervene earlier and prevent problems from occurring are currently often being missed.

Dr Liz Curran

Associate Professor Clinical Legal Education and School Research Impact Lead

https://www.ntu.ac.uk/staff-profiles/law/liz-curran

Nottingham Law School, Nottingham Trent University

Chaucer Building
Goldsmith Street
Nottingham
NG1 5LP

Submission complete

Your submission reference is UGC121384

This reference will be sent to Liz.Curran02@ntu.ac.uk.