



MAXIMISING OPPORTUNITIES: final evaluation report of the Healthier, Wealthier Children (HWC) project

Lynn Naven
Richard Withington
James Egan
Glasgow Centre for Population Health
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“The model for transformational change puts the onus firmly on universal services as key agents in delivering improved outcomes. A lot of people doing at least a little to effect change will achieve much more than a few people doing a lot within an early years context.”

*The Early Years Framework,
Scottish Government, 2009*

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Executive summary

Background

This report presents the evaluation findings from the Healthier, Wealthier Children (HWC) project. The project involved developing new approaches to providing money and welfare advice to pregnant women and families with children at risk of, or experiencing, child poverty across NHS Greater Glasgow and Clyde (NHS GGC). Funded by the Scottish Government, the 15-month project involved a range of partners including NHS GGC, Glasgow City Council, other council partners, and the voluntary sector.

By creating information and referral pathways between the NHS early years workforce and money/welfare advice services, it was envisaged that staff, such as midwives and health visitors, would strengthen the identification of need for advice among pregnant women and families, thereby mitigating the impact of child poverty.

Operating within the ten Community Health and Care Partnership (CH(C)P) areas that existed across NHS GGC in 2010, the project development and subsequent delivery was primarily coordinated by health improvement staff and commissioned HWC advice staff. It was supported by local planning groups operating in each CH(C)P area between October 2010 and March 2012.

The evaluation of the project was undertaken by the Glasgow Centre for Population Health (GCPH) and utilised a mixed methodology, with data collected between October 2010 and January 2012. The evaluation findings cover three key areas:

- Impact of the project on clients
- Factors associated with effective local HWC delivery models
- Impact of the project on workforce practice, policy and strategy.

HWC evaluation findings

Impact of the HWC project on clients

- Between October 2010 and January 2012, the project achieved an overall financial gain of £2,256,722 for pregnant women and families accessing HWC advice services
- In the period between January and March 2012, when the project delivery ended, it was estimated that further financial gain of £836,843 would be achieved for those clients still awaiting some type of financial outcome.
- Combining the achieved and estimated figures resulted in an overall project gain of just over £3 million.

- ⦿ 2,516 referrals were recorded by the HWC advice services across NHS GGC with the majority of referrals coming from health visitors (51%) and midwives (29%).
- ⦿ Of the 2,516 referrals, 1,347 (54%) accessed some type of advice. Almost one in two (663) people receiving advice were entitled to some type of financial gain, with an average annual client gain of £3,404.
- ⦿ Other gains from accessing advice included help with childcare and housing, support with charitable applications, advocacy, switching to cheaper utility options and an increased uptake of Healthy Start vouchers. One in twenty people receiving some type of gain were awarded Healthy Start vouchers to exchange for milk and vitamins for children.
- ⦿ Eight percent (110) of people accessing advice were referred onwards for additional help. The four most frequent reasons were other financial support, immigration issues, social work support and accessing voluntary organisations.
- ⦿ Follow-up interviews with clients accessing advice revealed that a number reported reduced stress, improved mood and increased sense of self-worth and security. Some also saw an improvement in relationships with families and friends.
- ⦿ The gains (financial and non-financial) achieved for pregnant women and families with children are important determinants of health that can contribute to improving overall family wellbeing.

In terms of the HWC project reaching targeted groups:

- ⦿ The majority (77%) of people accessing advice had a monthly household income of less than £1,399 which is slightly above the £1,349 eligibility threshold for Healthy Start vouchers, primarily offered to low income groups on certain types of benefits and tax credits.
- ⦿ Among those receiving gain, one in five families were awarded a Disability Living Allowance payment.
- ⦿ The majority of advice clients were lone parents (59%) with the project also successfully reaching minority ethnic groups in south and west Glasgow. However, it appeared to be less successful in reaching other groups, such as kinship carers and people using mental health and/or addiction services.

Factors associated with effective local HWC delivery models

To understand the role of local partnerships on the project outcomes, the key areas investigated were levels of agreement and commitment among local HWC partners; leadership and management; and effectiveness of project delivery.

- ⦿ There was strong evidence of effective commitment to the project among partners at a CH(C)P level, which led to a number of successful outcomes. Links between NHS and money advice staff that existed before the project set-up were helpful in delivering the HWC project in large urban areas. In smaller, more geographically contained areas, the inherent challenges of new partnership work were more easily addressed.

- ☺ The quality of working relationships among project staff was an important contributory factor in achieving successful delivery of outcomes. However, case studies demonstrated that attributing successful outcomes to partnership work requires a degree of caution as a range of other contextual factors could have impacted on local HWC outcomes.
- ☺ The joint working between health improvement and HWC advice staff promoted the development of a flexible delivery approach. New approaches included offering 'out-reach', home appointments and telephone client assessment.

Challenges to partnership working were also identified:

- ☺ The project was viewed by some HWC advice staff as being governed by an NHS agenda. They felt there was a need for more advice staff representation on strategic groups.
- ☺ Advice services considered existing NHS information sharing and data protection protocols a challenge, particularly when processing referrals. However, it was noted that this was not unique to the HWC project and further investigation might be needed to improve this area of partnership work in the future.

Impact on practice, policy and strategy

- ☺ Midwives and health visitors appeared to be integrating HWC into their daily practice, despite the challenges of ensuring 'buy in' from a workforce often responding to sizeable caseloads and a range of needs, with high child poverty rates in some areas. Both staff groups highly valued the work and reported a willingness to continue supporting families and referring onwards to advice services.
- ☺ At the outset, there were differences expressed about the referral criteria, particularly around the household income upper threshold level. Discussions were often shaped by views on adopting a targeted versus universal approach, but a strategic decision favoured a more universal approach, as the project aimed to target pregnant women and families not only experiencing, but also at risk of, child poverty.
- ☺ The HWC project was an important catalyst in supporting a system-wide move towards adopting and reporting on child poverty activity, thus ensuring that it is articulated and recognised within future NHS GGC performance frameworks and local CH(C)P plans.
- ☺ NHS senior management acknowledged the need to strengthen future collaboration with local authority partners to take this work forward. There was also evidence of its impact on a recent partnership approach to commissioning advice services in Glasgow city, which now includes aspects of HWC project delivery.
- ☺ In 2012-2013, the HWC advice services will receive reduced funding from the Scottish Government and NHS GGC to ensure this work continues to be embedded over the next year. Against the backdrop of constrained budgets and recognising the specific issues that pregnant women and families may face, some local HWC advice services are already delivering services in new ways by offering early intervention and initial telephone contact to identify and prioritise need.

Discussion and project lessons

The introduction of the HWC project across NHS GGC presented a range of practice, partnership and policy challenges. However, despite these, and operating within relatively short timescales, the project successfully achieved a range of client, workforce and policy outcomes, which offer learning points for the future direction and wider implementation of this work across NHS GGC and beyond.

Key client lessons

- A significant number of families were apparently unaware of their entitlements and may not have approached traditional advice services for help. This suggests an opportunity for further awareness raising among all early years and advice staff to maintain and increase uptake of advice among this target group.
- Although the level of Disability Living Allowance (DLA) awards was good, this area of work may require further attention as concern has been expressed in a recent Scottish Parliament Committee Report that the move from DLA to Personal Independence Payments could negatively impact at household and local authority levels.
- The broad range of client gains, both financial and non-financial, demonstrate that projects like HWC can potentially contribute to wider determinants of health, by influencing areas such as healthy eating, play and overall family wellbeing.
- There may be scope to consider developing links with local community networks and groups in contact with vulnerable groups likely to be affected by the unfolding welfare reforms, such as informal kinship carers and people with mental health/addiction problems, to ensure access to mainstream advice, information and support services.

Key partnership lessons

- Attributing successful outcomes to partnership work requires a degree of caution, as other contextual factors may have impacted on outcomes. However, pre-established NHS links with advice services, partnerships operating in smaller, more geographically contained areas, and the quality of working relationships appear to have been important factors.
- New approaches to offering advice services, which included 'out-reach', home appointments and telephone client assessment, may ensure that these services are more accessible to pregnant women, families and the early years workforce.
- Information sharing and data protection challenges suggested a need to improve this area of work between the NHS and advice services.
- There is a need to ensure that advice services become more involved in shaping the strategic decision-making processes involved in taking forward future project delivery.

Key practice, policy and strategy lessons

- This study adds to a limited evidence base by demonstrating that midwives and health visitors can play a significant, contributory role towards addressing child poverty. With two CH(C)P areas reporting higher midwifery referrals, compared with health visiting referrals, there may be engagement lessons to be shared from these areas.
- The project referral criteria incorporated a proportionate universal approach which involves developing a proportionate response to differential levels of disadvantage. This approach led to good uptake of advice services among low income households and lone parents. However, it was less successful in reaching other vulnerable populations. Therefore, there may be value in discussing the merits of combining a proportionate universal approach with additional targeting of specific groups.
- There is potential to share lessons from the recent partnership approach to commissioning advice services in Glasgow city that involved local authority, health and housing partners.

Conclusion

This evaluation demonstrated that the HWC project generated impressive gains for pregnant women and families, despite being a newly-established service operating over a short timescale. Many of these important gains may not have been accessed through traditional money/welfare advice service delivery. The HWC project also raised NHS workforce awareness of child poverty issues by providing a mechanism for referring vulnerable individuals and families for advice and support. Equally, it encouraged local money and welfare advice services to increase their engagement with the child poverty agenda.

Over the next decade, child poverty rates are expected to increase significantly. Despite these wider challenges, in 2012-2013 the HWC project will continue to build upon its positive outcomes, by supporting pregnant women and families at risk of, or experiencing, child poverty across NHS GGC. There is also scope to share lessons from the project with a range of other partners committed to reducing the harmful impact of child poverty.

1. Introduction

In November 2010, the Healthier, Wealthier Children (HWC) project was officially launched in Glasgow. The project secured a grant of £1,058,375 from the Scottish Government's *Achieving our Potential* programme to address child poverty across NHS Greater Glasgow and Clyde (NHS GGC).

A catalyst in the development of the HWC project was an attempt to increase the uptake of the Healthy Start voucher scheme which provides pregnant women and families on certain benefits access to healthy food and vitamins. The Healthy Start work, which involved targeting the NHS GGC workforce, revealed a need for clearer links between this workforce and money/welfare advice services (hereafter known as HWC advice services) to address child poverty.

In a collaboration that included NHS GGC, local authority partners, the voluntary sector and the Glasgow Centre for Population Health (GCPH), the central aims of the HWC project were to:

1. Test partnership models of providing local HWC advice services for pregnant women and families with young children at risk of, or experiencing, child poverty.
2. Build action on child poverty into mainstream services for children and families, and financial inclusion services, beyond the life of the project.

A HWC steering group was set up to provide strategic direction on the development, implementation, reporting arrangements and evaluation of the project. The group's membership included senior staff from GCPH, health improvement, children's services, financial inclusion, education, planning, mental health/addictions, voluntary sector and the Scottish Government.

An important part of the project delivery involved recruiting Development Officers (DO) and Money Advice Workers (AW). The DO staff were primarily located within local health improvement teams, with one post operating within community addiction services. The AW staff operated within voluntary and public sector advice services within local Community Health and Care Partnerships (CH(C)P) areas. These two workforces were tasked with working together, within the ten CH(C)Ps that existed at the beginning of the project across NHSGGC, to achieve the delivery outcomes.^a

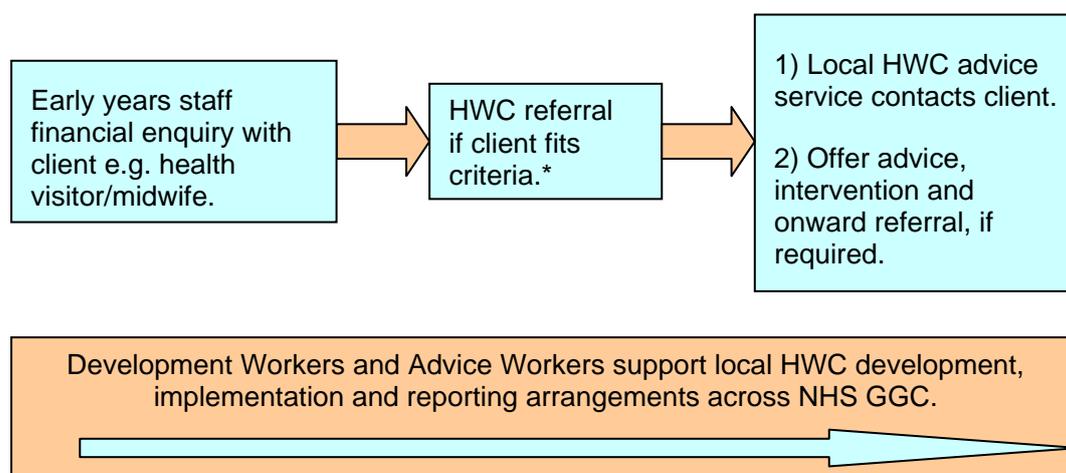
^a In October 2010, the five CH(C)P areas in Glasgow dissolved and subsequently reformed as a Glasgow city CHP with three sector areas: North West, North East and South. For the purposes of the evaluation, the original five CH(C)P structures were used.

The two key delivery outcomes involved:

- Ensuring early years staff had clear referral and information pathways to HWC advice services
- Increasing the numbers of pregnant women and families with young children receiving information, advice and support.

See Figure 1 for a schematic outline of the local HWC delivery process.

Figure 1: HWC project delivery process



* The agreed HWC referral criteria included pregnant women, families with children under five years and families with additional support needs for children up to 19 years old. Other criteria included minority ethnic groups (e.g. Roma), kinship carers and families affected by mental health and/or addiction problems. The maximum annual family household income for referral was set at less than £40,000 per annum – approximate with the upper Department for Work and Pensions threshold for child tax credit eligibility of £39,780.

The evaluation of the HWC project was undertaken by an evaluation team based at GCPH. The evaluation design utilised a range of quantitative and qualitative methods. The three key areas of investigation focussed on:

1. Impact of HWC on clients
2. Factors associated with effective local HWC delivery models
3. Impact on practice, policy and strategy

2. Background

A literature review was completed in August 2011 as part of the Healthier, Wealthier Children (HWC) evaluation. This focussed on the impact of poverty on children and women, initiatives set up to provide money advice in healthcare settings, partnership approaches to service delivery, and Scottish Government policy on child poverty. (A full copy of the Healthier Wealthier Children literature review is available on the Glasgow Centre for Population Health (GCPH) website: <http://www.gcph.co.uk/publications.>)

2.1. Poverty, children and women

There are important equality dimensions to child poverty. Pregnancy and the period after birth can impact on a family's circumstances with loss of earnings, increased costs of a larger family and the possible need for a larger house.¹ The responsibility of looking after a young child can make these changes more difficult with a greater impact likely among women living in or at-risk of poverty. With women more likely than men to live in poverty and work in part time and/or low-paid jobs,² they often have caring responsibilities which may limit their capacity for paid work. As the majority of lone parents are women, they are also at greater risk of poverty by having to combine employment and family responsibilities.³

The phenomenon of 'hidden poverty' is also more likely to impact women within the home, as they are more likely than men to go without in order to provide for families, and have responsibility for most of the management of poverty and debt which is likely to impact adversely on their mental health and wellbeing.⁴ There is also considerable evidence that families with disabled children, refugees, most minority ethnic groups and women with drug problems are at greater risk of poverty.^{5;6;7}

2.2. Providing advice services in health care settings

Most studies that investigated advice service provision in healthcare settings have focussed on the impact on older people and reported on three important outcomes: increased financial gain^{8;9;10}; greater financial knowledge and financial capability¹¹; and notable improvements in service users' mental health and wellbeing.^{12;13;14;15} However, one particular study that focussed on families with very young children accessing advice within a primary health care setting found that over half of them received some financial gain.¹ The Health Visitor's role appeared to be an important influence on whether families accessed advice. Women described a more empathic health visitor relationship in which there was a willingness to talk about money worries as well as encouraging advice uptake. In contrast, women who did not access advice reported their health visitor relationship as being shaped by a focus on health and development issues, instead of social and economic circumstances.

Some groups at risk of poverty – including those with young children and those with drug problems – may not be in regular contact with primary health care services and are more likely to be in contact with other parts of the NHS, such as Maternity and Addiction Services which may be better placed to ensure access to advice.¹⁶ To avoid a 'one size fits all' response, it has been argued that what is needed is the delivery of appropriate and accessible advice services for different individuals and groups.¹⁷

2.3. Developing partnership responses

An investigation into partnership work between advice and primary care services found a strong correlation between partnership processes (e.g. staff engagement; shared agreement and respect) and outcomes (e.g. improved staff experiences; financial gain for service users).¹⁸ A strong link was found between health staff enthusiasm for services and the high numbers of referrals to these advice services. In contrast, lower referrals were linked to a lack of staff commitment and awareness about advice services. With the authors noting that causality could not be established, it highlights the need for a degree of caution as outcomes may be the result of other factors (internal or external) that had little or nothing to do with partnership processes, per se. A framework has been designed to enhance understanding of successful partnerships with a focus on the relationship between partners, the 'health' of the partnership, outcome measures and whether the partnership leads to more efficient and effective services and improved outcomes for service users.¹⁹

2.4. Policy context and challenges

In Scotland, despite a previous reduction in child poverty levels over an eight year period, from 2004 onwards there has been little change, with levels remaining between 20% and 21%. However, the scale of the challenge ahead is acknowledged within three national frameworks that, collectively, aim to tackle child poverty: Achieving Our Potential, Equally Well and the Early Years Framework. These clearly identify financial inclusion and income maximisation in particular, as key approaches to address income inequality and poverty with an expectation that agencies work together to ensure better outcomes for young children. Reiterating the challenges ahead, the recent Child Poverty Strategy^{20 (p3)} noted that:

"It is unacceptable that one fifth of children in Scotland are growing up in relative poverty, and that these children's future outcomes are so heavily influenced by their parents' economic circumstance".

Against the backdrop of these high child poverty levels, there are more than 14,000 hospital births each year across NHS Greater Glasgow and Clyde (NHS GGC).²¹ With a combined midwifery and health visiting workforce of more than 1,200 staff,²² this HWC project provides an added partnership opportunity to address these high levels of child poverty.

3. Project set-up and delivery

3.1. Introduction

Before the project launch, a Healthier, Wealthier Children (HWC) steering group was established to take the work forward. This strategic group was supported by a monitoring and evaluation subgroup (overseeing data collection mechanisms and processes), and team development subgroups (which coordinated and facilitated project development across NHS Greater Glasgow and Clyde (NHS GGC)). These subgroups developed links with HWC staff operating within all Community Health and Care Partnership (CH(C)P) areas.

3.2. HWC steering group

The main remit of the HWC steering group was to provide strategic direction on the development, implementation, reporting arrangements and evaluation of the project. At the outset, the group had a sizeable and broad-ranging membership which included:

- Health improvement staff from each CH(C)P area
- NHS strategic staff (health improvement, addictions, inequalities, public health, mental health and employability)
- Local authority strategic staff (Glasgow city and Renfrewshire)
- National links (Scottish Government, Child Poverty Action Group (Scotland), Scottish Poverty Information Unit)
- Glasgow Centre for Population Health (GCPH).

There were two distinct phases in the HWC steering group development:

1. Initially, between October 2010 and January 2011, the group had a strong focus on operational delivery. However, there was recognition that a more strategic emphasis was required. This led to operational issues being fully devolved to development meetings attended by all Development Officer (DO) and Money Advise Worker (AW) staff and their respective line managers. It was also agreed that collation of evaluation data should be separated from performance reporting requirements. Local referral data would be coordinated by the NHS GGC corporate inequalities team (CIT) to support the project's future mainstreaming agenda.
2. In May 2011, the reformed steering group's membership was significantly reduced from more than 30 members to less than 15, with a focus on sustaining this work beyond the initial funding phase and strategic decision-making throughout the remainder of the pilot project. Three short-term subgroups were formed to work on issues of: future funding/commissioning; policy; and external communication. Subsequently, a HWC action plan (2012-13) was produced by the steering group.

3.3. HWC monitoring and evaluation subgroup

The principal role of the monitoring and evaluation subgroup was to develop and implement instruments and mechanisms for data recording and collection across all CH(C)P areas. These included:

- Establishing referral criteria and producing a HWC referral form
- Producing a client monitoring form to be used by the local HWC advice services
- Disseminating project developments via briefing papers and e-mail
- Developing a range of evaluation tools.

Subgroup membership included representatives from the Scottish Government, local authority, and NHS GGC staff from public health, corporate inequalities and health improvement. The group was chaired by a representative from the Scottish Poverty Information Unit. The evaluation team was employed by GCPH.

3.4 HWC development across NHS GGC

To support operational development across NHS GGC, local HWC projects developed links with the NHS GGC CIT. The CIT played a facilitative role which involved all HWC operational staff, including their respective line managers, attending regular development meetings. The aims were to discuss local project issues or concerns, share learning and develop resources. Tangible outputs from this work included:

- Producing and disseminating local resources and compiling a list of charitable foundations and organisations that other services could access for help
- Establishing a non-engagement protocol to address the high numbers of families not accessing the service at the outset
- Undertaking an Equalities Impact Assessment which highlighted training needs and led to changes to the client monitoring form to capture equalities data.
<http://www.equalitiesinhealth.org/>

Other NHS GCC development work, undertaken at the project outset, involved input from Save the Children – sharing their organisational learning and experience of developing effective engagement work with service users.

3.5 HWC planning and development within CH(C)P areas

The majority of CH(C)P health improvement leads (senior staff) set up new local HWC planning groups – or built links with established groups – to oversee project development and delivery. These local groups varied in composition but the majority included health improvement, early years' workforce and advice service or local authority representation.

At the outset, local development focussed on ensuring that early years' staff had clear information and referral pathways to advice services. The capacity-building work undertaken by the DO and AW staff included establishing communication links with frontline staff, raising awareness about the project, addressing training needs and supporting staff to refer clients on to local advice services (See Table 1). The initial intention was that early years education would also be a target for development work but most CH(C)P areas focussed in the first instance on health staff.

Table 1: Local HWC project delivery structures across NHS GGC

Local Area	Total HWC Staff		Local HWC Advice Services
	9.5 DO	8.5 AW	
East Glasgow	1	1	Third Sector
East Renfrewshire*	0.5	0.5	Public Sector
Inverclyde	1	1	Public Sector
North Glasgow	1	1	Third Sector consortium x 3
Renfrewshire	1	1	Public Sector
South East Glasgow	1	1	Third Sector
South West Glasgow	1	1	Third Sector
West Dunbartonshire	0.5	1	Public Sector
West Glasgow	1	1	Third Sector x 2
East Dunbartonshire**	0.5	-	Third Sector
Addictions Service***	1	-	Third Sector consortium x 3

* East Renfrewshire had one whole-time equivalent post covering the DO and AW roles.

** East Dunbartonshire did not receive local HWC advice service funding but submitted separate client monitoring data for inclusion in the project evaluation.

*** See Box 1 (page 37) for further details on the HWC addictions pilot.

Local HWC advice services developed four different types of service delivery:

- Type 1 replicated the 'core' service offered by established local money/welfare advice services i.e. a scheduled or drop-in appointment system.
- Type 2 involved 'out-reach' often within a health centre or clinic. Advice appointments were either scheduled or on a drop-in basis at various CH(C)P locations.
- Type 3 involved offering clients home-based appointments in some areas. This varied considerably across NHS GGC.
- Type 4 involved offering telephone appointments in many areas – providing basic advice and support over the phone to assess the need for further contact.

Most areas offered a combination of all four methods, shaped by factors such as the location of the HWC advice service, availability of NHS 'outreach' space, organisations' home visit policies, numbers of appointments and advice service capacity. Other factors, such as responding to local needs, impacted on the type of appointments offered. At the outset, those areas that identified a need for 'outreach' clinics believed that this approach brought added value when promoting and publicising the project to professionals and service users.

4. Evaluation questions and research methods

The key evaluation questions and main research methodologies used are summarised below. A multi-method approach was adopted which involved a range of qualitative and quantitative research methods. The project evaluation data were collected from October 2010 to January 2012.

Research Question 1: What was the impact of Healthier, Wealthier Children (HWC) on clients?

- Quantitative analysis of 2,516 client monitoring records, completed by local HWC advice services.
- Semi-structured interviews with a sample of 12 consenting participants that had received intervention(s) from local HWC advice services.

Research Question 2: What factors are associated with effective HWC delivery models?

- Documentary analysis of project staff diaries; recorded minutes from HWC meetings; needs assessment report completed by the addictions worker.
- Focus groups with money advice managers and advice workers

Research Question 3: How has HWC impacted on practice, policy and strategy?

- Workforce survey of an equally weighted random sample (30%; n=400) of the midwifery and health visiting workforces across NHS Greater Glasgow and Clyde (NHS GGC).
- Analysis of money advice managers' focus group transcripts.
- Documentary analysis of local 'project diaries' and strategic development reports.
- Six key informant interviews with senior representatives from NHS GGC (e.g. maternal and child health, CH(C)P, health improvement), local authority partners (financial inclusion) and the Scottish Government.
- Documentary analysis of local 'project diaries' and strategic development reports.

For more details on the evaluation instruments used to address the research questions, see Appendix 1.

Ethical approval

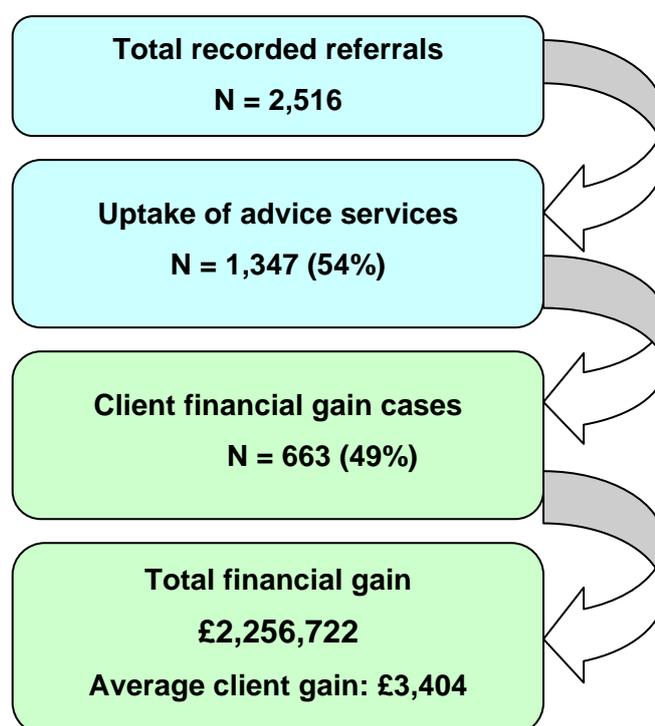
The HWC evaluation team sought ethical advice from the West of Scotland Research Ethics Service. It was advised that the evaluation work did not require NHS Research Ethics Committee review. However, all evaluation participants were provided with information sheets. Consent was obtained from service users before interviews were undertaken. The evaluation team ensured that all data were kept securely within password-protected electronic files, and hard copy data were stored in locked filing cabinets, in accordance with the requirements of the Data Protection Act (1988).

5. Impact of HWC on clients

5.1 Overall uptake of HWC advice services

Outcome data were obtained from monitoring records completed by local Healthier, Wealthier Children (HWC) advice services up to the end of January 2012. The key outcomes to assess overall project effectiveness included the number of client referrals received by money advice services, uptake of advice services and client financial gain. Referral sources were examined to assess if the project was engaging with the main workforce groups. Figure 2 outlines the key outcomes.

Figure 2: Project outcomes



Referrals

From 2,516 referral records, the overall uptake of advice services (54%) was an impressive proportion for a newly established service operating over a short timeframe within a complex and challenging landscape.

The overall 'Did Not Attend' (DNA) proportion of 46% included cases recorded as not contactable (23%), DNA (15%), declined services (5%) and not eligible or no information provided (2%).

The two main referring groups were health visiting (51%) and midwifery (29%). (See Table 2).

Table 2: Workforce referral to HWC advice services (Oct 2010-Jan 2012)

Total referrals	2,434	100%
Health visitor teams	1,246	51%
Midwifery	696	29%
Self referral	146	6%
Primary care	83	3%
Social work	75	3%
Education	56	2%
Money advice/welfare rights teams	25	1%
Staff nurse	25	1%
Paediatrician	24	1%
Voluntary health or social support service	23	1%
Health improvement	17	1%
Other specialist services/outreach clinics	18	1%

Additional referral data revealed that health visitors were the main referring group across all CH(C)P areas with the exception of Inverclyde and West Dunbartonshire which both recorded higher midwifery referrals. (Appendix 2 provides a breakdown of referrals from these workforce groups at area level).

HWC client financial gain

The analysis of client financial gain was based on the 1,347 clients who engaged with HWC advice services. For evaluation purposes, the final data were downloaded in January 2012 – two months before the project end date of March 2012. The method of calculating gain was adapted from an agreed approach used by Citizens Advice Scotland.

Client gains were presented as an annual figure which involved adding all income generated from intervention(s) undertaken on a client's behalf. Potential money advice interventions included:

- ☺ Child-related benefits
- ☺ Other benefits e.g. working tax credits
- ☺ Savings from debt written off, reduced debt payments or switching to a social tariff i.e. gas and electricity
- ☺ One-off payments e.g. Social Fund awards and backdated benefit amounts.

The project set out to provide Type I and Type II levels of service provision which covered welfare rights, income maximisation and debts. This work included active information, signposting, explanation (Type I) and casework (Type II). Although not part of the project remit, an option for onward referral for Type III service provision was available, which included advocacy, representation and mediation at tribunals or court action level.

With almost half (663/1,347; 49%) of those accessing advice receiving some type of financial gain, the overall actual gains, during the evaluation period, were £2,256,722. This figure included annual gains, covering benefits and savings, (£2,030,915) and all one-off payments received (£225,807).

All local HWC advice services were also invited to estimate future financial gain for cases awaiting an outcome between January 2012 and the project end date of March 2012. The total estimated gains for this three month period amounted to £836,843

(Appendix 3). This figure included annual gains covering benefits and savings (£746,336) and all one-off lump sum payments (£90,507). The actual and estimated financial gains for all HWC clients together yielded a total project sum of £3,093,565.

Further analysis of the money advice interventions offered to pregnant women and families revealed that 50/663 (8%) of all gain cases received a Social Fund award. More than eight out of ten were community care grants, with the remaining being a mixture of budget/crisis loans and unspecified awards.

Other non-financial gain

A number of clients received non-financial gain in addition to or instead of a monetary sum. These interventions included:

- Advice on benefit entitlements and timing of eligibility
- Childcare, employment and housing tenancy issues
- Charitable applications for household equipment and advocacy to re-negotiate payments to creditors
- Healthy Start vouchers

In the case of the Healthy Start scheme, one in twenty (33; 5%) client cases were awarded vouchers to exchange for milk and vitamins for children.

5.2 Local area outcomes

Table 3 shows local prevalence of 'child poverty', engagement with the HWC project and client financial outcomes by CH(C)P area.

Table 3: Local CH(C)P area outcomes

CH(C)P - % of 'children in poverty', 2009*		Engagement		Financial Gain		
		Referrals	Advice uptake	Annual gain (£)	Number (%) gain cases	Average gain per case (£)
E. Glasgow	38%	429	201 (46%)	412,832.80	110 (55%)	£3,753
North Glasgow	39%	278	129 (47%)	154,588.20	29 (22%)	£5,330
South East Glasgow	31%	311	153 (52%)	166,596.80	36 (24%)	£4,628
South West Glasgow	31%	358	214 (59%)	242,935.00	70 (33%)	£3,471
West Glasgow	33%	229	97 (42%)	169,602.20	32 (33%)	£5,300
West Dunbartonshire	25%	258	138 (53%)	253,640.30	45 (33%)	£5,636
Inverclyde	23%	248	153 (63%)	203,326.30	90 (59%)	£2,259
Renfrewshire	19%	375	241 (64%)	494,962.80	90 (37%)	£5,561
East Renfrewshire	10%	30	21 (70%)	15,293.80	5 (24%)	£3,058
East Dunbartonshire**	10%	-	-	155,460.00	156	£997
Overall		2,516	1,347 (54%)	2,256,722	663 (49%)	£3,404

* 'Children in poverty' definition: number of children living in families in receipt of Child Tax Credit whose reported income is less than 60 % of median income or in receipt of Income Support or (income-based) Job Seeker Allowance, divided by the total number of children in the CH(C)P area, as determined by Child Benefit data. These aggregated CH(C)P estimates are not directly comparable with the national relative child poverty figures and were used only for evaluation purposes.

** As East Dunbartonshire was not funded by the HWC project, the standard evaluation monitoring form was not used in this area. Therefore, data on local financial gain was obtained from their 'in-house' recording system.

Referral and advice uptake

In most areas the referral rate ranged from 229 to 375 with lower and upper exceptions in East Renfrewshire and East Glasgow, respectively. Good uptake of advice services was reported and ranged from 42% to 70%, with six areas reporting uptake higher than 50%, while rates in three Glasgow city areas were below 50%.

Financial gain

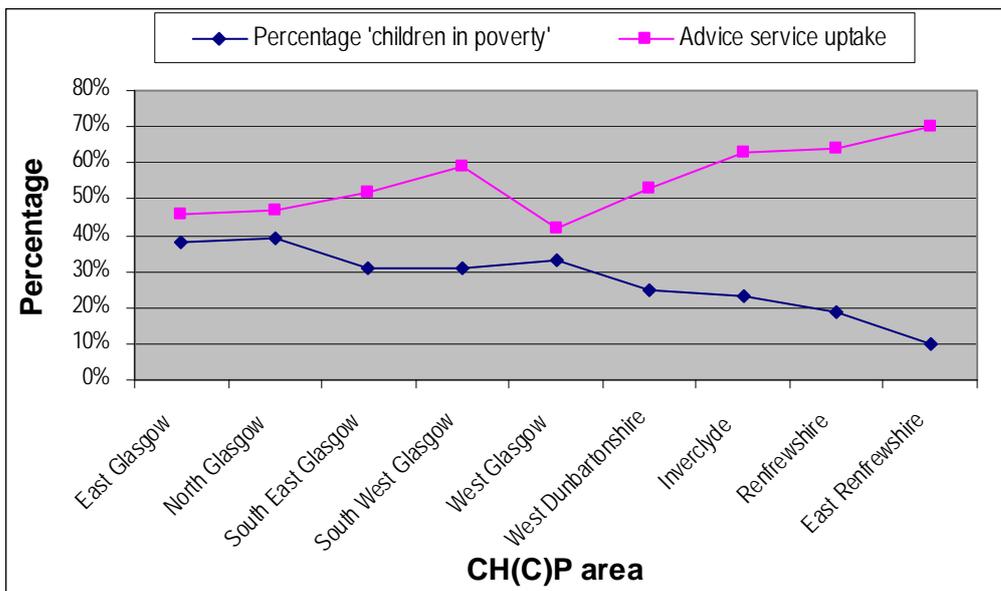
Most local areas reported higher average client gain than the overall average (£3,404). Four areas reported average gain above £5,000 – North Glasgow, Renfrewshire, West Dunbartonshire and West Glasgow.

At a CH(C)P level, East Glasgow and Renfrewshire reported gains in excess of £400,000. More than one in two clients receiving advice in East Glasgow had some type of gain compared with nearly four out of ten in Renfrewshire.

Although Inverclyde had the highest percentage of clients receiving some type of gain (nearly six out of ten), they also recorded the lowest average client gain (£2,259) across all CH(C)P areas.

Further investigation which involved comparing child poverty prevalence and advice service uptake across all CH(C)P areas revealed an apparent inverse relationship. As can be seen in Figure 3, there was higher advice uptake in areas with lower prevalence of child poverty, particularly outside Glasgow City.

Figure 3: Relationship of advice service uptake to 'children in poverty' by CH(C)P area.



5.3 Household needs recognised, referred and responded to by the project

In exploring the household needs recognised, referred and responded to, three key areas were investigated:

- 🌀 Family household income and types of families accessing advice
- 🌀 Disability Living Allowance (DLA) awards
- 🌀 Reach among at-risk groups.

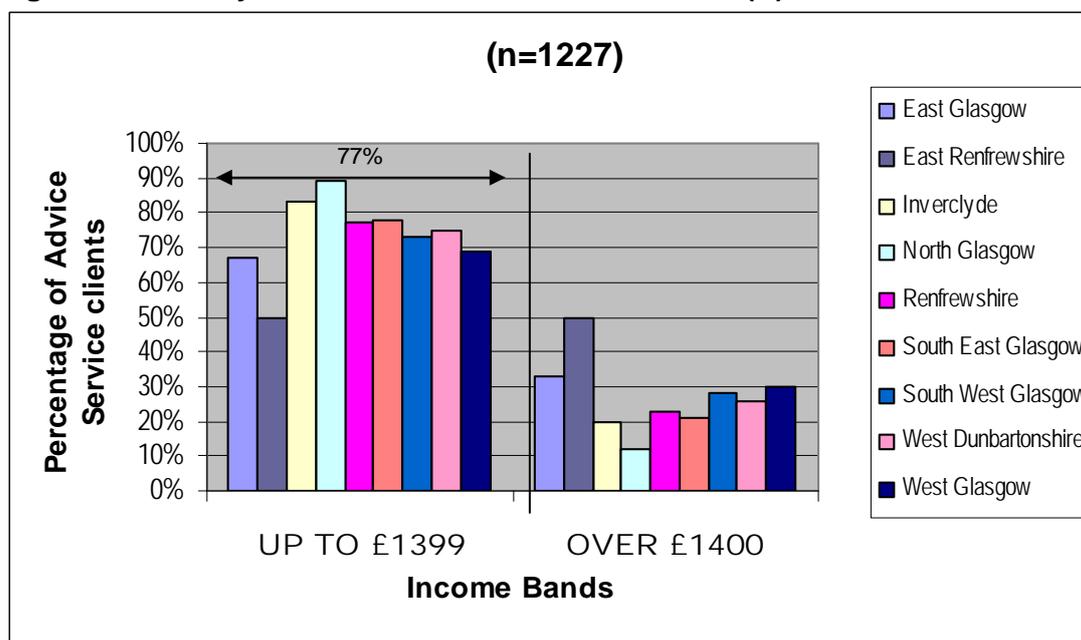
Family household income

Family monthly household income served as a key indicator of whether the project was reaching those most in need. Data were available from 1,227 of the 1,347 cases who engaged with advice services. Overall, more than 77% of people accessing advice had a monthly household income of less than £1,399, which is approximately equivalent to the £1,349 eligibility threshold for Healthy Start vouchers.^b

A breakdown by CH(C)P area reveals that North Glasgow had the highest percentage of clients (89%) reporting an income of less than £1,399, followed by Inverclyde (83%). The lowest percentage was reported in East Renfrewshire (50%).

The percentages of clients in the 'lower' monthly household income band in all other areas ranged between 67% and 78%.

Figure 4: Monthly household income of clients in CH(C)P areas



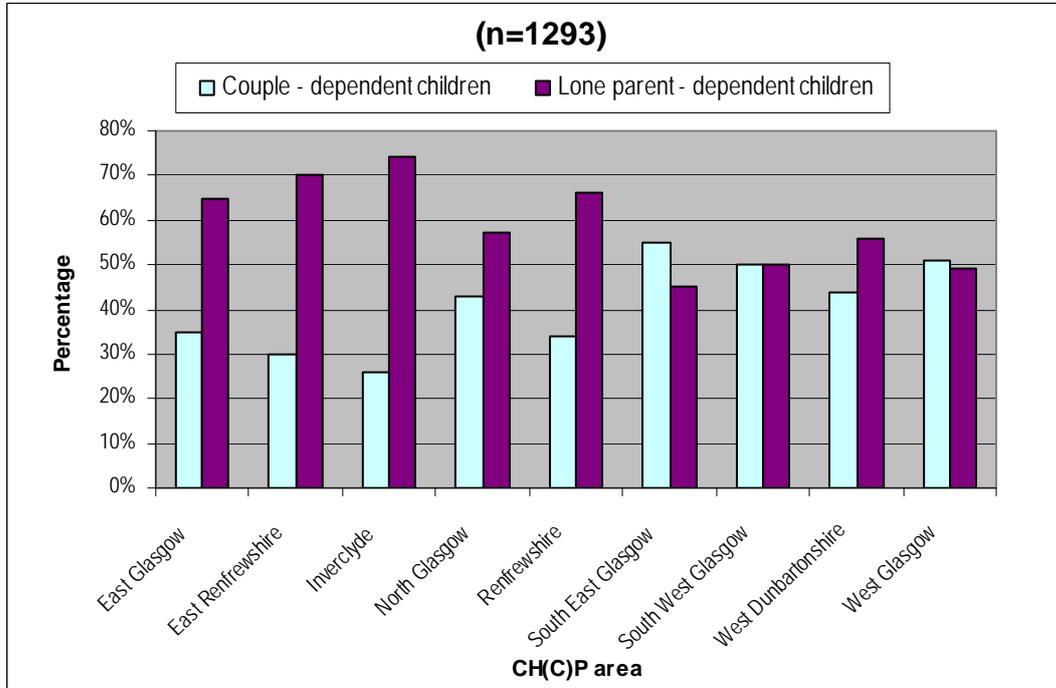
Further exploration revealed that a range of interventions were also carried out for clients with household income in excess of £1,400 per month. For example, 32 child DLA claims were either successfully made or awaiting an outcome across households with monthly income ranging from £1,400 to £4,000. This was equivalent to 24% of all adult and child DLA claims across the project.

^b Healthy Start eligibility includes pregnant women and families with children under age 4 that collect certain benefits, including Child Tax Credit (annual family income: £16,190 or less).

Types of families accessing advice services

The project appears to have been successful in targeting lone parents. Data recorded for 1,293 clients reveal that, overall, almost 60% of advice cases were lone parents compared with 40% who were couples. At a CH(C)P level, contact with lone parents ranged from 45% to 74% with most areas reporting rates of over 50%. See Figure 5 for a breakdown of family composition by CH(C)P area.

Figure 5: Family composition by CH(C)P area



Disability Living Allowance (DLA) awards

Almost one in five financial gains (133/663) resulted in a DLA payment being awarded. The three highest reported DLA areas were Renfrewshire (22%), East Glasgow (19%) and South West Glasgow (18%) (See Table 4). It was not possible to differentiate adult and child DLA award payments and there may be an element of under-reporting due to the time delay between applications and the award being granted.

Table 4: Percentage of Disability Living Allowance (DLA) payments by area

CH(C)P	Percentage of all DLA Awards
East Glasgow	19%
East Renfrewshire	2%
Inverclyde	3%
North Glasgow	8%
Renfrewshire	22%
South East Glasgow	13%
South West Glasgow	18%
West Dunbartonshire	2%
West Glasgow	14%

Reach among at-risk groups

The project appears to have had relatively good reach among minority ethnic groups. The ethnic background of most people referred to advice services was White Scottish, British and Irish origin (83%). This was followed by Pakistani (6%) with a range of other groups recorded in smaller proportions. In the 'other' reported category most were of Polish and African origin.

A comparison across CH(C)P areas shows that the highest proportions of minority ethnic groups were found in South East Glasgow (57/311: 18%) and South West Glasgow (54/358: 15%), followed by West Glasgow (20/299: 9%).

There was little reported evidence available to suggest wider reach among other at-risk groups, such as kinship carers and others with additional needs, such as people using mental health and/or addiction services.

The uptake of advice services by kinship carers across NHS GGC was very low with 22 (0.9%) formal kinship carers and 3 (0.1%) informal carers accessing advice. There was also low project reach among people living with mental health and addiction issues. People attending mental health services accounted for 37 (1.5%) cases. Uptake from people with addiction issues was even lower (21; 0.8%), despite a HWC addictions pilot. See Box 1 (page 37) for further details on the pilot.

Local advice services were encouraged to refer clients onward if they had other additional support needs. This resulted in 8% (n=110) of all clients accessing advice services being referred onwards. The four most frequent reasons for onward referral were:

1. Money advice/other financial services (n=38)
2. Immigration status (n=34)
3. Social work services (n=16)
4. Voluntary organisations (n=12)

Other less frequent referrals were made to employability, health and early education or childcare services.

5.4 Lessons from the client's 'journey'

To learn lessons from the HWC client journey, semi-structured interviews were undertaken with a sample of 12 service users who had had contact with HWC advice services across NHS GGC. Participant selection was based on the following criteria:

- ④ Referral route
- ④ Household composition e.g. pregnant/children under five
- ④ Referral outcome (financial gain/no financial gain)
- ④ Additional needs (child with disabilities, kinship carer etc).

The follow-up interviews covered clients' experiences of being referred for advice and their expectations of the service. Views were sought on the financial impact of receiving advice, changes in their knowledge, capability and confidence, and reported differences in mental wellbeing.

5.4.1 Referral experiences

Interviewed clients appeared to have a limited knowledge of the project during the referral process. They reported little in-depth discussion with referring staff about the project or what it could offer. Despite this limited awareness, most clients reported a good relationship with referring staff, which is likely to have made the referral process easier. Some clients did report less rapport. One mentioned that a social worker knew about the breakdown of her marriage and her financial difficulties but chose to refer, rather than provide financial advice and assistance. Another client was surprised that no one at the health centre mentioned the Sure Start maternity grant. This resulted in her losing out as the application was too late. Another was not informed that she was entitled to DLA, despite her son seeing a number of specialists who could have referred her for advice and help.

Case Study One illustrates the limitation of using a leaflet to signpost and the positive health outcomes from engaging with advice services and receiving additional support for onward referral to other financial inclusion advisors within the service.

Case Study One

Single mother working full-time: in debt through an on-line money lender as a result of borrowing money to pay off another bill. Mum now going without food so that she can feed her son.

In contact with local mental health services as the situation was getting her down. The mental health worker provided her with a leaflet about the HWC project but did not refer onwards. She kept the leaflet for one week before e-mailing the local HWC DO, as she felt she had no one to turn to.

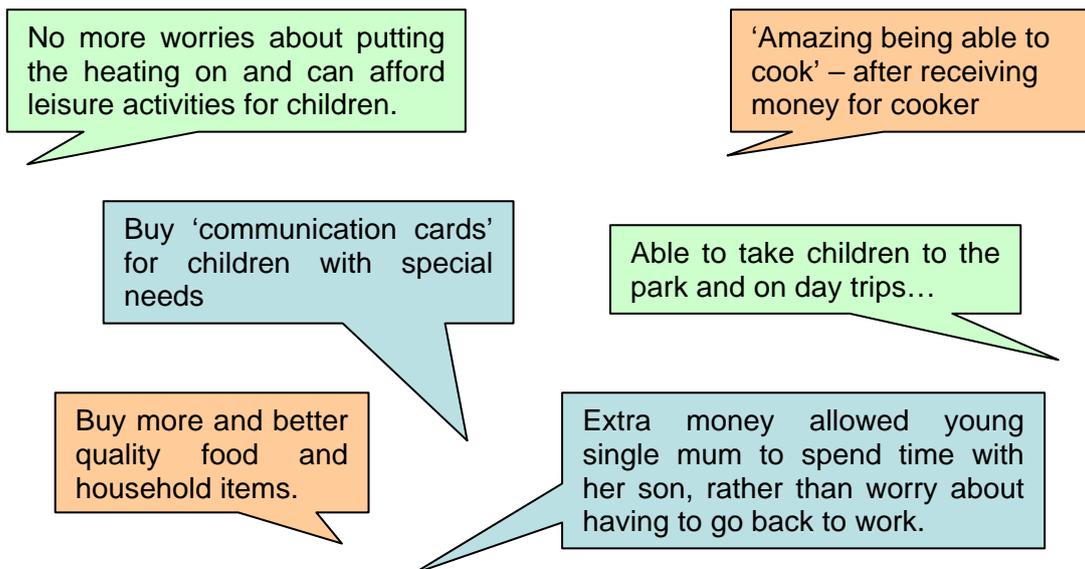
She was subsequently referred to the HWC advice service, which made an onward referral for debt advice management within the same organisation. Given help to re-negotiate debts into manageable payments which gave her enough money to buy food and take her son on trips. She reported feeling much better with less worry and stress.

5.4.2 Expectations of advice services

In general, clients had very few expectations of the services – based on lack of prior knowledge, due to never having been in a situation where they needed advice or expected to qualify for benefits. Despite many expressing initial apprehension about meeting advice staff, they valued their input and the assertive approaches adopted to address their needs: “*went out of her way*”; and “*knocked down barriers*”. The personal qualities of the advice staff, such as an informal approach to help put people at ease, were equally valued as professional skills.

5.4.3 Financial impact

Reported financial gains were variable. Some clients received new or additional weekly benefits and modest gains such as Healthy Start vouchers, others received one-off lump sums from charities, while some received no financial gain. However, what was evident was not the significance of the financial gain, per se, but its potential impact on other determinants of health, such as food, housing and quality of life for parents and their children.



Another positive outcome for service users was the ability of the money advisor to identify other financial concerns, especially debt, and give advice on how to control it.

5.4.4 Financial knowledge, capability and confidence

Clients valued advice staff's ability to explain, in an accessible and understandable way, the complexity of the 'system' and how to go about claiming some benefits. Other financial inclusion information, such as credit union savings accounts and mentored loans, was also viewed as particularly helpful. This is noteworthy, as the project has been able to build on an initial aim of maximising clients' income by encouraging onward referral and engagement with other financial inclusion services and options.

To assess financial capability before and after receiving advice, clients were invited to complete a standardised scale as part of the interview schedule. The five point capability scale ranged from:

1. Managing very well
2. Managing quite well
3. Getting by alright
4. Having some financial difficulties
5. In deep financial trouble

Some clients reported no change before and after receiving advice. However, some did report improvements: moving from 5 to 3 and from 3 to 1 on the above scale. One client reported moving from 5 to 1 on the scale which indicated a significant change from being in deep financial trouble to managing their financial affairs very well.

A similar process was used to assess confidence in managing money before and after receiving advice (in Appendix 1, service user interview schedule). The four point confidence scale ranged from feeling:

1. Very confident
2. Somewhat confident
3. Not very confident
4. Not at all confident

Again, the findings were largely positive. Some clients reported moving from 4 to 1 and from 4 to 2. As a result of some financial gain, clients appear to feel more confident in managing their money. One client who moved from 4 to 2 described the “*whole situation really getting me down*” to progressively “*feeling better*”. Perhaps surprisingly, even those who received no financial gain felt their confidence to manage their finances had increased, as the money advisor had acted as a catalyst.

The opportunity to access on-going support beyond initial appointments was considered important: for example, being able to call the advisor for help when letters came in that were difficult to understand. Case Study Two highlights two different scenarios and contrasting ways of offering on-going support.

Case Study Two

(A)

A woman with two children: recently separated from partner. No past experience of the ‘benefits’ system or eligibility etc. Given information and advice on benefits and applied successfully. Only saw HWC advice worker once, but appreciated a follow-up call asking how she was getting on with the applications. Keeps the HWC card in her purse just in case she needs to make contact again.

(B)

A single parent with two children: recently separated from partner. She needs a new bed for the youngest child, new kitchen flooring (unsafe for children) and new front-door lock (damaged by ex-partner). Receiving all her benefit entitlements, however a successful community care grant allowed her to buy flooring and a new bed, but not a lock.

The family’s kitchen space is safer and youngest child has a bed. She appreciates being able to call for advice on money-related issues, such as an unexpected bill. She is still in contact with the advice worker as a result.

5.4.5 Mental wellbeing

A number of clients commented on a reduction in stress or worry after intervention from advice services, with others reporting an improvement in their mood and an increased sense of self-worth and security. One client reported that the extra money put her “*mind at ease*” and she felt “*more relaxed with family and friends*” and felt better being able to buy her own things. Another was no longer concerned about safety in her home now that she had new flooring, and another no longer worried about “*what’s coming next*”.

Some saw an improvement in their relationship with families or friends. One client felt she was getting on better with her ex-partner now that the stress of money had gone, whereas another was no longer arguing with her husband or “*snapping at her kids*”. Another felt she now had money for some “*me time*”, like going to the bingo once a week with friends. A friend of one client noted: “*You’re in a good mood. Have you seen [the money advisor] this week?*”.

Not all clients felt an improvement in their mental wellbeing as a result of intervention from advice services. Some still had to contend with significant money worries or worries about how they would cope in the future. This is likely to be the case for many reliant on benefits and may suggest a need to consider approaches that move beyond managing crisis towards a more preventative approach. (See Case Study Three which illustrates the impact of a small, successful charitable application on reducing high levels of family stress and conflict.)

Case Study Three

Couple with three children: low income and mum suffering from mental health problems and debt-related worries. No family cooker or washing machine. Family meals microwaved. Laundry carried back-and-forth between friends' and grandmother's homes on a daily basis. The middle child has bed-wetting problems. High stress levels and poor relationships: arguing with partner and '*snapping at kids*'.

Awarded £500 from charitable trust – family buy new washing machine and cooker. "*Over the moon*" with stress levels reduced considerably. No longer snapping at the kids or arguing with partner over money worries. They also have healthy meals.

Advised to return their TV to the high-cost credit store and buy a new one from the supermarket. Shocked to discover 'real' cost of this types of loan. Since then, they've stopped using these stores to buy household items.

6. Factors associated with effective HWC delivery models

The evaluation sought to examine factors that could potentially influence overall service delivery. In-depth case studies were also undertaken in four Community Health and Care Partnership (CH(C)P) areas. Drawing on a theoretical framework designed to enhance understanding of successful partnerships,¹⁸ the project was assessed with reference to processes and outcomes from this framework. The key areas investigated were agreement and commitment among local Healthier, Wealthier Children (HWC) partners; leadership and management; and effectiveness of project delivery.

6.1 Agreement and commitment among local HWC partners

Overall, partners reported a shared understanding of the project's aims and objectives and high levels of commitment to ensure its successful implementation and delivery. This involved an NHS focus on building and incorporating referral pathways into routine early years workforce practice with advice services keen to build trusting NHS relationships to ensure onward referrals to their services.

Within each CH(C)P area, new HWC groups, or pre-existing local groups, sought to engage with a range of early years staff to ensure that the project had a wide-reach. There was strong evidence of local collaboration between health improvement and money advice staff across a number of areas which included:

- Targeting access points within health centres, nurseries and clinics
- Delivering joint training on project-related issues to frontline staff working with pregnant women and families
- Producing local financial inclusion and benefits resources for use across NHS GGC
- Setting up a HWC website and developing online video and e-learning resources.

There was limited engagement with early years education services across NHS Greater Glasgow and Clyde (NHS GGC) with the exception of a dedicated referral pathway pilot within South East Glasgow CH(C)P – case study details are available on the HWC website.^c

Good working relationships were reported where pre-existing collaborative local structures were in place. A Glasgow city CH(C)P area with a long history of health improvement and money advice collaboration and a smaller CH(C)P area which reported good working relationships fostered between local authority services and health improvement staff were two examples of these productive working relationships.

Although good examples of collaboration were clearly evident, there were also some reported challenges:

c

<http://library.nhs.gov.uk/mediaAssets/Healthier%20Wealthier%20Children/Healthier%20Wealthier%20Children%20Partnership%20work%20with%20Nurseries%20in%20South%20East%20Glasgow.pdf>

- Some money advice managers had difficulties with NHS information-sharing protocols, which prevented referral data being sent electronically or faxed outside secure NHS servers. This caused delays where referrals across CH(C)P boundary areas were made, and in areas where advice provision was shared between services. There was also a perception that this NHS protocol undervalued advice services' information-sharing protocols.

6.2 Leadership and management

In the first six months of the project, the strategic steering group had an operational focus with a sizeable group membership. This approach was utilised to ensure 'buy in' across NHS GGC and among local partners. Subsequently, the steering group transition towards a more strategic focus was important to ensure the project achieved the outcomes linked to project sustainability and impact on policy (discussed in a later section).

Throughout the project duration various stakeholders were involved in providing leadership and management support. Senior health improvement and advice service staff were actively involved in a range of HWC groups and ensured that operational concerns were responded to at a strategic level. Although this involved a significant time commitment for managers, it was instrumental in facilitating joint work and aiding effective local delivery. The NHS GGC corporate inequalities team (CIT) provided system-wide support, led on an Equality Impact Assessment, facilitated the transition from operational to strategic priorities and actively supported planning work. Glasgow Centre for Population Health (GCPH) also had a distinct role which involved working closely with a senior health improvement colleague tasked with chairing the strategic work of the HWC steering group.

The main challenges that emerged in terms of leadership and management of the project revolved around concerns with the referral criteria, strategic decision-making processes, administration requirements and providing local feedback to referring staff.

- At the project outset, there were many discussions and expressed differences when reaching agreement on the referral criteria, especially the £40,000 threshold which some HWC staff considered too high.
- Although not widely reported among line managers, in the early stages some Money Advice Worker (AW) staff expressed concerns about feeling 'out of the loop' when decisions were made, with communication described as a 'one-way' process.
- AW staff reported that the project's administrative requirements were an additional burden which impacted on delivery. The burden included recording all client contact attempts, introduction of performance reporting and completion of monitoring and evaluation data. These activities were over and above in-house recording requirements.
- There was a perceived lack of strategic direction, from the steering group to local areas, on the issue of provision of feedback to staff referring patients to advice services.

6.3 Effective HWC project delivery

Despite the reported challenges described above, the overarching commitment of local partners ensured that the project continued to be delivered as intended.

Important aspects of project delivery were linked to access, ongoing support, flexible approaches and buy-in.

- Rapid access to HWC advice services was viewed as important by Development Officer (DO) and AW staff and clients. However, AW staff felt that the information-sharing challenges previously described, impacted on their attempts to deliver 'fast-track' services as postal referral forms could take more than a week to reach them.
- Clients appreciated the opportunity to have advice beyond one appointment. Additionally, attempting to make client contact beyond one attempt was a new way of working for advice services, and was viewed as important in ensuring uptake:

"We are not able to do that in the Bureau. I think that's why we reached the most vulnerable."

- Flexible appointments within a range of locations (e.g. client's home or outreach clinics) were welcomed by clients. The AW staff also valued outreach clinics as they helped the process of establishing and maintaining NHS links, encouraged pro-active referrals among staff and ensured client access:

"They're young mums, or they've got issues, or the kids aren't well, or it's raining and they need to get the kids in a buggy. There's no way they're going to come all the way up for a half hour appointment to be told maybe you'll get something, maybe you won't... I can understand that".

Building on these approaches, some advice services incorporated a new triage system into their contact protocol, whereby clients were offered telephone appointments to assess and prioritise need and filter referrals.

- Although there was reported 'buy-in' from key referring groups, this varied across CH(C)P areas. Some areas reported initial challenges when attempting to engage with midwifery teams which in some cases was due to having short timescales to 'pitch' the project at midwifery team meetings.

6.4 In-depth investigation of local HWC models

In August 2011, four local areas were chosen for an in-depth examination of processes and outcomes and the development of local partnerships over time (see Table 5). The selection of these four areas was shaped by an interim assessment in August 2011, which involved a documentary analysis of local processes and outcomes data. It is worth noting that these areas were not intended to be indicative of all local area partnerships as many factors were likely to be context specific.

Four focus groups were undertaken which, in most cases, involved local representation from all partners involved in HWC development and delivery. The focus groups explored:

- Approaches adopted
- Operational and strategic relationships
- Efficiency and effectiveness of service delivery
- Successes, challenges and future plans
- Outcomes relating to client uptake and financial gain.

Table 5: Local HWC partnership models

Location	Type	Advice Agency
Glasgow City 1	CH(C)P	Third Sector
Glasgow City 2	CH(C)P	Third Sector (Consortium x3)
Non-Glasgow City 1	CH(C)P	Third Sector
Non-Glasgow City 2	CHP	Public Sector

* In Non-Glasgow City 2, not all invited partnership members attended the focus group: only two operational staff members were available for this discussion.

The assessment of the four areas is summarised in the following case studies.

Glasgow City 1		
Processes	Approach	<ul style="list-style-type: none"> Adopted a pragmatic and opportunistic approach in the absence of DO.
	Operational Relationships	<ul style="list-style-type: none"> Existing and well-established working links between NHS and advice service.
	Strategic Relationships	<ul style="list-style-type: none"> High commitment levels to HWC aims and objectives. Initial disagreement with the HWC steering group regarding target groups, performance reporting and evaluation monitoring requirements.
	Effectiveness	<ul style="list-style-type: none"> Good workforce buy-in particularly amongst health visitors – largely attributed to relationship developed with advice staff. Organisational barriers to information-sharing highlighted, in context of feedback to health visitors on referral outcomes.
	Challenges	<ul style="list-style-type: none"> Identified 'systems failure' around how specialist children's services recognised financial need for some children with disabilities.* Identified need for system change involving addictions and homelessness services.
	Future Plans	<ul style="list-style-type: none"> Money advice and health improvement workforce thinking about future service provision for those at-risk of poverty. Highlighted the need to make connections at key transition stages from children's to adult services to prevent people being 'lost'.
Outcomes	Successes	<ul style="list-style-type: none"> Good engagement with midwives – historically difficult to engage. Positive feedback from health visitors.
	Referrals and Uptake	<ul style="list-style-type: none"> Highest number of referrals, but less than half led to uptake of advice.
	Access	<ul style="list-style-type: none"> Nearly seven out of ten referrals made by health visitors with approximately two in ten from midwives.
	Financial Gain	<ul style="list-style-type: none"> Very good rate of financial gain: 55% (110 cases). Average annual gain: £3,753.

* The steering group responded to this and in collaboration with the specialist children's services, this area will be a focus of planned work in 2012 - 2013.

Glasgow City 1

Despite the absence of a DO for most of the project duration, this area reported effective partnership work which was attributed to a long-standing collaborative relationship between health improvement and advice staff, and the commitment of the health improvement lead. Some strategic tensions were reported in terms of defining target groups and reporting/evaluation data requirements. Nevertheless, this CH(C)P managed the highest referrals of all areas which translated into a low proportion of

clients accessing advice and receiving moderate average financial gain. There was successful health visitor and midwife engagement and a number of lessons around engaging specialist services, as well as insights into the most appropriate stage in pregnancy and post-birth for money advice interventions.

Glasgow City 2		
Processes	Approach	<ul style="list-style-type: none"> Decision to deliver advice service across three agencies with one referral point to overcome differences between NHS and money advice boundaries. This decision was also shaped by local geography, poor bus routes and territorialism.
	Operational Relationships	<ul style="list-style-type: none"> Initial awareness of cultural differences between NHS and money advice led to an increased understanding and improved relationships as the project progressed. Some internal difficulties between the advice services and internal tensions with the health improvement team having to respond to addictions services' referrals.*
	Strategic Relationships	<ul style="list-style-type: none"> Initial misunderstandings between local and HWC strategic groups on the expected AW role. Central steering group tensions vis-à-vis addictions referrals in this area.* Perception that local developments were happening too fast to await steering group guidance which led to unilateral local decisions, such as modifying the referral form. Glasgow city CH(C)P re-structuring linked to internal tensions and some resultant communication difficulties.
	Effectiveness	<ul style="list-style-type: none"> Operating across three advice services resulted in co-ordination and monitoring challenges. Good workforce buy-in was reported.
	Challenges	<ul style="list-style-type: none"> Burden of performance and evaluation reporting. Resistance to taking addictions referrals due to capacity issues and underlying beliefs about where responsibility lies for addictions service users' needs.
	Future Plans	<ul style="list-style-type: none"> Advice partners keen to play a part in the future child poverty agenda. High project profile within local authority could result in future multi-agency working. Project prompted action to prioritise child poverty in a strategic partnership (Area Delivery Group) with a new focus for child health teams to address child poverty. Suggested that the best option for addictions was to locate advice provision within the Welfare Officers' role in addictions team.
	Outcomes	Successes
Referrals and Uptake		<ul style="list-style-type: none"> 278 referrals recorded which resulted in 47% uptake of advice services.
Access		<ul style="list-style-type: none"> Most referrals from health visitors (45%) closely followed by midwives (40%).
Financial Gain		<ul style="list-style-type: none"> Less than a quarter of client cases resulted in financial gain but average gain was high (£5330).

* See Box 1 (page 37) for more details of the Addictions pilot

Glasgow City 2

Notwithstanding reported partnership challenges, this area reported a commitment from health improvement and advice service staff to resolve them in the interests of effective project delivery. A key challenge involved the division of advice provision between three local advice services. This led to referral allocation and communication difficulties. Having an 'advice service partnership' within the broader local HWC partnership exacerbated challenges, despite the view that this approach would lead to a more flexible service. The expectation that addictions referrals would be responded to, and the perceived pressures on advice services, eventually led to a change in the addictions protocol (see Box 1, page 37). Even with the described challenges, strong links were reported which resulted in effective workforce engagement and future collaborative opportunities. This area reported moderate outcomes with regard to referrals and uptake with high average client gain.

Non-Glasgow City 1		
Processes	Approach	<ul style="list-style-type: none"> Newly integrated CH(C)P which adopted a 'holistic' approach.
	Operational Relationships	<ul style="list-style-type: none"> Good partnership work and sense of project ownership facilitated by CH(C)P integration.
	Strategic Relationships	<ul style="list-style-type: none"> Good support from NHS GGC CIT and the HWC steering group to flexibly develop their preferred approach. Some conflict around performance reporting requirements versus local measurement of outcomes.
	Effectiveness	<ul style="list-style-type: none"> Successful delivery of HWC attributed to CH(C)P partnership. Long lead-in time to ensure referral buy-in. HWC viewed as providing a practical and tangible way for the NHS workforce to address financial inclusion.
	Challenges	<ul style="list-style-type: none"> Engaging midwives was found to be challenging. *A pilot of the addictions service provision proved unsuccessful with no reported referrals to the advice service.
	Future Plans	<ul style="list-style-type: none"> Developing a pack for advice and health visiting staff as a legacy to aid future referrals. Suggestion of a central point for all referrals to appropriate services (Keep Well, HWC etc) to reduce silo working.
Outcomes	Successes	<ul style="list-style-type: none"> Development of working relationships between advice and NHS staff and local services. Increased profile for Healthy Start and opportunity to promote a previously developed 'Cost of Credit' leaflet.
	Referrals and Uptake	<ul style="list-style-type: none"> Low number of referrals (248) but more than six out of ten resulted in uptake of advice.
	Access	<ul style="list-style-type: none"> Higher proportion of referrals from midwives (38%) compared with health visitors (29%).
	Financial Gain	<ul style="list-style-type: none"> Financial gain in 59% of client cases which was the highest proportion of gain cases in all areas across NHSGGC. Average gain: £2,259.

*See Box 1 (page 37) for further details of the addictions pilot.

Non-Glasgow City 1

This area attributed successful partnership work to their new CH(C)P status. The partners believed it opened a number of doors that would otherwise have been difficult to access. Integration was viewed as being advantageous to providing an in-depth

service in a small and contained geographical area. Local advice delivery involved a holistic social work model which attempted to address clients' wider needs and was therefore likely to be more time and labour intensive. Some time was lost as the AW post was not filled until late December 2011; two months after the majority of other AW staff appointments. Although initially slow, the early years workforce buy-in became successful and resulted in new relationships between NHS and advice staff. Uptake of advice was high and although the average financial gain per client was low – compared with the other three case study areas – this area recorded the highest percentage of clients receiving financial gain across all CH(C)P areas.

Non-Glasgow City 2		
Processes	Approach	<ul style="list-style-type: none"> • Strategy for development work agreed by DO and AW with an initial focus on NHS staff. • Decision to limit referrals to 30 each month to avoid a waiting list and ensure a full service for clients, as expected by the money advice service.
	Operational Relationships	<ul style="list-style-type: none"> • A very good operational relationship and partnership work between DO and AW was reported.
	Strategic Relationships	<ul style="list-style-type: none"> • Initial tensions around the evaluation commitment and expected role of the AW led to the view that advice management representation on the steering group would have been helpful. • Perception that the major focus of HWC was on Glasgow city, which left partners feeling peripheral.
	Effectiveness	<ul style="list-style-type: none"> • Good health visitor buy-in. • Realisation that providing feedback to referrers was important in raising staff confidence to ask questions and building relationships with them. • View that building relationships with clients is as important as financial gain. • View that project had demonstrated need but also produced a gap to be filled at the project end.
	Challenges	<ul style="list-style-type: none"> • Challenge engaging with midwives.
	Future Plans	<ul style="list-style-type: none"> • Lessons learned for advice service on importance of collaboration with health structures, use of referral form to ensure continued referrals, and preference for more locally-led services in future. • Advice worker recommendation on optimum referral times for target groups.
Outcomes	Successes	<ul style="list-style-type: none"> • Reaching new client groups and generating a new referral source
	Referrals and Uptake	<ul style="list-style-type: none"> • 375 recorded referrals of which 241 (64%) resulted in advice uptake.
	Access	<ul style="list-style-type: none"> • Lowest percentage of referrals from the midwifery workforce (10%) with over half from health visitors (55%). • Highest proportion of self-referrals (19%) and social work referrals (9%).
	Financial Gain	<ul style="list-style-type: none"> • Highest annual financial gain of all areas which represented 37% of cases (90/241). Average gain: £5,561.

Non-Glasgow City 2

There were some initial tensions around partnership work relating to the advice managers' expected scope of the AW role and project expectations. This seems to have been resolved as the project progressed and led to effective joint work. This area provided a broad-based approach to delivery within a money advice oriented model. There were reported difficulties gaining access to and engaging with midwives.

Although intentionally limiting the number of monthly referrals, this area reported impressive outcomes in terms of referrals, uptake, and financial gain. A recommendation was made about the most appropriate time to offer advice to target groups.

Summary

This in-depth investigation of the four partnership models provided insights into the nature of the working relationships among HWC partners and the types of issues likely to emerge in such an ambitious project. It was clear that among the four models, a commitment to collaborative working was important to overcome some of the initial challenges that emerged. Local areas with pre-existing working relationships or a newly-integrated partnership felt this was beneficial in the development of the project and subsequent project delivery. Where greater challenges emerged, they appeared to result from more complicated local structures.

Local outcomes were evaluated in relation to referral numbers, uptake of advice service and resulting financial gain for clients. Although not the primary project aim, assessing client financial gain was a useful outcome indicator. Equally, lessons from the client journey (see section 5.4) reinforced the importance clients placed on other outcomes that could positively impact on family wellbeing, such as reducing money worries, buying or preparing better quality food or managing household bills.

Because of the importance of local contextual factors, such as existing links and relationships, and capacity within services, comparisons of project outcomes presented challenges. Indeed, it was recognised at the outset that local areas should be encouraged to develop their project in response to local factors. Although demonstrating the inherent difficulties in establishing causal links between partnership processes and subsequent client outcomes, nevertheless, some learning points have been identified as to how local areas developed approaches, achieved successes and responded to partnership challenges.

Box 1: HWC addictions pilot

Addictions pilot development

At the outset, it was intended that HWC advice would be contracted out to local advice services, with development workers based within local health improvement teams. However, it was agreed that a local CH(C)P area would pilot a referral pathway involving addiction clients and the local HWC team. By March 2011, the local HWC team expressed ongoing concerns about capacity issues and a reluctance to incorporate addictions work within money advice services.

It was agreed by the local HWC group (which included health improvement and addictions staff) and the steering group, that there would be a change of direction. A needs assessment would be undertaken with community addictions services before a second pilot was undertaken with another local HWC team. The needs assessment found some evidence of good financial inclusion work being carried out by addictions staff, but also patchy and inconsistent delivery across the addictions services involved in the assessment. Some of the key themes to emerge from the assessment were:

- A need to raise awareness and provide training for addictions staff
- Build on the good examples of work, but ensure that a comprehensive and quality financial inclusion service is delivered across addictions service
- Future income maximisation or financial inclusion services would be better placed within addictions service rather than contracted out, as this would encourage a more tailored approach to meet service users' needs
- A preventative approach – emphasising financial capability with links to services such as employability services – may be more effective.

Despite undertaking a second pilot within another CH(C)P area, there was an absence of addiction referrals for advice. Moreover, across all the CH(C)P areas, the percentage of people with addictions that accessed HWC advice services, through alternative referral routes, was very low (0.8%).

Addictions pilot challenges and opportunities

At the outset, there appears to have been a lack of shared agreement, and perhaps shared understanding, about the addictions role. There was a view from addictions staff that the pilot played a secondary role to the local HWC team achieving their specific outcomes. However, the local team involved in the first pilot believed that social work staff should manage addiction clients' advice needs, which were viewed as being too complex for local HWC advice services.

The prevailing health improvement model was viewed as not being suitable for building 'addiction links' with others, particularly social work which was considered an important part of service delivery for people with addictions.

There were also reported strategic challenges which included difficulty tabling this work as part of the steering group agenda, and limited involvement in the initial discussions around the re-configuration of the steering group that took place in May 2011, and the future mainstreaming of the HWC project.

Despite these challenges at an operational level, there may be opportunity to offer training and raise awareness amongst staff engaged in addressing child poverty to increase their understanding of the role and function of addictions services, and the strong links between addictions and poverty.

A positive outcome from the needs assessment involved a paper being presented to the Senior Addictions Management Team, which outlined recommendations to strengthen advice provision for people attending their services.

7. Impact on practice

Across NHS Greater Glasgow and Clyde (NHS GGC) the midwifery and health visiting workforce were central to ensuring that two of the project outcomes were achieved, namely, that both workforces had clear referral and information pathways to advice services and there was an increase in the numbers of pregnant women and families with children receiving information, advice and support. A workforce survey targeting midwives and health visitors was undertaken to explore their awareness and attitudes towards the project and its impact on practice.

Although not the primary focus of this part of the evaluation, a documentary analysis was also undertaken to assess the wider impact of the project on health improvement and money advice workforce practices.

7.1 Midwifery and health visiting

To explore the midwifery and health visiting roles, a random sample from both staff groups (30%; n=400) was surveyed. A questionnaire was posted to 230 midwives and 170 health visitors who may or may not have been engaged with the Healthier, Wealthier Children (HWC) project. The sample of health visitors and midwives was weighted by workforce population across each Community Health and Care Partnership (CH(C)P) across NHS GGC.

The aims of the workforce survey were to:

- Explore workforce awareness and attitudes towards the project
- Identify workforce changes towards child poverty and financial inclusion
- Investigate the impact of the project on workforce practice.

The midwifery response rate (63/230; 27%) was significantly lower than the health visiting response (79/170; 46%). This could be a result of the random sampling strategy as the midwifery sample was not specifically weighted in favour of community midwives and, therefore, comprised mainly hospital midwives.

Awareness and attitudes towards the project

The overwhelming majority of health visitor respondents (99%) were aware of the project compared with 56% of midwives.

Additionally, more health visitors (83%) than midwives (36%) reported referring clients to the HWC advice services. Despite these differences in awareness and referring, both groups believed they, combined, were the most suitable workforce to refer people for advice.

Workforce attitudes to financial difficulties

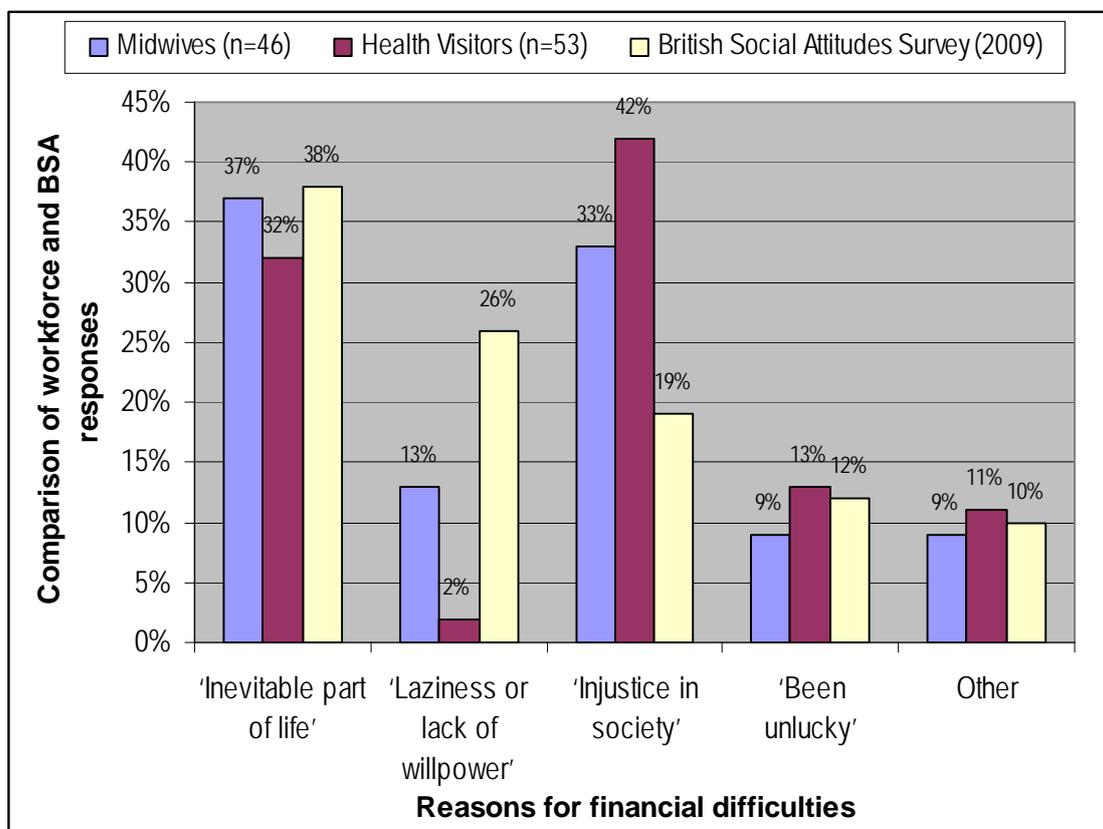
Workforce attitudes were explored by inviting staff to consider why people experience financial difficulties. Four possible explanations from the British Social Attitudes (BSA) (2009) survey were put forward:

- Laziness or lack of willpower
- Because they have been unlucky
- Because of injustice in society
- An inevitable part of modern life.

The explanations chosen by midwives and health visitors were compared with the BSA survey explanations offered by a sample from the general population (see Figure 6).

There was a slightly higher response rate to this attitudinal question from midwives 73% (46/63) compared with health visitors 67% (53/79). More than seven out of ten midwives and health visitors selected the two options (*because of injustice in society and an inevitable part of modern life*) which can be described as a ‘social explanation’²³ of poverty. Both staff groups were less likely to choose an ‘individual explanation’. However, midwives (13%) were more likely to choose it when compared with health visitors (2%).

Figure 6: Midwifery, health visiting and general population explanations of reasons for financial difficulties



Additional comments identified themes linked to staff explanations of why people experience financial difficulties. Some comments related to individual explanations such as addictions, intellectual disability and clients’ attitudes towards seeking work. Others referred to social explanations linked to the economic climate, unemployment, life’s complexities and not being in receipt of appropriate benefits.

Workforce changes towards child poverty and financial inclusion

To identify how the HWC project was viewed within their existing work context, midwives and health visitors were invited to rank six areas in order of importance in their day to day work:

- 🕒 Breastfeeding
- 🕒 Child oral health
- 🕒 Child health weight

- ☉ Parenting
- ☉ Smoking cessation
- ☉ Income inequalities.*

* It was envisaged that income inequalities would reflect staff views of the HWC project.

The surveyed workforce found it challenging ranking the six areas in order of importance and some respondents selected more than one option. For example, when listing their main priority, 79 health visitors provided 110 responses with 63 midwives offering 84 responses.

Explanations put forward to clarify selecting more than one area included: staff beliefs that all areas were equally important and that families have different needs; and a duty of care to ensure that priorities were based on need. Less frequently mentioned comments about ranking all six areas included feeling powerless to address clients' money worries which was why it was not a priority and some respondents rating according to expected work roles instead of personal opinion.

An analysis of the main priority area revealed that the three most frequently mentioned midwifery choices were breastfeeding, parenting and smoking cessation, respectively. The health visiting choices were parenting, followed by breastfeeding with child healthy weight and income inequalities joint third. Health visitors rated income inequalities work as being more of a priority than midwives. (See Table 6).

Table 6: Workforce: priority number one among six areas of work

Midwifery priority area 1	n=84	HEAT target
Breastfeeding	30	Yes *
Parenting	19	No
Smoking cessation	15	Yes
Income inequalities incl. financial poverty	7	No
Child healthy weight	7	Yes
Child oral health	6	Yes
Health visiting priority area 1	n=110	HEAT target
Parenting	42	No
Breastfeeding	21	Yes
Income inequalities incl. financial poverty	16	No
Child healthy weight	16	Yes
Child oral health	8	Yes
Smoking cessation	7	Yes

* Status in 2010/2011

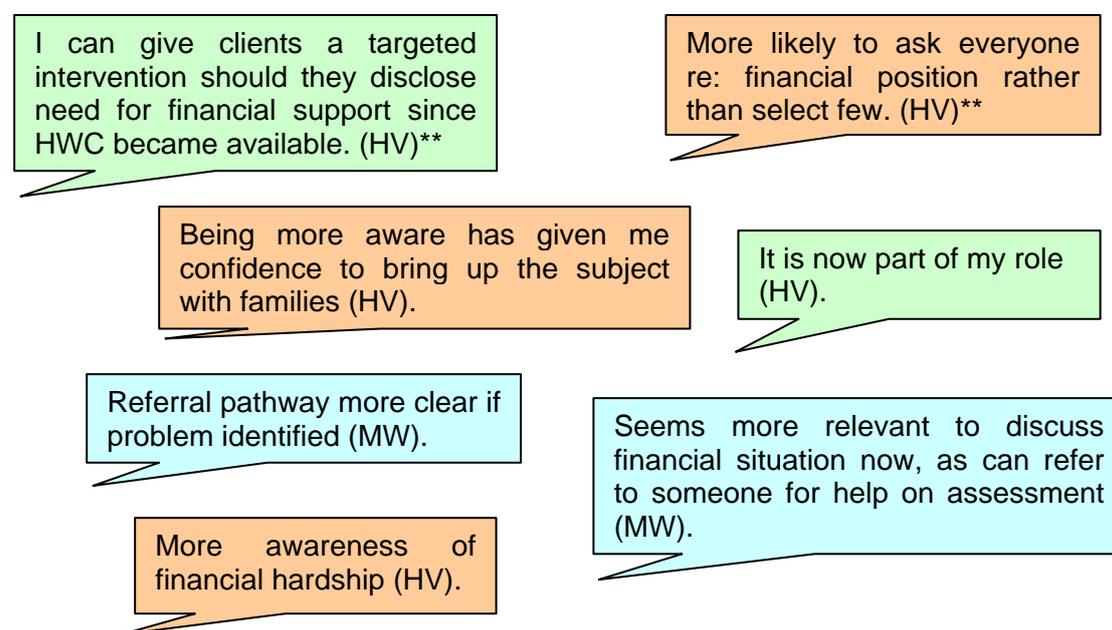
Table 6 shows that, when comparing Health Improvement, Efficiency, Access and Treatment (HEAT) target activity (2010/2011) with income inequalities work, health visitors viewed inequalities work as being equal to child healthy weight interventions and more of a priority than child oral health and smoking cessation.

For midwives, income inequalities work was equal to tackling child healthy weight but more of a priority than child oral health which was a HEAT target.

Discussing patients' financial worries

The workforce was asked if they have the opportunity to discuss patients' financial worries during contact with them. Of those who responded to this question, all health visitors (61; 100%) and the majority of midwives (20/23; 87%) reported routinely discussing patients' financial worries.

When asked if attitudes to financial inclusion enquiry had changed as a result of referring people for advice, slightly more health visitors (31/65; 48%) than midwives (7/20; 35%) reported attitude change. The comments below suggest that those actively involved in the project were more likely to discuss financial issues with patients.

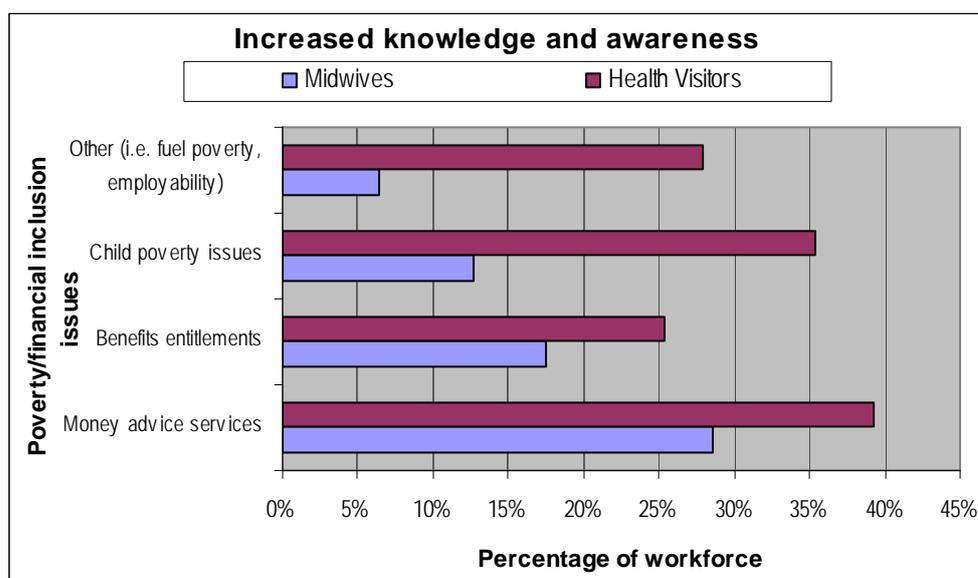


** The two comments above highlight different staff approaches to financial inclusion enquiry: one involves more universal routine financial inclusion enquiry, whereas the other suggests a more targeted approach based on responding to clients disclosing a need for financial support.

Workforce changes: knowledge and awareness

Of the total combined health visitors and midwives in the survey (n=142), higher proportions of health visitors indicated increased knowledge and awareness of a range of issues (Figure 7). However, the greatest increase in knowledge and awareness was in relation to 'income maximisation and money advice services', where 18 (29%) midwives and 31 (39%) health visitors reported increases. A higher proportion of health visitors (29; 37%) than midwives (8; 13%) reported increased knowledge and awareness of 'child poverty issues'.

Figure 7: Changes in workforce knowledge and awareness



* Categories were not mutually exclusive, therefore the number of responses to this question exceed the total number of survey responses for each workforce group.

Staff indicating no increase in their knowledge and awareness commented that they already had an existing awareness of some of these issues or where to refer people for advice.

Referral practice

Survey responses revealed that 83% of health visitor respondents referred patients to advice services compared with 36% of midwives. This could, as previously discussed, be an artefact of the midwifery sample drawn for the study.

Changes in working relationships

More midwives (9/22; 40%) than health visitors (15/65; 24%) reported new working relationships as a result of being part of the project, mainly with the Development Officer (DO) and Money Advice Worker (AW). However, the majority of both health visitors (76%) and midwives (60%) did not develop new relationships.

Impact on future practice

In terms of future referring intentions, the majority of both midwives (20/21; 95%) and health visitors (61/63; 97%) who answered this question stated they would continue to refer patients, post HWC.

Other staff revealed that some were referring to advice services before the HWC project and will continue or advise people to make contact themselves. However, it was acknowledged that this new project provided a quick and effective pathway which would not have been available in the past. There were sustainability concerns in that staff wanted to continue having access to advice services and the option to refer. Some health visitors found the project very helpful, with both groups indicating that feedback on outcomes would be welcomed as those referred for advice might not be seen by the same health professional.

Some staff identified barriers that prevented referral to advice services and potential solutions to address them (See Table 7.) The barriers could be grouped into

organisational and client-related factors with facilitating factors grouped into staff support and delivery themes.

Table 7: Reported facilitators and barriers

ORGANISATIONAL FACTORS	
Facilitators	Barriers
<ul style="list-style-type: none"> • Simple referral pathways and information leaflets for patients. • Training on how to engage with the project. • 'Ward folder' with information and referral forms. • Senior staff cascade information. • Insert HWC leaflet into child health records. • Information on referral outcome. 	<ul style="list-style-type: none"> • Unable to let client know when they were likely to be seen. • Lack of knowledge about the project. • Lack of time in busy clinics. • Some difficulties contacting advice services by telephone. • Working across different practice locations (absence of referral forms and service contact details).
CLIENT-RELATED FACTORS	
Facilitators	Barriers
<ul style="list-style-type: none"> • Mix of home and agency-based appointments. • Text and telephone appointment reminders. • Refund some families' public transport costs. • Have advice staff on-site at clinics for direct referrals and opinion on suitable referrals. • Option to refer to specialist advice rather than social work services. • More advice staff involved in the project. 	<ul style="list-style-type: none"> • Clients' reluctance to discuss money matters – more comfortable discussing health issues. • Language and cultural barriers. • Engagement difficulties with advice services due to mental health issues.

Some of the perceived facilitating factors have already been put in place. For example, advice services reported offering 'outreach', in the form of fixed and drop-in appointments in health centres and other CH(C)P locations, in addition to home visits and telephone appointments.

7.2 Health improvement

For most health improvement teams, the introduction of the HWC project has impacted on workforce practice at a local level. A key influence was the capacity-building work undertaken by the DO staff within local teams. An increased awareness of the financial inclusion and child poverty agendas within health improvement teams has led to some staff thinking about new approaches to their work. Some health improvement leads have stated that child poverty is being placed at the centre of many work streams, with others looking at how it could be incorporated within specific work such as child oral health. However, concern was expressed that more resources or capacity would be required to progress work on child poverty.

Another significant change in health improvement practice has been the move towards improving systems to capture HWC activity to ensure it is reported within NHS GGC performance frameworks and articulated within local CH(C)P plans. The change in local practice also served as a foundation to support the strategic move towards a partnership approach to commissioning advice services in Glasgow city.

In February 2012, a development day was undertaken and involved all health improvement teams operating across CH(C)P areas, with the aim of incorporating this work into local teams when the fixed-term DO contracts ended. All teams agreed that this work would be incorporated within their existing structures.

7.3 Money advice services

The HWC project has impacted on HWC advice service practice. Some areas embraced new ways of working during the project in response to emerging difficulties in contacting clients and responding to 'failure to attends'. This included offering telephone and home appointments and outreach clinics. Other changes in workforce practice involved:

- Money advice staff reported an increased knowledge of local health issues and services. The project served as a vehicle to engage with 'hard to reach' NHS staff, particularly midwives, and a target client population that had not previously accessed their services.
- The project created new external links (e.g. housing associations) and internal links by acting as a 'bridge' to other financial inclusion services for clients who may benefit from further specialist advice. There was an example of HWC becoming integrated within other local financial inclusion structures and with voluntary sector projects, such as Barnardos.

Although keen to engage further with the child poverty work, local advice services also echoed the concerns of their NHS partners around the need for additional resources if this work was to continue beyond the pilot project.

8. Impact on policy and strategy

The recent Child Poverty Strategy for Scotland outlines three principles behind the approach to tackling child poverty: early intervention and prevention; building on assets; ensuring that children and families are at the centre of service design and delivery. Within NHS Greater Glasgow and Clyde (NHS GGC) a range of established responses are in place to tackle child poverty. The NHS Financial Inclusion Strategy Group takes a lead role in overseeing financial inclusion work across the Health Board area, and within Glasgow city the Children's Services Child Poverty Subgroup's framework sets out key actions to tackle child poverty in the city.

Within this strategic context, two approaches were taken to assess the impact of the Healthier, Wealthier Children (HWC) project on related policy and strategy:

1. Six interviews with key informants
2. Documentary analysis of local plans and related documents.

8.1 Key informant interviews

To assess the project impact on future policy and strategy, six key informants were recruited to take part in face-to-face interviews. They included senior representatives with remits that covered maternal and child health, early years, health improvement and financial inclusion. There were four senior NHS GGC representatives, including two Directors, a local authority representative and Scottish Government policymaker. The main themes explored were:

- influence of the HWC project
- perceived opportunities and/or challenges resulting from HWC
- future direction of the HWC model and action required to address child poverty.

8.1.1 Influence of the HWC project

There was a majority view among key informants that the HWC project was successful in both raising awareness of, and generating a focus on, child poverty and that it should become a mainstream function among services. The project was seen as providing an operational example of how the NHS could engage with the child poverty agenda. It was thought that there would be increased engagement as a result of the UK welfare reforms and their subsequent impact on poverty levels within Glasgow city. Although the local authority representative noted that an anti-poverty strategy was being developed within the council, child poverty, per se, was not prioritised as a discrete area of work but it was hoped that it would become a key component of the strategy.

8.1.2 Perceived opportunities resulting from HWC

A range of reported HWC opportunities included using frameworks and planning structures as levers of change and building on current NHS inequalities work. Raising workforce awareness, training, and a lead role for health visitors were identified, as were more partnership opportunities as a result of reduced public spend. These are discussed in relation to strengthening NHS and local authority responses, workforce capacity and partnership opportunities.

NHS and local authority responses

An NHS view was that the HWC project would directly inform and influence redesign of the integrated Health Visitor assessment framework, which, when linked to children's social work care plans, could ensure that the plans are more targeted and focussed on addressing poverty. The HWC project was also considered to be a catalyst in developing local authority approaches to strengthening internal council links and building on current financial capability work being delivered in schools as part of the Curriculum for Excellence. There was also consensus that, at a national level, the Scottish Government should take a lead role in supporting child poverty action at CH(C)P levels.

The view was expressed that ongoing NHS GGC inequalities work to encourage sensitive routine enquiry is an important vehicle for developing a wider anti-poverty approach among NHS staff engaging with patients in a range of settings.

Workforce capacity

There was support from the Scottish Government informant for incorporating HWC learning into continuing education for health staff, as part of a core curriculum module to address inequalities. Training and development on cross-cutting issues was considered important in overcoming obstacles to embed financial inclusion routine enquiry into mainstream practice. However, there was an NHS view that training alone would not address different attitudes across the NHS. The majority view was that a mixture of methods would be necessary to convince and support staff to embed routine enquiry and create a culture change.

Changing practice by increasing NHS staff awareness was considered equally important as incorporating HWC workforce activity within formal processes, such as assessment frameworks. Despite the project not being incorporated within frameworks, such as the health visitor 24-30 month assessment framework, it activated more than 2,500 referrals across NHS GGC to local advice services.

The majority of informants considered health visitors to be the lead NHS workforce to take HWC forward. There was a view expressed that midwives need not take an operational lead on all public health issues but instead have an overarching view. This was suggested in the context of the implementation of skill mix teams to address wider public health issues.

Partnership opportunities

The growing constraints on public spend were viewed by many as an opportunity to move towards more partnership work to address child poverty. It was recognised that services need to improve in 'joining up the pieces' within their own organisations, as future efficiency savings will require more shared services and learning. There was overall agreement that projects like HWC can only work in partnership and an expressed concern that in Glasgow city there had been a slow cultural drift away from partnership working:

"We appear to be retreating into silos again rather than joining up, which is what the Christie Commission is requiring us to do".

However, there was some local authority optimism that the HWC project could help address this cultural drift as no single agency can respond to the unfolding UK welfare reforms.

8.1.3 Perceived challenges resulting from HWC

Some of the major HWC challenges identified were future concerns about the capacity within advice services, the need for new ways of delivering services, budget priorities in a challenging landscape and ensuring effective policy links at an operational level.

Advice service capacity

At an operational level, the main challenge of embedding routine enquiry into NHS staff practice was thought to revolve around capacity issues within third sector advice services and within NHS staff roles. The majority view was that increased action to identify and refer those experiencing, or at risk of, poverty would impact on advice services as they attempted to meet the increased demand:

“The challenge will be... the extent to which services are there to meet people’s needs... welfare advice, benefits advice, those sorts of services are being severely squeezed, so I would be concerned about whether people can actually get the help they need.”

Service delivery

Important local authority concerns related to developing new ways of delivering services to address child poverty and mitigate the impact of UK welfare reforms. This would require consideration of alternative responses beyond traditional face-to-face advice models, which although highly effective, are resource intensive. Less intensive approaches proposed were self-help advice and support using electronic and telephone methods, and an emphasis on budgeting and debt management to improve financial capability. Although these approaches support the principles of early intervention and a focus on assets, there was recognition that:

“People have to be quite open to change, and be flexible, and actually be quite bold in what they’re prepared to do.”

Local HWC advice services appear to be embracing this change. New ways of delivering advice services were reported in many areas, such as offering telephone appointments to provide basic support to assess the need for further contact. (See Case Study Two which describes a mix of face-to-face advice and telephone support.) There is also evidence that the project had influenced thinking on future service delivery as a result of having access to new NHS groups and new ways of working.

Budget priorities

NHS representatives held the view that maintaining and improving quality delivery amidst increasing levels of poverty and homelessness, and within constrained budgets, would be a challenge. It was believed that efficiency savings could impact on NHS flexibility to respond to child poverty. There was a particular anxiety that acute medical interventions would be prioritised over approaches, like the HWC project, which attempt to address the wider determinants of health. However, the view was expressed that efficiency savings would not impact on the midwifery role within the HWC project and poverty issues could be addressed through skills mix teams in the future.

Effective policy links

At a policymaking level, the challenges of a busy policy landscape were acknowledged, and the need to ensure that effective links are established at an operational level highlighted:

“...people are under so much pressure that if they have been given, say, an action plan, that is what they will be doing and they won't necessarily be thinking about how other things can fit with that. And I think it's really important for the Scottish Government to make the links for people because joining up these policy areas is quite challenging for people at local level when they have obviously got the statutory obligations for their own areas.”

8.1.4 Future direction of the HWC model and action needed to address child poverty

Many respondents found it difficult to predict the future direction of the HWC model because of what was described as a paradoxical policy situation: the UK Government's focus on reducing public and welfare spend, which was likely to lead to more people living in poverty and more people requiring access to advice services. Despite these challenges, there was overall agreement that partnership or multi-agency work was vital to developing links across sectors and among specialist services. Although NHS GGC has been the lead HWC partner, there were clear NHS views on the importance of a collaborative approach with local authority partners and community planning structures, in order to progress and sustain this child poverty work. Equally, it was also noted that changes in local authority delivery of services could impact on the future direction of the HWC model.

There was a pessimistic tone among NHS respondents that UK Government policies will inevitably lead to increasing inequalities and place additional burden on vulnerable groups, such as people with disabilities. It was recognised that action to address child poverty required macro level political decision-making across a range of policies: welfare, employment, education, childcare and financial inclusion services. However, it was clearly stated that NHS staff have an important role to play to ensure that issues such as child poverty remain on the wider agenda by identifying need and offering appropriate support to families. It was suggested that the Scottish Government had a key role to play to ensure that the infrastructure was in place in order to offer families this onward support for advice.

8.2 Impact on local plans

In May 2011, the HWC steering group produced a new action plan (2012-2013) in anticipation that funding could be secured after the project end in March 2012. The agreed priorities were to continue embedding HWC within the early years workforce, explore the development of early intervention links between advice services and other partnership agencies, test new approaches with specific groups, such as children in hospital, and ensure that learning from the project was built into local strategies and delivery structures.

To assess the current impact on local strategies and delivery structures, a documentary analysis was undertaken of five CH(C)P plans and two NHS GGC board-wide plans. The analysis revealed that the project was having a noticeable impact on local plans with child poverty work being incorporated into a range of work streams.

In addition to the HWC project impacting across local planning structures, further documentary analysis reveals additional impact:

- A template to assess the mainstreaming of the project was recently completed by local health improvement staff. The template showed that nearly all areas had integrated the topic within local Single Outcome Agreements, had put plans in place to ensure direct referral rather than signposting and have a dedicated HWC advice worker for 2012-2013.
- The needs assessment of financial inclusion work within Glasgow Addictions Services led to a paper being presented to their Senior Management Team which outlined recommendations for financial inclusion staff training and a 'model' for providing wider advice services within addictions services. Although the paper is currently under consideration, this development is a tangible project outcome that could influence future development and delivery of financial inclusion advice within the addictions service.
- In December 2011, Glasgow City Council awarded a three year contract (2012-2015) for Financial Inclusion, Housing Information and Advice Services. These services will be available to all citizens regardless of age and household composition. Supported by NHS GGC, this new contract now includes an early years component as a subsequent result of the HWC project.

9. Discussion and lessons from the project

The introduction of a new partnership initiative, like the Healthier, Wealthier Children (HWC) project, across a sizeable organisation like NHS Greater Glasgow and Clyde (NHS GGC) presented a range of practice, partnership and policy challenges. The practice challenges included ensuring 'buy-in' from a large early years workforce with many already managing sizeable caseloads, supporting pregnant women and families with a range of needs and often working in areas with high child poverty rates. A key partnership challenge involved distinct workforce cultures coming together to develop effective delivery pathways that included nearly 1,200 midwives and health visitors and local advice services. Some of the policy challenges involved ensuring that this new work became embedded as part of routine workforce enquiry within the context of improving services during a period of constrained budgets. Yet, despite these challenges, and operating within relatively short timescales, the project successfully achieved a range of client, workforce and policy outcomes which can provide key learning points for the future direction and wider implementation of this work across NHS GGC and beyond.

9.1 Clients

Across NHS GGC, the HWC project appears to have demonstrated positive client outcomes which may provide valuable lessons. They include:

- The project appears to have incorporated aspects of a proportionate universal approach which has been described as being necessary to reduce the steepness of social gradients in health and involves a response proportionate to levels of disadvantage.²⁴ In adopting this approach, the project demonstrated good reach in accessing low household incomes and lone parents.
- Impressive financial gain, totalling in excess of £2.25m, was achieved for clients accessing advice services. The project revealed that a significant number of families were apparently unaware of their entitlements and may not have approached traditional advice services for help. This suggests an opportunity for awareness-raising among all early years and advice staff to maintain and increase uptake of advice among the target groups.
- With many families living with disability facing additional costs, such as laundry, food and transport, it was encouraging that one in five of the clients achieving some type of gain received a Disability Living Allowance (DLA) payment. This area of work may require further attention as there has been growing concerns that the move from DLA to Personal Independence Payments for working age adults could negatively impact at household and local authority levels.²⁵
- Follow-up client interviews revealed that, in addition to financial gains, other related gains were equally important for families. These included the ability to buy better quality food, improved personal financial knowledge/confidence and a better family life. A small number of clients reported a reduction in stress or worry after contact with advice services. These wide ranging gains demonstrate that projects like HWC can potentially contribute to wider determinants of health, such as healthy eating, play and overall family wellbeing.

The main challenge related to client outcomes was:

- Although adopting a proportionate universal approach was successful in reaching low household incomes, lone parents and minority ethnic groups, there was less success in reaching kinship carers and people with mental health and addiction problems.

9.2 Midwifery and health visiting

Learning points from the midwifery and health visiting workforce outcomes include:

- Most evidence investigating the impact of advice services in healthcare settings has focussed on an older population⁷⁻¹⁰ with only one cited study demonstrating the important role that health visitors can play when engaging patients in financial inclusion work.¹ Therefore, the findings from this system-wide study, across NHS GGC, adds to the evidence that midwives and health visitors can play a significant contributory role towards addressing child poverty.
- There was a distinct variation in referral rates, with 51% from health visitors and 29% from midwives. This may be explained by the fact that health visitors engage with families over a longer period of time. There was also strong evidence that some HWC staff had more success engaging with the health visiting workforce compared with midwifery.
- Despite these variations, both midwives and health visitors seem to be integrating HWC into their daily practice. Both workforces placed a high value on the project and were willing to continue enquiry into families' financial situation and referral to advice services. There is good evidence that continuing to provide a referral and information pathway will allow staff to continue to raise the subject of finances with pregnant women and families.
- Although midwives were willing to engage with the project, there is still scope to expand their future contributions to the child poverty agenda. Two areas reported higher midwifery engagement, compared with health visiting, with one of these areas achieving the highest average client gain of all Community Health and Care Partnership (CH(C)P) areas. There may be engagement lessons to be shared from these areas.
- Advice service feedback suggests that some pregnant women referred in the early stages were not eligible for important entitlements until the later stages of pregnancy. Subsequently, many women did not return for advice after birth and may have lost out on these welfare entitlements. It was suggested that referring women at the 29-week stage of pregnancy and/or within the first month after birth may be more beneficial. This may merit further discussion among HWC partners as to whether emphasising this approach may achieve more positive outcomes.

Some of the key challenges from the midwifery and health visiting outcomes include:

- Some evidence demonstrated the limitations of staff signposting clients onwards to advice services, and staff adopting a targeted approach based on client disclosure instead of a more universal approach characterised by routine enquiry. There may be a need to reinforce the limitations of signposting – not

- In terms of explaining and understanding poverty, a small percentage of midwives attributed 'laziness or lack of willpower' as a possible explanation. Although these attitudes did not impact on their willingness to refer to advice services, national guidance to reduce antenatal health inequalities emphasises the importance of positive staff attitudes to ensure service engagement.²⁶ Beyond the scope of this project, there may be a need for capacity building amongst the workforce to ensure that the new Health Improvement, Efficiency, Access and Treatment (HEAT) target aimed at improving early access to antenatal services is achieved.

9.3 Money advice services and health improvement teams

The money advice services and health improvement workforce outcomes provided valuable learning that included partnership themes:

- There was strong evidence of effective commitment among many advice services and health improvement staff which led to a number of successful outcomes. Pre-established links were beneficial in delivering an intervention such as HWC in large urban areas. In smaller, more geographically contained areas partnership challenges were more surmountable. It was also evident that the quality of working relationships was an important factor in ensuring successful project delivery. However, as the case studies demonstrated, attributing successful outcomes to partnership processes requires a degree of caution, as a range of other contextual factors may have impacted on outcomes.
- Some new external links with housing associations and internal links within advice services were developed. These could be further developed to create new areas of work, such as linking smoking cessation and/or parenting interventions with pregnant women to money advice support.
- The project was an important catalyst in supporting a system-wide move towards adopting and reporting on child poverty activity, thus ensuring it is articulated and recognised within local CH(C)P plans and NHS GGC performance frameworks.
- HWC advice service engagement with the health improvement workforce was an important factor in developing a flexible delivery approach. These new approaches to delivery, which included 'out-reach', home appointments and telephone client assessment, could ensure that advice services continue to work flexibly with NHS and other partners in the future.
- Whilst some links with early years education were established, this tended to be on an ad-hoc basis. A case study of a pilot of early education referrals may help inform discussion on how to take this work forward with a range of other partners.

Some of the key challenges involving the money advice services and health improvement workforce outcomes included:

- The project was sometimes viewed by advice staff as being governed by an NHS agenda. A potential solution could involve advice managers being more actively involved in shaping decisions and having representation on the HWC steering group. However, there may be a need to address possible challenges around fairness, representation and power relationships, as the steering group includes senior public sector staff with past, and potentially future, involvement in commissioning money advice services.
- Some local advice services reported a significant administrative burden associated with the project's monitoring and recording requirements. Some services did provide in-house support but the majority reported that any future project would need to consider full cost recovery.^d
- There were some advice service views that NHS information sharing and data protection protocols delayed provision of advice and did not take into account their existing procedures and policies. This concern was shared by some health visitors who expressed a preference for referral by email or secure on-line forms. It was also noted that these challenges are not unique to the HWC project and that if the NHS continues working with voluntary sector partners, then an agreed information sharing protocol needs to be developed between both sectors.
- There may be a need to consider the project's future role in supporting informal kinship carers. The majority of kinship arrangements are informal with no local authority contact.²⁷ Moreover, this group of kinship children are a sizeable, hidden majority that often live in the poorest areas with older carers, often grandmothers, with significant health problems.²⁸ There may be scope for the HWC project to consider developing links with others – such as local community networks and groups in contact with this 'hidden group' – to support access to mainstream advice, information and support.
- There are indications that more engagement work could be undertaken with mental health services to increase uptake of advice information and support among this vulnerable population which is likely to be affected by the unfolding welfare reforms.

9.4 Addictions

Key learning from the addictions work outcomes includes:

- The low referral to and uptake of HWC advice services among people with addiction problems across NHS GGC requires further attention among partners. A positive outcome from the needs assessment was the recognition that community addiction services need to strengthen their response to offering advice provision.

^d Full cost recovery means recovering or funding the full costs of a project or service. In addition to the costs directly associated with the project, such as staff and equipment, projects will also draw on the rest of the organisation. For example, adequate finance, human resources, management, and IT systems, are integral parts of any project.

- There is potential for the health improvement workforce to develop stronger early years working links with addiction services. These links could involve workforce mentoring/shadowing and joint training opportunities to address the very poor HWC outcomes and support any agreed broader response.

A key strategic addiction challenge is:

- Despite an encouraging move by community addiction services to strengthening their approach to offering advice to people with addictions, there may be a need to consider a broader response that involves other mainstream partners offering money and welfare advice. There are an estimated 20,800 problem drug users across NHS GGC.²⁹ Many within this group are not in contact with addiction services but living with children experiencing poverty and may benefit from mainstream advice and support.

9.5 Policy and strategy

Some of the key policy and strategic outcomes that could provide valuable learning include:

- The initial project focus on operational delivery was an important catalyst to ensure 'buy-in' among local partners, as was the midway transition to a more strategic focus. Despite some of the partnership challenges, the HWC project displayed visible elements of distributive leadership, particularly among NHS staff. A distributive approach involves the sharing of leadership roles among individuals with different remits. This approach was important in mitigating local central tensions, supporting critical transition periods and ensuring subsequent project development.
- At the outset, there were many discussions and expressed differences towards reaching agreement on the project inclusion criteria. The upper family income threshold emphasised that the project was not just targeting vulnerable groups but aimed to prevent families moving from being at-risk to actually experiencing poverty. Although a proportionate universal approach did achieve a degree of good reach, there may be value in further discussion on the merits of combining this approach with additional targeting of some of the other vulnerable groups.
- Interviews with key senior informants revealed a different emphasis placed on sustaining positive outcomes, from increasing staff awareness, workforce training, and building on current inequalities work to using NHS assessment frameworks as levers of change. There may be a need to ensure that there is a shared agreement on which operational and strategic priorities are emphasised in 2012-2013.
- The HWC project appears to have influenced the recent commissioning of Financial Inclusion, Housing Information and Advice Services in Glasgow city. There is potential to share lessons with others as this new contract involved the introduction of an early years component that involved local authority, health and housing partners. Equally, there is also scope to learn from the East Dunbartonshire model which, although not HWC commissioned, demonstrated effective levels of collaboration on this agenda and a range of positive outcomes.

- There was strong evidence indicating that the HWC project has had a positive impact across a range of CH(C)P plans. There was also a clear NHS strategic acknowledgement of the need to strengthen future collaboration with local authority partners to take this aspect of the child poverty agenda forward.

The main challenges within the context of the policy and strategic outcomes include:

- Welfare reform: Over the next two years, UK welfare reforms will significantly impact on low-income households, women and children.³⁰ A Glasgow city report suggests that the reforms could lead to 65,000 child benefit claimants facing an annual loss of £74 per claimant which will place additional pressure on advice services when the reforms are implemented.³¹ During the interviews with key senior informants, there was recognition of the need for new ways of delivering advice services within a rapidly changing and difficult environment.
- Future funding and sustainability: In 2012-2013, the Scottish Government will fund advice services to continue embedding this HWC work over the next year. Some services have already started developing early intervention approaches and using new ways of engaging and supporting clients, such as telephone appointments to identify and prioritise need. In addition to taking forward new ways of offering advice, there is a strategic need to strengthen local authority engagement across NHS GGC to take this child poverty agenda forward. This has been recognised in the new HWC action plan (2012-2013) and will require significant attention over the next year.

10. Limitations of the evaluation

- ⦿ There was differential recording of Healthier, Wealthier Children (HWC) outcomes at advice service level which in some cases was influenced by the type of contact with service users. Some advice staff did not fully complete all fields on the monitoring form, resulting in some missing data. Additional feedback revealed that one area's in-house system reported higher numbers of referrals and outcomes, than the HWC monitoring system.
- ⦿ There were some difficulties in recruiting service users for the 'lessons from the client journey' work. Assistance was sought from HWC advice staff which involved the staff contacting clients to invite them to participate in interviews. This approach may have introduced an element of social desirability bias whereby respondents answer questions in a way that will be viewed favourably by others.
- ⦿ The service user follow-up interviews were conducted, in some cases, prior to the intended six-month timeframe following the intervention. Therefore, it may have been too early to establish changes in financial capability, mental wellbeing and other elements of project impact.
- ⦿ The workforce sample of midwives was not weighted in favour of community midwives due to difficulties in identifying this group within different delivery models of midwifery care across NHS GGC. This resulted in the majority of midwife respondents being recruited from hospital-based settings and included staff in specific areas of clinical work that were less engaged with the project.

11. Conclusions

Overall, the HWC project has had a positive impact on pregnant women and families with young children in terms of maximising income, reducing and managing debt, and providing support to increase financial capability, confidence and wellbeing. It has provided an important new pathway to securing access to other types of support to mitigate the impact of poverty and disadvantage. Alongside this, it has raised awareness of child poverty issues among the early years health workforce and provided a mechanism by which they can refer vulnerable individuals and families with money worries to advice services. Additionally, this study has contributed to the evidence-base around the NHS workforce role in responding to child poverty and provides valuable lessons for taking this work forward among the wider early years workforce across Scotland.

Within a wider UK context, child poverty is likely to remain high on the policy agenda. Under the Child Poverty Act 2010, current and future governments have committed to reduce relative child poverty levels to 10% by 2020. Yet, recent work undertaken by the Institute for Fiscal Studies has predicted that under the current policy direction, relative child poverty rates will reach 24% by 2020, which will be the highest rate since 1999.³²

The macro policy decision-making processes that will shape future child poverty rates are beyond the scope of this work. Nevertheless, the HWC project has achieved positive outcomes with plans in 2012-2013 to continue embedding routine financial enquiry within the NHS workforce practice. The recognition that multi-agency collaboration is essential, as is the need to develop new preventative ways of working to address child poverty, reflects some of the priorities identified in the 'Christie' report into public service reform.³³ As the HWC project continues over the next year, there is scope to share project lessons, work with, and influence, other partners in their attempts to reduce the harmful impact of poverty on children, families and other vulnerable groups identified within this report.

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