HEALTHIER, WEALTHIER CHILDREN:
learning from an early intervention child poverty project

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Healthier Wealthier Children HWC

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Contents

List of Tables

List of Figures

Appendices

Glossary of acronyms and terms

CAB	Citizens Advice Bureau is a voluntary sector organisation, which provides people with money and legal worries by providing free, independent and confidential advice.
CAT	Community Addictions Teams operate within NHS Greater Glasgow and Clyde and comprise health and social care staff.
CH(C)P/CHP	A Community Health and Care Partnership (CH(C)P) is an integrated health and social care structures. A Community Health Partnership (CHP) is a health only structure. Both structures are responsible for coordinating the planning and provision of a range of primary and community services in their areas.
CIT	The Corporate Inequalities Team takes a lead role in maximising NHS Greater Glasgow and Clyde Health Board's potential for addressing the causes and health consequences of inequality and discrimination.
CPP	Community Planning is a process whereby public services in local authorities across Scotland are planned and provided after consultation and co-operation among all public bodies and with community bodies.
DLA	Disability Living Allowance.
DWP	Department for Work and Pensions
ESA	Employment and Support Allowance
FNP	Family Nurse Partnership, an intensive, health visitor-led home-visiting programme for new teenage parents.
GAIN	Glasgow Advice and Information Network is a network of agencies that give free, confidential and impartial advice and includes voluntary agencies, citizen's advice bureaux, legal, housing and independent money advice agencies.
GCC	Glasgow City Council
GCPH	Glasgow Centre for Population Health
GEMAP	Greater Easterhouse Money Advice Project is a financial inclusion and money advice service located in Glasgow city.
HI	Health Improvement (HI) can be a distinct function carried out by HI staff or activities involving a wide range of people with the aim of achieving demonstrable change in people's health, wellbeing and quality of life.
HMRC	Her Majesty's Revenue and Customs
HWC	Healthier, Wealthier Children project
NHSGGC	NHS Greater Glasgow and Clyde
SNIP	Special Needs in Pregnancy (services)

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Executive summary

Introduction

The Healthier, Wealthier Children (HWC) project is a partnership approach to addressing child poverty across NHS Greater Glasgow and Clyde (NHSGGC), that involves health, local authority and voluntary sector partners. Launched in October 2010, and funded by the Scottish Government, the project established referral links between health and money advice services to support pregnant women and families at risk of, or experiencing, poverty.

During phase one of the project (October 2010 to January 2012), there were 2,516 referrals to local advice services with an overall annual financial gain in excess of £2.25 million for those accessing advice services. To build upon these positive outcomes, the project received limited funding for a further year (2012-2013) to embed the work across practice, policy and strategic areas.

HWC project – phase two evaluation

A phase two evaluation of the HWC project, from April 2012 to March 2013, demonstrated that, despite reduced ring-fenced funding, staff continued working together across a range of areas to tackle child poverty within NHSGGC.

At an operational level, local health improvement staff continued updating frontline staff on the latest welfare reforms and promoting the project. Frontline staff maintained similar levels of referrals achieved during phase one, which were dealt with by advice services who continued to provide flexible, outreach and telephone advice. Despite these achievements, constrained funding posed challenges to further project expansion.

There was evidence that the project was being integrated across a range of local NHS plans, performance reporting mechanisms and strategic groups, particularly child and maternal health and financial inclusion groups.

At a local authority level, there was clear evidence of the project being embedded within two of the six local authorities operating across NHSGGC, with reported plans for future integration among the remaining four areas.

Some of the other key project evaluation findings during phase two included:

- There were 2,487 referrals to advice services, which resulted in annual financial gain of £2,323,484 for pregnant women and families.

- A breakdown of the 2,487 referrals revealed that 2,289 were from mainstream referral pathways established during the first phase of the project but also included small numbers from two additional antenatal projects. The remaining referrals were from two new HWC pilots involving a homelessness service (112) and a children's hospital (86).

- The majority of referrals to advice services were from health visitors (41%) and midwives (14%). Other referrals included primary care staff (8%) and *ad hoc* sources (19%), primarily social work staff.

- Referring pregnant women and families on to mainstream advice services resulted in a 45% (1,027 / 2,289) uptake of advice.

- Household data, recorded for 1,021 of the 2,487 advice clients revealed that the majority (69%; 703/1,021) were lone parents.

- Since the project launch in October 2010, a cumulative total of 5,003 referrals led to just over £4.5 million in annual financial gain for those who accessed advice services.

Despite the impressive gains achieved since the HWC launch, there is a significant risk that these gains will be reversed, as the current austerity and welfare reform measures are predicted to result in a future increase in child poverty rates across Scotland and the UK. Therefore, based on the evidence from the HWC evaluation, we make the following recommendations to enable continued action on child poverty across three geographical levels:

NHSGGC

- With child poverty rates expected to increase, it is important to extend workforce engagement with the HWC project to include other health, social care, education and voluntary sector staff groups. This will require the protection and strengthening of resources and capacity across the range of sectors and workforces engaging with this agenda.

Local authorities and NHS boards

- In Scotland, local authorities have an important leadership role to play within Community Planning Partnerships and are the most significant providers and commissioners of money advice services. Based on the experience described in this report, there is a strong case for wider adoption of the HWC partnership model within local Community Planning Partnerships across Scotland.

- Similarly, as NHSGGC is the only NHS health board area in Scotland to have implemented a system-wide preventative approach to addressing child poverty, there is a need for other board areas to engage actively with local partners to strengthen their strategic responses to addressing child poverty.

Scotland and beyond

- Scottish Government plans to integrate health and social care services will involve significant change processes within local areas. Building on past experience of 'change funds', there is a potential opportunity to establish a 'change fund' aimed at promoting financial security and tackling poverty across Scotland. This could support the development costs involved in establishing HWC-type partnerships prior to their mainstreaming.

- There are also opportunities to share HWC project lessons across the UK and beyond, linked, for example, to the policy changes in England leading to local authorities taking a more central role in tackling health inequalities and also linked to the UK government's commitment to devolving more decisions about how families are supported to local authorities.

1 Introduction and background

The Healthier, Wealthier Children (HWC) project is a partnership approach to addressing child poverty that involves NHS Greater Glasgow and Clyde (NHSGGC), local authorities and voluntary sector money advice providers. The HWC project was established in October 2010 and received Scottish Government funding of £1 million, covering an 18-month period, to address the high levels of child poverty throughout NHSGGC. The two aims of the project in this first phase were: to test new ways of providing money advice and support to pregnant women and families with young children; and to develop information and referral pathways between early years health services and money advice/welfare rights partners and mainstream these responses to child poverty.

1.1 HWC phase one – October 2010 to March 2012

During phase one, HWC operated within the ten Community Health (and Care) Partnership (CH(C)P) areas that existed across NHSGGC in 2010 (Appendix 1). In July 2012, the Glasgow Centre for Population Health (GCPH) published a detailed evaluation report, which covered the first 15 months of the project[1]. The report identified positive findings across three important areas: impacts on pregnant women and families; workforce practice; and policy and strategy.

The phase one evaluation revealed 2,516 referrals to local HWC advice services with an overall financial gain in excess of £2.25 million for pregnant women and families accessing this type of advice. Additional non-financial gains, such as advice on childcare, employment and housing tenancy issues, and applications to charities for household goods, as well as improvements in wellbeing, were also reported. There was clear evidence of active NHS staff engagement with the referral process, with eight out of ten referrals to HWC advice services initiated by health visitors and midwives and lower proportions from other health professionals. Equally, joint work involving development workers, primarily based in local health improvement teams, and money advice staff attached to commissioned advice services, led to new ways of offering money/welfare advice, such as 'outreach' sessions in baby clinics and at weaning fayres. The project was also influential in shaping a new rolling contract to commission mainstream advice services in Glasgow city. This significant investment involving local authority, housing and health partners now contains an early years component.

1.2 HWC phase two – April 2012 to March 2013

The positive outcomes achieved during phase one provided an impetus for HWC project partners to continue mainstreaming this response to child poverty. Moreover, the emerging UK government's welfare reforms were viewed as a potential risk factor for vulnerable individuals and families accessing the project. A subsequent assessment of the impact of some of the reforms on families in Scotland reported negative financial outcomes in relation to the freezing of Child Benefit, changes involving Working Tax and Child Tax Credits, abolition of the Health in Pregnancy Grant and restriction of Sure Start Maternity Grants[2]. Further analysis of the gender impact of the reforms noted that changes to the benefits system will have a significant impact on women, largely due to their caring responsibilities[3].

Within this changing context, the project received reduced funding for phase two, amounting to £362,500, which included £200,000 from the Scottish Government, from April 2012 to March 2013, with the remainder from local areas across NHSGGC.

The overall aim of phase two was to continue embedding good practice in tackling child and family poverty within early years, local authority and voluntary sector money advice services by providing support to maximise income. The key phase two objectives were:

1. To embed good practice on routine enquiry into money worries within early years services.
2. To extend development of good early years practice, such as in-reach clinics and home visits, into money advice services to support families with children.
3. To test new approaches with groups of children facing specific disadvantages, such as children in hospital or children with disabilities.
4. To build learning from the HWC project into local anti-poverty strategies and service delivery, through work with commissioners and service planners across the six local authority areas in NHSGGC.

The GCPH team undertook the phase two evaluation, which primarily focused on assessing the project being embedded across a range of partnership activities, the new pilot approaches to supporting children and families facing specific disadvantages and the subsequent project outcomes for pregnant women and families with young children.

2 HWC project planning structures

Throughout phase two from April 2012 to March 2013, the planning structures driving the HWC project included the continued role of the strategic steering group and an extended role for the NHSGGC Corporate Inequalities Team (CIT). A new 'learning network' was also set up to support local delivery since the majority of local HWC planning groups set up in phase one were either dissolved or incorporated into other local planning structures.

The HWC steering group, which was set up before the project launch in 2010, continued to provide strategic direction on implementation, reporting arrangements and recording mechanisms. The group retained its multidisciplinary membership with senior representation from the NHS, local authorities, third sector organisations, the Scottish Government, and the GCPH. There was an added emphasis towards strengthening and creating new links with local and national groups during phase two.

With the CIT already involved in providing a range of support to HWC projects within local CH(C)P areas, their strategic role was supported in phase two by the recruitment of a part time board-wide HWC Development Officer. This post-holder was tasked with developing working links with local CH(C)P areas and the central project. Other important changes involving the CIT role included:

- Transfer of the data-collection role from the GCPH evaluation team to the CIT as part of the mainstreaming process. This resulted in less comprehensive client data being required from money advice services compared with phase one.

- In addition to collecting data, the CIT role involved monitoring project developments, supporting dissemination of the phase one evaluation findings and facilitating the new learning network.

The learning network offered staff directly involved in the project, such as NHS and money advice staff and their line managers, a mechanism to provide feedback and access to ongoing support and information. The learning network also served as a platform for other work, such as developing new resources to support health staff to make referrals to advice services, providing welfare reform guidance to staff, and information resources for patients. These are available on the NHSGGC Healthier, Wealthier Children (HWC) project website[4].

In phase one most CH(C)P areas had local HWC planning groups in place. However, in phase two, the majority of these groups had either been dissolved or incorporated into wider local planning structures, with the exception of Renfrewshire, which retained their phase one HWC planning group.

2.1 HWC project organisation and delivery

The reduction in HWC funding, from approximately £1 million in phase one to £362,500 in phase two, had a subsequent impact on local delivery by health improvement teams and money advice services across NHSGGC.

2.1.1 Health improvement

A considerable change involved the withdrawal of the 9.5 whole time equivalent (WTE) development worker posts – primarily attached to local health improvement teams – which had played a pivotal role in the establishment of referral and information pathways in phase one (see Table 1).

Table 1. Health Improvement input across NHSGGC – phases 1 and 2.

Location*	Development Officers	
	Phase 1 Oct 2010 – Jan 2012	Phase 2 Apr 2012 – Mar 2013
East Dunbartonshire CHP	0.5	-
East Renfrewshire CH(C)P	0.5	-
Glasgow CHP North East sector*	1	**
Glasgow CHP North West sector*	2	-
Glasgow CHP South sector*	2	-
Inverclyde CH(C)P	1	-
Renfrewshire CHP	1	-
West Dunbartonshire CH(C)P	0.5	-
Addictions service	1	-
NHSGGC Corporate Inequalities Team	-	0.6
Whole time equivalent workers	**9.5**	**0.6**

***** *In October 2010, the five CH(C)P areas in Glasgow city were dissolved and reformed as one Glasgow City CHP with three sectors – North West, North East and South.*
****** *A health improvement senior was employed in Glasgow city (North East sector) with unused phase one funding, due to initial recruitment difficulties.*

Table 1 shows that the development worker resource decreased from 9.5 WTE workers to 0.6 WTE workers between phases one and two with this new part-time post based in the CIT. Moreover, there was strategic agreement that in 2012-2013 local health improvement teams would incorporate this child poverty work into their existing team structures.

2.1.2 Money advice services

Another delivery change involved allocation of a significant amount of the 2012-2013 funding to advice services to ensure maintenance of the established referral pathways. This new funding was still a reduction from the phase one level and resulted in a contraction of more than one-third in advice provision across NHSGGC from 9.5 to 6.2 WTE posts (see Table 2).

Table 2. Advice input across NHSGGC – phases 1 and 2.

CH(C)P	Service type	Staffing	
		Phase 1 Oct 2010 – Jan 2012	Phase 2 Apr 2012 – Mar 2013
East Dunbartonshire CHP	Citizens Advice Bureau	0	0.2
East Renfrewshire CH(C)P	CH(C)P	0.5	1
Glasgow city CHP – North East sector	Advice agency	2	1
Glasgow city CHP – North West sector	Citizens Advice Bureaux	2	1
Glasgow city CHP – South sector	Advice agency	2	2
Inverclyde CH(C)P	Advice agency	1	0
Renfrewshire CHP	CHP	1	1
West Dunbartonshire CH(C)P	CH(C)P	1	0
Whole time equivalent		**9.5**	**6.2**

In phase two, eight advice services across NHSGGC were commissioned to continue taking HWC referrals, with limited funding. In Glasgow city, the HWC advice provision was incorporated within a substantial rolling contract for voluntary sector advice services. This Glasgow Advice and Information Network (GAIN) contract was commissioned by Glasgow City Council (GCC), in partnership with health and housing services. Two advice services (covering South and North West sectors) shared their provision with subcontracted services. Most services outside Glasgow city received reduced funding for one year with the exception of Renfrewshire, where the local CHP provided funding to employ the full time HWC advisor until March 2016.

The extended funding streams in Glasgow and Renfrewshire allowed continuation of HWC by dedicated staff (more or less on a full time basis). However, a more uneven picture emerged elsewhere. For instance, East Dunbartonshire gained a part time administrative post (two days per week); East Renfrewshire identified an existing member of staff to work on the project; Inverclyde lost their dedicated HWC post, due to the reduced funding, and the West Dunbartonshire money advisor had secured a new role within the service and was not replaced with a dedicated HWC advisor. However, Inverclyde is currently in the process of increasing administration support to the local Financial Inclusion team in order to manage referrals.

3 Phase two evaluation objectives and methodology

3.1 Phase two evaluation objectives

The four evaluation objectives in phase two focused on:

1. Assessing the continuing development and engagement with the HWC project at local CH(C)P areas among all partners.
2. The testing of new approaches with groups of children and families facing specific disadvantages.
3. Assessing the strategic embedding of the project across a range of planning, strategy and policy areas.
4. Assessing the project outcomes for pregnant women and families with young children.

3.2 Phase two evaluation methodology

A multi-method approach was adopted which involved a range of qualitative and quantitative research methods and comprised:

- An online 'SurveyMonkey' questionnaire with eight health improvement staff within the six CH(C)P areas across NHSGGC.
- Telephone interviews with nine money advice managers.
- Synthesis of reports from specialist services and new areas of work that included the HWC pilot at the Royal Hospital for Sick Children, Glasgow; Hunter Street Homelessness Service, Glasgow; Special Needs in Pregnancy (SNIP) services; Specialist children's services; and Antenatal group work.
- Documentary analysis of delivery progress reports compiled by the CIT, minutes of HWC meetings (steering group and learning network), local planning documents (single outcome agreements) and other strategic documents to assess the extent to which the project was linking into local authority and health plans and the wider UK government's welfare reform agenda.
- A face-to-face interview with a key senior informant within NHSGGC.
- Secondary analysis of project monitoring data using Microsoft Office Excel.

The SurveyMonkey questionnaire, and telephone and key informant interview schedules are detailed in Appendix 2.

3.2.1 Ethical approval

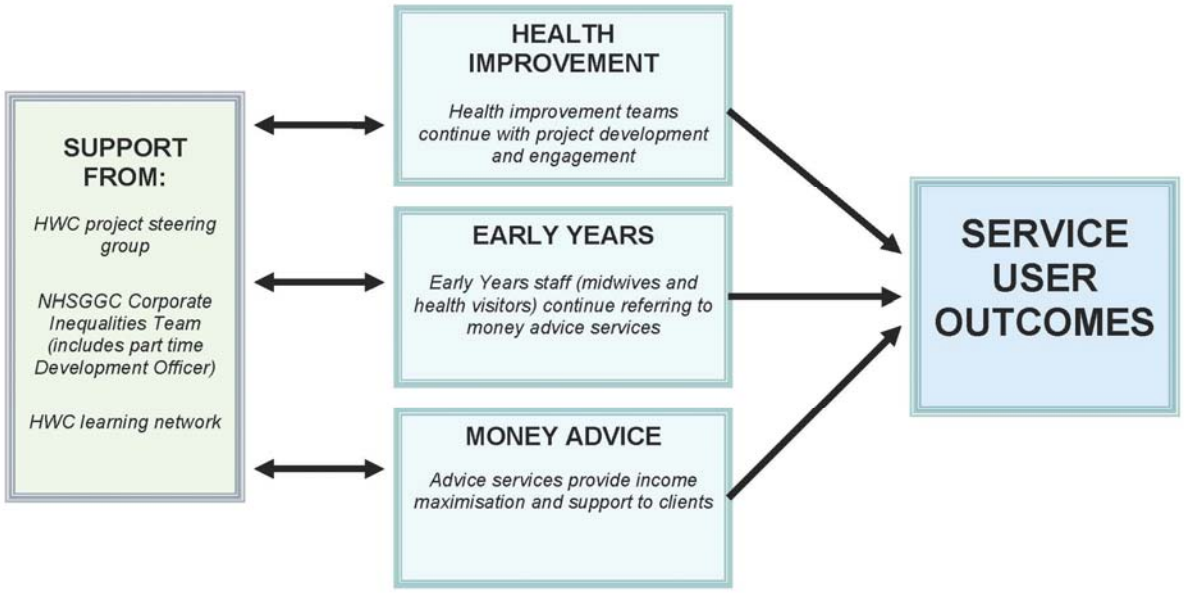
As phase two was a continuation of the work carried out in phase one, and constituted service improvement, NHS Research Ethics Committee approval was not required.

4 Findings

The main aim of phase two was to continue embedding the HWC project within mainstream services, with a particular emphasis on health improvement, early years and money advice services. Supported by the planning structures described in Section 2, steering group members and the CIT continued to work together to influence embedding across a range of networks and groups and to develop sustainable links.

An important element of embedding the operational and development work involved building on the positive referral pathways that were established in phase one. To strengthen workforce engagement and development, local health improvement teams continued to take a lead role in raising awareness of the referral pathways, particularly among midwives and health visitors. Money advice services also contributed to ongoing dissemination and awareness-raising, in partnership with health improvement staff. Figure 1 provides an overview of the engagement and development work during phase two.

Figure 1: Phase two project engagement and development.



The phase two evaluation included an exploration of the roles of health improvement teams and money advice services involved in a range of operational engagement and development work with early years health staff.

4.1 Health improvement engagement and development

The role of health improvement (HI) leads (senior staff) was critical during phase two, as they were expected to integrate most of the work previously carried out by the 9.5 WTE development workers in phase one. To investigate this transition, an online survey of the eight HI leads focused on exploring time devoted to the project, developmental and capacity-building work and engagement with other project partners.

4.1.1 HWC remit

All eight HI leads reported having an HWC remit during phase two. However, changes in some local areas led to referral processes not being fully maintained since phase one. For example, project work was suspended in Inverclyde whilst awaiting the appointment of a new lead for wider financial inclusion work that would include HWC activity. Renfrewshire, parts of Glasgow and West Dunbartonshire all reported ongoing HWC activities: the HWC role in Renfrewshire was being integrated into a wider financial inclusion remit with a change of HI leads; in two Glasgow city sectors (North East and South) and West Dunbartonshire, the role was being incorporated into local, wider financial inclusion services.

4.1.2 Time allocated to the HWC project

The HI leads in each CH(C)P area were asked to estimate the number of hours per week allocated to the HWC project in phase two compared with phase one. Table 3 outlines the reported time allocations.

Table 3. Time allocated to HWC.

HI – time allocated to the HWC project		
Area	**Phase 2 – allocated hours per week**	**Phase 2 comparison with Phase 1 (hours)**
East Dunbartonshire CHP	4	Fewer
East Renfrewshire CH(C)P	Variable	Greater
Glasgow city CHP – North East sector	7.5	No change
Glasgow city CHP – North West sector	6	Fewer
Glasgow city CHP – South sector	7.5	Greater
Inverclyde CH(C)P	0	Fewer
Renfrewshire CHP	5.5	Fewer
West Dunbartonshire CH(C)P	2	Greater

Four areas reported spending less time on the project compared with phase one (East Dunbartonshire, Glasgow North West, Inverclyde and Renfrewshire) while three other areas spent more time on the project during phase two (East Renfrewshire, Glasgow South and West Dunbartonshire). In Glasgow North East, there was no reported change in time allocated by the HI lead.

Renfrewshire and the three Glasgow city sectors all reported providing more than five hours per week input. In Renfrewshire, this input was shared between the HI lead and another HI staff member. In Glasgow North East, the allocated 7.5 hours input from the HI lead was boosted by a significant input of 27.5 hours a week from the development worker recruited with unused phase one funds. Four other areas reported spending fewer than five hours per week on the project, although East Renfrewshire reported variable weekly allocations of time to the project. Although project activity was interrupted in Inverclyde, new work was being undertaken to re-establish local HWC referral pathways with plans to increase administrative support to manage and record referrals to the local financial inclusion team from health visitors, midwives and other colleagues.

Overall, the HWC project and wider financial inclusion work appears to have been adopted by HI leads. The majority of teams were also integrating it into wider health improvement roles around financial inclusion.

4.1.3 HWC development work

Local development work was characterised by dissemination of the GCPH research findings from phase one to staff groups, staff updates on the UK government's welfare reforms and local promotion of the project through raising staff awareness and training to encourage further referrals. Table 4 outlines the reported HI development work undertaken.

Table 4. Health Improvement development work.

Health Improvement development work			
Area	**Dissemination: HWC research and welfare reforms update**	**Promotion of HWC project**	**Staff training and raising project awareness**
East Dunbartonshire CHP	√	√	√
East Renfrewshire CH(C)P	√	√	√
Glasgow city CHP – North East sector	√	√	X
Glasgow city CHP – North West sector	√	√	X
Glasgow city CHP – South sector	√	√	√
Inverclyde CH(C)P	X	X	√
Renfrewshire CHP	√	√	√
West Dunbartonshire CH(C)P	X	√	X

Six of the eight HI leads undertook local activities to disseminate research findings from the previous GCPH evaluation report. This work served as a platform to encourage ongoing referrals, as well as providing staff with information on the welfare reforms and their potential impact on vulnerable groups.

The majority of areas reported promoting the project locally, for example in East Dunbartonshire promotional work was targeted at children and families, and primary care mental health staff groups. Ongoing training directed towards other HI staff was reported in five areas (East Dunbartonshire, East Renfrewshire, Glasgow South, Inverclyde, and Renfrewshire) to ensure overall awareness of the HWC referral process within HI teams, with Glasgow South indicating that they are also involved in providing financial inclusion awareness and welfare reform sessions to all primary care staff.

Renfrewshire reported the development of information for community care service groups, in addition to exploring the provision of staff information through the local staff partnership forums. In West Dunbartonshire, an exercise mapping access to financial inclusion was initiated with additional plans to deliver targeted briefings to other HI staff and the early years workforce. Inverclyde reported plans to re-establish referral pathways by autumn 2013, which will include promotional activity with front-line staff.

4.1.4 HWC project engagement with early years staff

In phase one, attempts to engage staff, such as midwives and health visitors were undertaken by health improvement development officers and money advisors. This joint approach was considered vital in raising workforce awareness and encouraging advice referrals. Table 5 outlines the reported engagement with the two key referring groups, health visitors and midwives.

Table 5. Health improvement and money advice engagement with early years staff.

Health Improvement (HI) and Money Advice (MA) engagement				
CH(C)P	**Engaging midwives**		**Engaging health visitors**	
	HI	**MA**	**HI**	**MA**
East Dunbartonshire CHP	√	√	√	√
East Renfrewshire CH(C)P	√	√	√	X
Glasgow city CHP – North East sector	√	X	√	√
Glasgow city CHP – North West sector	√	√	√	√
Glasgow city CHP – South sector	√	√	√	√
Inverclyde CH(C)P	X	X	X	X
Renfrewshire CHP	√	X	√	√
West Dunbartonshire CH(C)P	√	X	√	X

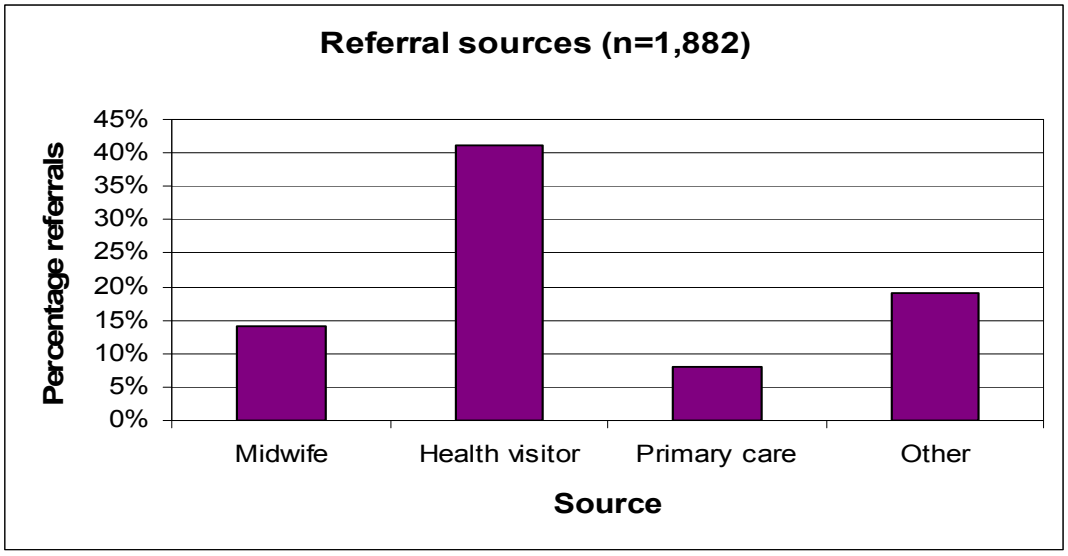
In the majority of areas, HI leads reported engagement with both midwives and health visitors, with the exception of Inverclyde, which, as previously noted, had suspended HWC work until a new lead for financial inclusion had been appointed and a new money advice post was in place. East Renfrewshire reported being in the early stages of development and engagement with plans to include midwives in their workforce engagement strategy. East Dunbartonshire reported engagement with community midwifery teams and with the child and family team. Additionally, Glasgow North East reported more engagement with health visitors and midwives in phase two, having observed wider engagement with other groups during phase one, such as child development services.

The majority of advice services reported engagement with health visitors and midwives through outreach clinics (offering opportunities to provide feedback on referrals) and joint dissemination events with health improvement staff. Additional documentary analysis revealed that the nature of engagement in many areas varied: from one-off staff sessions, which may have involved some midwives and health visitors, to embarking on a programme of dissemination and awareness-raising sessions to health visitor/midwifery teams, in addition to other staff groups.

4.1.5 Early years referrals

In phase one, engaging with midwives and health visitors was an important factor in encouraging referrals to advice services. Phase two engagement resulted in 2,289 recorded referrals to HWC advice services from April 2012 to March 2013. Referral sources were recorded for 1,882 cases – see Figure 2 for a breakdown by workforce group.

Figure 2: HWC referral sources by workforce group.



Among health staff, the majority of referrals were from health visitors (41%), followed by midwives (14%) and primary care staff (8%). A number of 'other' *ad hoc* referral sources were documented, most of which (19%) comprised referrals from social work staff within East Renfrewshire, an integrated CH(C)P area.

4.2 Money advice project development and engagement

An important project strand involved further embedding of HWC activity into local money advice service work to ensure future sustainability. To assess the extent of this, telephone interviews were conducted with the managers of nine commissioned money advice services.

4.2.1 Money advice service delivery

During phase one, there were changes in the delivery of advice services to improve access and uptake among pregnant women and families with young children. These changes included providing outreach advice in baby clinics and other community health settings, home visits, and introducing telephone appointments to prioritise need. In phase two, the nine money advice managers were asked whether these delivery changes had been maintained or developed (Table 6).

Table 6. HWC money advice service delivery.

CH(C)P	Outreach	Home visits	Telephone
East Dunbartonshire CHP	√	√	√
East Renfrewshire CH(C)P	√	√	√
Glasgow city CHP – South sector	√	√	√
Glasgow city CHP – North East sector	Reduced to 0.5 days/week	Only when necessary	√
Glasgow city CHP – North West sector	√	√	√
Inverclyde CH(C)P*	X	X	√ + office-based
Renfrewshire CHP	√ (several sites + credit union)	Only when necessary	√ + office-based (drop-in)
West Dunbartonshire CH(C)P	X	Only when necessary	√ + office-based, if necessary

* Although Inverclyde reported no current provision in phase two, their phase one approach primarily involved home visits. *Ad hoc* referrals in phase two were offered telephone and office-based appointments.

In terms of outreach advice, the majority of areas that offered this type of provision in phase one continued to offer it, with Glasgow North East reporting a reduction in sessions. Three areas (Renfrewshire, West Dunbartonshire and Glasgow North East) reported a reduction in their capacity to carry out routine home visits, instead limiting them to needs-based appointments.

Although the majority have maintained an outreach component for pregnant women and families with young children in phase two, prioritisation of telephone appointments has been reported as a preferred delivery method.

4.2.2 Opportunities and challenges to embedding HWC work

The nine advice managers were asked to describe their views of opportunities, strengths and challenges to embedding HWC project activity during phase two. These are outlined in Table 7.

Table 7. Advice service opportunities and challenges of embedding HWC work.

Opportunities and strengths	Challenges
▪ Overall benefits to target groups ▪ Money remains in local economy ▪ New links with health staff leading to more insight into advice work ▪ Opportunity to provide flexible delivery models, such as telephone triage leading to increased client engagement ▪ Clarity of purpose of the project	▪ Capacity i.e. challenge of reporting outcomes ▪ Impacts of UK government's welfare reforms ▪ An expected increased demand among HWC project and other client groups ▪ Reports of a reduction in advice referrals in some areas thought to result from: – Loss of the phase one health improvement posts which meant there was no longer a person linking between health and advice – Less scope for advice staff to undertake developmental work with front-line staff – Changes to the use of the NHS secure email system for referrals, causing confusion for some referring staff and advice services

Opportunities and strengths

Benefits to target groups
One of the main project opportunities was thought to be the benefits of easier access to advice and help for hard-to-reach groups not previously known to advice services, thus ensuring they received their entitled financial support. Moreover, the financial gains meant that money remained within local economies.

Benefits to health and advice staff
At a workforce level, it was felt that NHS links ensured that health staff had an increased awareness of the role of advice services. Equally, advice services benefited by demonstrating changes in service provision that included telephone triage which increased client engagement. This triage approach was extended to all service users within an advice service operating in Glasgow North East.

Clarity of purpose of HWC
The HWC project was considered as being easy to integrate into existing advice services because of its clear aims and objectives, levels of engagement and partnership efforts across different sectors, which ensured successful delivery. Advice services considered it pioneering in that it demonstrated unique partnership work and support from a broad range of partners and all managers indicated that they would like the project to be part of their core service provision. However, the extent to which they could offer the same holistic, flexible service rolled out in phase one would be restricted without additional resources for dedicated staff, particularly with an expected workload increase because of the welfare reforms.

Challenges

Capacity issues
Reduced capacity was reported as a challenge for some areas. For instance, in the first six months of phase two, the funded advice post in Inverclyde was reduced to two days per week up until October 2012, which led to there being no further dedicated post. Although there were reports of continued local referrals, they were apparently not being monitored. Overall, capacity among voluntary sector advice services was an important issue, illustrated by the East Dunbartonshire CAB, which was dependent on input from a large number of volunteers but which lacked capacity to train them.

Impacts of UK government welfare reforms
All services reported being under pressure in preparation for the impacts of the welfare reforms, which they predicted would negatively affect pregnant women and families with young children. With an expected increase in demand from HWC and other target groups, these pressures, combined with reduced resources, particularly outside Glasgow city, would present challenges towards providing the type of flexible delivery offered in phase one.

Reduction in referrals
In Inverclyde and West Dunbartonshire, there were anxieties expressed that momentum had been lost with a drop in referrals from health staff. In West Dunbartonshire, this drop was explained by the loss of the health improvement post after phase one. Elsewhere, the perceived reduction in referrals was attributed to advice staff not having the time to undertake the same level of partnership development work as in phase one, resulting in the loss of NHS links fostered during phase one. There was also a view that the move from paper-based referrals, to emailing through the NHS secure email address, thought to be more efficient, had caused some confusion among referrers and advice services alike.

Interestingly, two services delivering HWC activity as part of the new GAIN contract in Glasgow stated that the contract limited attempts to seek additional funding from alternative grant-giving bodies. It was reported that some external funding bodies were less inclined to provide funding since the services became part of the Glasgow City Council contract, as they were therefore viewed as having a statutory obligation to provide council and health service initiatives.

5 Testing new approaches with children facing specific disadvantages

Building on phase one work, there was a recognised need to strengthen support for parents and children facing disadvantage due to specific needs or circumstances. This resulted in a particular focus on the following approaches during phase two:

- An in-reach pilot located at the Royal Hospital for Sick Children, Glasgow
- A homelessness pilot located at the Hunter Street Health and Social Care Centre, Glasgow
- Engagement with the Special Needs in Pregnancy service based in Possilpark, Glasgow
- Piloting of antenatal group work sessions
- Engagement with the specialist children's services to facilitate referrals
- Existing links with the Glasgow Community Addictions Service pilot and *ad hoc* links developed throughout phase two.

Analysis of the new approaches drew upon two separate reports on the Children's Hospital and Hunter Street homelessness pilots, other project documents and contact with staff involved in the pilots.

5.1 Royal Hospital for Sick Children (Yorkhill, Glasgow)

A carers' needs assessment involving families attending the Royal Hospital for Sick Children identified financial issues as a priority concern, due to regular and prolonged periods of hospital attendance. Subsequently, a one-year money advice pilot was established in the hospital – see Box 1 for details of the pilot processes and outcomes. The in-reach pilot at the Royal Hospital for Sick Children received a combination of funding from the Carers Information Strategy and the Glasgow city HWC contract.

Box 1. Royal Hospital for Sick Children (Yorkhill, Glasgow) – HWC pilot.

Processes	**Approach**	This hospital-based pilot was initiated in August 2012 with a focus on four areas: diabetes, neurology, cardiology and renal services. An advice worker (three days per week) offered families type 1 (information, signposting) and type 2 (casework including welfare benefits, money advice, financial capability, employment, housing and legal advice) services. The service is provided to families of in-patients whether residing inside or outside NHSGGC. Residents outside Glasgow city requiring type 2 (casework) or type 3 (representation) support were referred to their local agencies.
	Strengths	A named worker visible to hospital staff Clear referral pathways Good relationships with hospital staff Low non-attendance rates
	Challenges	Clients unable to self-refer Service currently limited to four specialist areas Wide geographical spread of service users i.e. beyond NHSGGC
	Future plans	Year two funding has been approved Scoping work progressed to identify unmet need Other referral pathways and sustainability beyond year two being considered

The case study below provides an example of the work carried out by the money advisor at the Royal Hospital for Sick Children.

Case study 1. Royal Hospital for Sick Children

Background: Lone parent with one child living in socially rented accommodation and undertaking temporary agency work – paid hourly. Since child became ill with a long-term condition, the parent was unable to work; expected recovery period of 12-18 months. Struggling financially and emotionally due to a drop in household income and increased expense linked to daughter's illness. Unsure of benefit entitlements and requires interpreter (English not her first language).

Current income: child benefit, child tax credits and working tax credits (WTC), but no longer entitled to WTC as she had stopped working. Applied for Income Support but received notification that she was not entitled.

HWC pilot – interventions: Parent advised to visit GP to obtain a 'fit note' and request an Employment Support Allowance (ESA) application from the Department for Work and Pensions (DWP). Referrals made to both Social Work and Family Support and Information Services to provide help with emergency funds and application for charitable grants. ESA applied for and applications for Housing and Council Tax benefit, Disability Living Allowance (DLA), Carer's Allowance and Income Support. Her Majesty's Revenue and Customs (HMRC) notified of changes in household circumstances.

HWC outcomes: Parent awarded ESA and Carer's Allowance (topped up by Income Support and additional carer's premium) and full housing and council tax benefits. Daughter awarded the high rate for both the care and mobility component of DLA. The Child Tax Credit award was increased through a disability and a severe disability premium. Working Tax Credit was no longer payable.

The client is now in receipt of the correct benefit entitlement with an annual household income of £19,600.

5.2 Hunter Street Health and Social Care Centre – homelessness pilot

During phase one, HWC project engagement with homelessness services across Glasgow was low. Therefore, a phase one pilot (from November 2011 to April 2012) offered advice services, two days per week, at the Hunter Street Health and Social Care Centre, which targets homeless people. Following a marked increase in engagement rates among homeless families, the pilot was extended for a further year and is now operating as part of overall HWC provision in Glasgow North West. Box 2 provides details of the homelessness service pilot.

Box 2. Hunter Street Health and Social Care Centre – homelessness pilot.

Processes	**Approach**	Most homeless client cases are too complex to be managed by mainstream drop-in advice services. The majority of clients are initially assessed in temporary accommodation, with follow-up appointments at local venues e.g. health centres, citizens advice (CAB) outreach venues and the Glasgow Central CAB.
	Strengths	Both clients and staff report positive experiences: "That's my money in today. Thanks for all your work. Now we can buy a new bed for our son." (Client) "Thanks for your help. I feel much calmer about it all now." (Client) "It is a valuable service which enables us to assist our patients." (Service provider)
	Challenges	Over 25% of homeless clients were either asylum seekers or had humanitarian protection, and over 50% had some disability in the family unit. Key challenges identified for families in temporary accommodation included: ▪ Lack of access to a landline telephone and little or no credit on mobile phones. ▪ Accessing DWP and external advice services because of mobile telephone charges, including lengthy call waiting times (DWP and HMRC). ▪ Frequent changes in circumstances and additional support needs. ▪ Complex benefits issues leading to protracted casework. ▪ A significant number require interpreters with language barriers causing confusion if various professional and teams involved. ▪ Welfare reforms are likely to have a disproportionate and early effect on this group. For example, the move towards universal credit, changes to disability benefits and the move to online applications.
	Future plans	• To promote the service among partner organisations within and outside NHSGGC. • To develop links with services/projects working with homeless patients/clients. • To generate funding to ensure sustainability of the project.

Case study 2 below demonstrates two examples of the types of intervention provided for homeless clients at the Hunter Street Health and Social Care Centre pilot.

Case study 2. Hunter Street Health and Social Care Centre – homelessness pilot.

- Mr and Mrs B and their child were referred for a benefits health check due to their complex situation. An assessment of their circumstances revealed an anomaly in their Employment and Support Allowance payments, dating back almost three years. Advice interventions over several months (phone calls and letters to the DWP) led to a first tier tribunal and a positive decision to award a backdated payment of several thousand pounds and an ongoing weekly gain of £34. At the outset, the family were unaware of this additional ESA entitlement.

- Mr and Mrs C have two children (4 and 16 years old), the oldest of whom has a disability. The family were struggling to pay bills in their temporary accommodation. With Mr C employed full time, the family thought they were in receipt of all they were entitled to. However, they had not claimed Working Tax Credits (WTC), as Mr C's hours and pay fluctuated, and they thought this meant they could not make a claim. The advice intervention involved helping the family with their WTC application, which resulted in an award of around £80 per week.

5.3 Special Needs in Pregnancy Service

The Special Needs in Pregnancy (SNIP) service operates an outreach service in Possilpark Health Centre, in Glasgow CHP – North West sector. See Box 3 for details. The Special Needs in Pregnancy clinic aims to target women who do not engage with mainstream early years health services. HWC referrals were supported through the sector's involvement with the Glasgow three-year mainstream advice contract.

Box 3. Special Needs in Pregnancy (SNIP) service, Possilpark Health Centre.

Processes	**Approach**	Discussions with the SNIP obstetrician in phase one led to an agreement to provide an HWC service when the clinic operated.
	Strengths	▪ Targets some of the most vulnerable women in communities. ▪ Sense of achievement for all i.e. clients, antenatal and advice staff. ▪ Some very positive outcomes for women and families.
	Challenges	Many SNIP clients face significant complexities and require workforce patience and a high level of skill to navigate the advice obstacles.
	Future plans	The service intends to build on previous experience to tackle some of the most intractable inequalities faced by this group of women.

5.4 Antenatal group work sessions

During phase one, midwives referred a much lower proportion (29%) of cases than did health visitors (51%). With this pattern of referrals remaining a challenge in the first six months of phase two, outreach advice was subsequently provided to some antenatal groups across NHSGGC. See Box 4 for details.

Box 4. Antenatal group work sessions.

Processes	**Approach**	Antenatal group work operates in Inverclyde and Glasgow (North West and North East) and involves collaboration between midwives, social work and the voluntary sector (i.e. Barnardos in Inverclyde). The programme targets young women who are not in contact with antenatal classes. An outreach advice clinic was tested at Possilpark Health Centre in north west Glasgow with Greater Easterhouse Money Advice Project (GEMAP) providing advice input to the service. This HWC pilot is working closely with leads for the Universal and Vulnerable Children's Pathways to ensure mainstreaming of this approach to money advice and support. This includes investigating avenues of influence and action to: ▪ Strengthen midwifery referrals to money advice. ▪ Extend outreach advice for women with complex needs. ▪ Extend provision of financial capability within antenatal group-work models.
	Future plans	Glasgow North West aims to continue using this approach and in Glasgow North East, antenatal group work is a rolling monthly programme for those accessing universal services.

Experiences of referring some women with complex needs for advice can be found on a DVD resource available on the NHSGGC HWC project website[4].

5.5 Other developments

A number of links explored in phase one were revisited to determine if the HWC project could provide additional support and remain a useful resource. These included Specialist Children's Services, Community Addiction Teams and new links with the Family Nurse Partnership initiative, which aim to support vulnerable, young pregnant women.

5.5.1 Specialist Children's Services

Across NHSGGC, Specialist Children's Services (SCS) care for children and young people suffering from a range of conditions that include long-term illnesses, mental health problems, child health problems and learning disabilities. The phase one evaluation report revealed that almost one in five families achieving some type of gain were awarded a Disability Living Allowance (DLA) payment. It was within this context that phase two SCS links were made in Glasgow to establish a referral pathway for

families not accessing the project through mainstream midwifery or health visitor referral pathways.
In phase two, the CIT worked with the Child Poverty Action Group (CPAG) Scotland to provide DLA training sessions for health visitors but this was subsequently extended to SCS staff.

5.5.2 Addictions service

In phase one, attempts to develop two pilot referral pathways that would link Community Addiction Teams (Glasgow city and Inverclyde) with the HWC project were not successful. A subsequent review of the Community Addictions Team (CAT) in Glasgow led to a number of recommendations to strengthen money advice provision for service users. They included the need to develop local action plans in conjunction with Welfare Rights Officers and to undertake staff briefing and training sessions. It was also recommended that routine enquiry on financial needs and benefits should be recorded and links strengthened with housing and homelessness services in addition to giving consideration to establishing money advice posts within each CAT.

5.5.3 Family Nurse Partnership

The Family Nurse Partnership (FNP) is an intensive, home-visiting programme for new teenage parents, which aims to give their children the best possible start in life. The FNP aims to address elements of three important policy areas: health inequalities; child poverty; and early years. Therefore, it was agreed that in phase two, the HWC project would develop links with the FNP, which operates in Glasgow (North East), East Dunbartonshire, and West Dunbartonshire.

The CIT undertook a well-received HWC awareness-raising session with FNP health visitors. With links created in Glasgow (North East), a local HWC aim is to develop referral pathways targeting 205 young women accessing the local FNP programme. The FNP staff were informed of the optimal times to refer young women for advice during pregnancy, based on evidence from the phase one HWC evaluation. Local HWC advice services will also record FNP as a referring group with plans for the local health improvement lead to join their FNP operational group.

6 Strategic embedding

The impact of strategically embedding the HWC project across a range of policy and planning processes was primarily assessed through documentary analysis and an interview with a key NHSGGC senior informant.

In phase two, strategic activities were undertaken to encourage ongoing project engagement and ensure that it was embedded across a range of policy and planning processes. Table 8 outlines the extent of this activity at NHSGGC, CH(C)P, local authority and national levels.

Table 8. Strategic embedding of HWC project activity.

Level	Area	Project embedding activity
NHSGGC and CH(C)P	Planning Frameworks and CH(C)P Development Plans	NHSGGC Planning Frameworks inform local CH(C)P Development Plans on a range of planning themes. Local plans report on financial inclusion activities under the following themes: Children and families; Adult mental health; Disability; and Cancer services. HWC project activity was linked to new planning guidance and will be reported on at NHSGCC organisational performance reviews where local CH(C)P progress on a range of health improvement targets is monitored.
	Child and Maternal Health Strategy Group (CMHSG)	The CMHSG leads on the Children and Maternity Planning Framework. The key actions supported by the group include: ▪ Ensuring HWC referral materials were included in the NHSGGC electronic child health recording system: EMIS Web. ▪ Adapting the NHSGGC Universal Pathway* to include routine enquiry on financial worries; the pathway is a framework for midwifery and health visiting staff in contact with families with children under five years of age.
	Health Improvement & Inequalities Group (HIIG)	With the HIIG leading on the Health Improvement Planning Framework, this group was updated on the mainstreaming of HWC work within local health improvement teams.
	Policy Frameworks and CH(C)P Development Plans	NHSGGC Policy Frameworks inform local CH(C)P development plans on cross-cutting themes. The NHSGGC Financial Inclusion Strategy Group is a strategic planning group and part of the Employability, Financial Inclusion and Responding to the Recession Policy Framework. This group will take over responsibility for strategic direction of the HWC project after phase two.
Local authority	Glasgow city Tackling Poverty Action Plan	Addressing child poverty is a work strand within this forthcoming action plan, which has incorporated learning from the HWC project.
	East Renfrewshire and Renfrewshire	HWC project links with the Children's Services Planning Groups were reported in both areas.
National	NHS Health Scotland (HS)	HWC project lessons were shared with HS as part of the national Early Years Collaborative (EYC)** to develop an online resource to support local Community Planning Partnerships in addressing child poverty.

* The Universal Pathway is the core contact protocol for all women and families with children (0-3 years). A further Vulnerable Care Pathway outlines the care protocol for vulnerable families with children (0-3 years).

** Shifting the emphasis of public services towards early intervention and reducing inequalities for vulnerable children are important priorities within the Scottish Government's Early Years Collaborative (EYC).

6.1 NHS Greater Glasgow and Clyde

Although the HWC steering group was the primary locus for strategic decision-making, links were created with three NHSGGC groups focusing on financial inclusion, child and maternal health, and health improvement and inequalities. These groups are involved in supporting a cross-cutting range of NHS policy, planning and performance processes.

An important planning outcome was the development of NHSGGC local guidance (2013-2014) which proposed the following key actions:

- A shift to early intervention and prevention, including action to address 'mind the gaps'.
- Ongoing implementation of the Healthier Wealthier Children project.

This new planning guidance is linked to a target to maintain HWC referrals at a local CH(C)P level. Subsequently, HWC activity will be reported at NHSGCC Organisational Performance Reviews, which involve areas reporting on agreed targets within their CH(C)P plans.

Two 'child and maternal health' outcomes involved changes to the Universal Pathway and child health recording systems within NHSGGC. The Universal Pathway is the core contact protocol for early years staff, such as midwives and health visitors, in contact with families with children under three years of age. It has been locally adapted to include routine financial inclusion enquiry with pregnant women and families, and will be implemented following workforce training. Additionally, the HWC project referral materials were included in EMIS Web, an online system that records child health. The CIT are also developing a proposal to audit related work and action on child poverty across the six CH(C)P areas.

There was evidence that the HWC project continues to embed within the NHSGGC Financial Inclusion Strategic Group with regular project updates provided to this group. This group has a lead role in supporting financial inclusion work across the health board, including developing local responses to the welfare reforms. Responsibility for strategic direction of the HWC project was assumed by the Financial Inclusion Strategic Group in September 2013.

Some additional insights into the strategic opportunities and challenges facing the project within NHSGGC were identified during the interview with the key senior informant:

- The need to ensure ongoing support for the project across the three NHSGGC groups, ('financial inclusion', 'child & maternal health', and 'health improvement & inequalities') after phase two.

- With project developments and decision-making often occurring at local CH(C)P level, the NSHGGC financial inclusion and health improvement & inequalities groups could be useful forums to support local work.

- The uncertainty about future resources for advice services and the subsequent challenge for services of not being able to respond effectively to referrals could negatively impact on NHS staff referrals and the project continuity.

- Glasgow City health improvement teams are facing a significant savings challenge, which will see their budgets reduced substantially from 2014 onwards. This will mean a focus on strategic priorities in the first instance.

- The negative impact that reduced resources and capacity will have on ensuring consistency in recording and monitoring ongoing HWC project data.

6.2 Community Health (and Care) Partnerships

All six CH(C)P areas reported that their local plans were committed to building on the legacy from the project by ensuring that referral pathways to local advice services were maintained to address child poverty. Table 9 demonstrates examples of ways in which the project was integrated within local priorities.

Table 9. Integration of HWC into local CH(C)P priorities.

CHP/CH(C)P	Embedding activity
East Dunbartonshire	East Dunbartonshire has committed to continuing with the HWC programme, and referral pathways to local advice services will continue. Income maximisation is a core outcome identified within the 2013-2016 East Dunbartonshire Joint Health Improvement Plan, which is itself the public health plan for the Community Planning Partners.
East Renfrewshire CH(C)P	There is an aim to mainstream the HWC project advice activities through the existing Welfare Rights Team.
Glasgow city CHP	The HWC project is part of the GAIN contract in Glasgow that involves local authority, housing and health partners. There has been engagement with Community Planning partners to ensure that the referral processes are an important part of the ongoing responses to poverty.
Inverclyde CH(C)P	There are plans to develop a local financial inclusion strategy. The HWC project is linked to the Early Years Family Support Group which underpins the CH(C)P child and maternal health remit. HWC staff engagement to be measured in the CH(C)P Organisational Performance Review. Plans to link in with the local authority single outcome agreement delivery group to increase awareness of the project.
Renfrewshire CHP	There is a financial inclusion policy commitment to establish child poverty as a priority for Community Planning Partners and progress a Child Poverty Action Plan through the Regeneration and Economy Group.
West Dunbartonshire CH(C)P	A CH(C)P scoping exercise is being carried out to identify the most appropriate strand of work to maximise access to financial inclusion services.

Incorporating the project work into the GAIN contract across Glasgow CHP ensured that it was subject to performance reporting along with the other advice provision. With HWC project work in Renfrewshire aligned within Community Planning structures, there are plans to recruit a financial capability post into their Employability Service with the aim of helping mental health service users access advice and help.

In East Dunbartonshire, Glasgow South and Renfrewshire, services reported an interest in expanding their remit to cover education services, with one local authority area

exploring the possibility of funding the local project to accept referrals from education services.

6.3 Local authorities

At a local authority level, integration into Community Planning and local anti-poverty strategies were priority areas for the HWC project. Analysis of single outcome agreements (SOA) in the six local authorities operating across NHSGGC revealed that explicit child poverty indicators were included, to a limited extent, in some SOAs.

In three areas, East Renfrewshire, Renfrewshire and Glasgow, it was reported that the HWC project was an agenda item on Children's Services planning groups. Most other local authority areas were attempting to integrate HWC into other planning structures that would allow planning for sustainable project delivery and money advice provision after phase two.

In Glasgow, a key development involved the establishment of a short-life 'Tackling Poverty Working Group', comprising Community Planning Partnership representatives, poverty organisation representatives and people facing poverty on a daily basis. The group's work culminated in the development of the forthcoming Glasgow city anti-poverty action plan that covers five themes, and includes child poverty and welfare reform amongst these. In an attempt to do things differently across the city, this new action plan will implement best practice from the HWC project and work on maximising family income and uptake of 'passported' benefits. Individuals in receipt of means-tested out of work benefits or tax credits may be entitled to a number of 'passported' benefits, such as free school lunches, support for travel costs to health appointments or discounts on charges or fees, such as leisure discounts.

6.4 National

Improving outcomes and reducing inequalities for Scotland's vulnerable children and shifting the balance of public services towards early intervention and prevention are important priorities within the work of the Early Years Collaborative (EYC). The HWC project played an influential role in the development of a national EYC resource to be launched in October 2013. This new resource aims to support Community Planning Partnerships (CPPs) take forward local plans to improve child health and tackle child poverty, through maximising income for families with young children[5].

This forthcoming resource contains shared reflections from the HWC project since its launch in October 2010, including some of the potential infrastructure requirements in relation to policy, strategy, partnerships and commissioning which could be beneficial to other CPPs considering setting up a similar partnership project.

7 Service user outcomes

Project outcomes were investigated through secondary analysis of monitoring reports submitted to the CIT by local HWC advice services, and progress reports detailing mainstream work and new approaches. The outcomes presented include referrals and uptake of advice services, financial gain, family composition, and data on children with disabilities and ethnicity.

7.1 Phase two referrals and uptake

Overall, between April 2012 and March 2013, there were 2,487 referrals to the HWC project. Table 10 provides a breakdown of referrals and uptake data from the mainstream HWC project and two of the four pilot approaches for which these data were available.

Table 10. Overall phase two referrals and uptake (April 2012 to March 2013).

Service	Referrals	Uptake	Comments
Mainstream HWC project	2,289	1,027 (45%)	
Royal Hospital for Sick Children (Yorkhill) – pilot	86	78 (91%)	50% clients reside outside NHSGGC 41% Glasgow city residents
Hunter Street Health and Social Care Centre – homelessness pilot	112	84 (75%)	
Total referrals	**2,487**		

7.1.1 HWC mainstream project – referrals and uptake

As previously noted in Section 4, the mainstream project recorded 2,289 referrals to HWC advice services from April 2012 to March 2013. These referrals included small numbers from two of the four pilots: Special Needs in Pregnancy (15) and the Antenatal group work (35).

Of the 2,289 referred, 1,027 (45%) attended for advice and help. A further 24 were recorded as awaiting an appointment, 410 as failures to attend, and 79 as having declined the service. No status report was recorded for the remaining 749 referrals.

7.1.2 HWC pilot projects – referrals and uptake

Among the four pilots, the Hunter Street homelessness pilot recorded the highest number of referrals (112) with 75% of those accessing advice. This pilot commenced at the end of phase one of HWC and was therefore reasonably well established in the early stages of phase two.

The Royal Hospital for Sick Children pilot, which was established about six months into phase two, achieved 86 referrals with very high uptake (91%). Subsequent (post-March 2013) data on client's place of residence for 143 referrals revealed that 50% of hospital clients resided outside NHSGGC, the majority of whom were from Lanarkshire, Ayrshire and Arran and Fife. Smaller proportions were spread across Grampian, Forth Valley, Lothian, Dumfries & Galloway and Tayside board areas.

7.2 Financial gain

Data on financial gain were available from the HWC mainstream service, and the Royal Hospital for Sick Children and Hunter Street homelessness pilots. Table 11 outlines the aggregated financial gain during phase two.

The method of calculating gain was adopted from the approach used by Citizens Advice Scotland and issued in their staff guidance[a].

Table 11. HWC project aggregated financial gain – phase two.

Service	Financial gain
Mainstream HWC project	1,976,680
Royal Hospital for Sick Children (Yorkhill) Hospital pilot	123,824
Hunter Street homelessness pilot	222,980
TOTAL	**£2,323,484**

The aggregated gain from the mainstream HWC project and two pilots amounted to £2,323,484 with the largest amount (£1,976,680) coming from mainstream advice services. In addition to gains made from the receipt of entitled benefits and improved debt management, this figure includes one-off lumps sums totalling £72,427.

Table 12 provides a breakdown of financial gain by CH(C)P area. The highest reported figures were in Glasgow North East (£456,586), and Renfrewshire (£417,389). East Renfrewshire and Glasgow South recorded sums in the region of £300,000. Financial gain in the remaining areas ranged between £125,000 in Glasgow North West and £180,000 in East Dunbartonshire. No data were submitted from West Dunbartonshire.

Table 12. Financial gain by CH(C)P across NHSGGC.

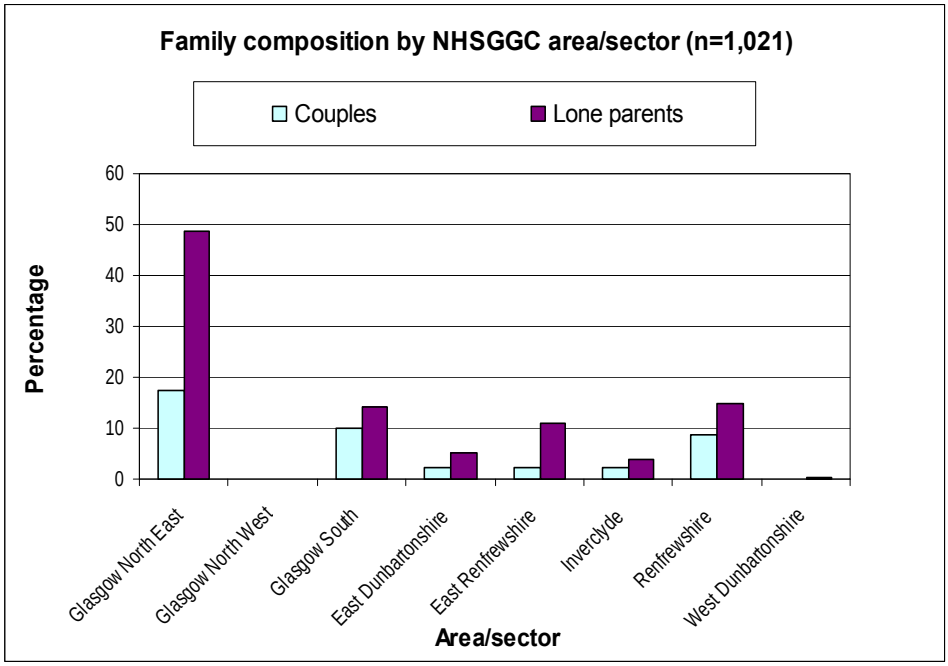
CHP/CH(C)P area	Combined annual total and debt-managed (£)	Total one-off sums (£)	Total financial gain (£)
East Dunbartonshire CHP	179,773	1,100	180,873
East Renfrewshire CH(C)P	321,105	0	321,105
Glasgow CHP – North East sector	456,586	0	456,586
Glasgow CHP – North West sector	125,621	0	125,621
Glasgow CHP – South sector	300,059	0	300,059
Inverclyde CH(C)P	141,000	0	141,000
Renfrewshire CHP	417,389	34,047	451,436
West Dunbartonshire CH(C)P	-	-	-
TOTALS	**£1,941,533**	**£35,147**	**£1,976,680**

[a] Citizens Advice Scotland guidance: awards paid in regular amounts, and reductions in, or write-off of debt payments are aggregated and calculated over 52 weeks as an annual figure.

7.3 Family composition

Data on family composition were recorded for 1,012 clients. The majority of clients were lone parents (69%; 703/1,012) and 31% (318/1,012) were couples. In most areas, the ratio of lone parents to couples was approximately 2:1 but it was slightly higher in Glasgow North East at almost 3:1 (see Figure 3).

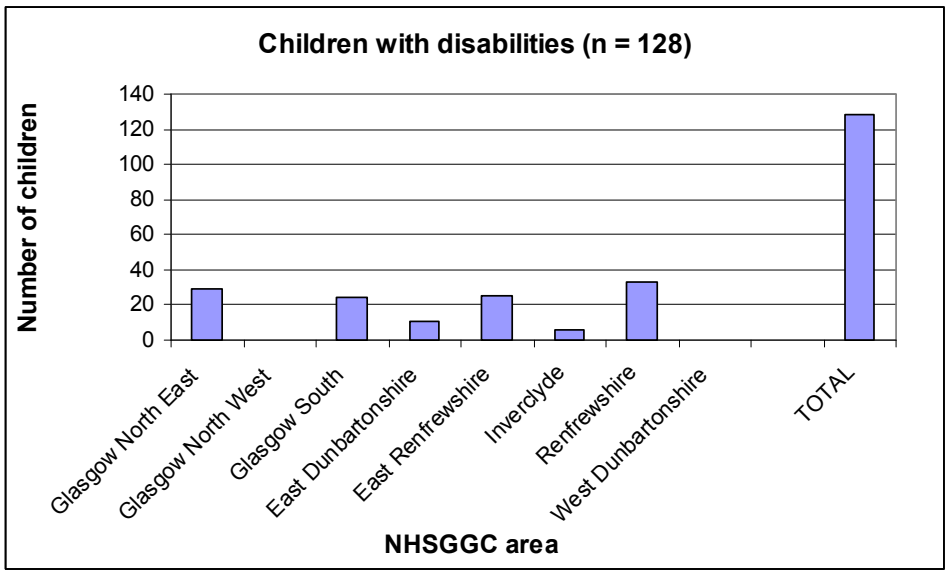
Figure 3: Family composition by area.



7.4 Children with disabilities

Overall, 128 (12%) children with disabilities were recorded from the 1,027 clients who made use of the service. The majority of these were spread across Glasgow (North East and South), East Renfrewshire and Renfrewshire. Smaller proportions were reported in East Dunbartonshire and Inverclyde. Figure 4 outlines the breakdown by area.

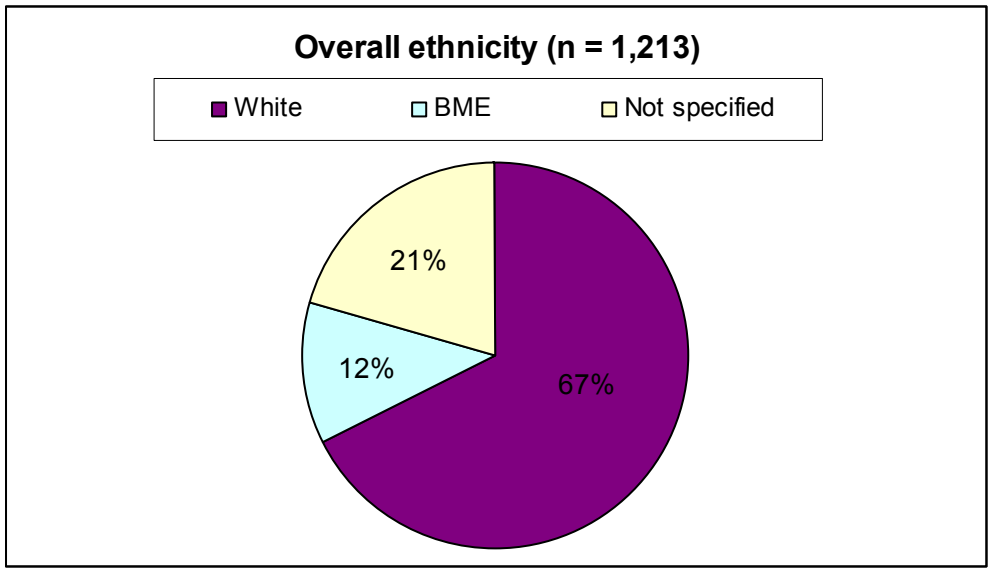
Figure 4: Children with disabilities by area.



7.5 Ethnic origin

Ethnicity was recorded on 1,213 records. The majority were White (67%; 818/1,213), 12% (146/1,213) were from a Black or Minority Ethnic (BME) background and ethnicity was not specified for 21% (249/1213) of cases (see Figure 5).

Figure 5: Money advice clients' ethnicity.



The highest percentages of minority ethnic groups were reported in Glasgow South (7%) and Glasgow North East (4%).

7.6 Other reported outcomes

Additional local area feedback highlighted other local outcomes. For example, within the Glasgow GAIN contract, fuel poverty interventions were incorporated into HWC work with the expectation of automatic referrals to the Glasgow Home Energy Advice Team (G-HEAT) for all clients. This service provides independent advice on energy-related issues to households and assists the local authority aim of eliminating fuel poverty.

8 Limitations of the study

- There were some omissions in data recorded for the project. As these were secondary data, it made it difficult for the evaluation team to draw conclusions about these gaps.

- In phase two, money advice services reverted to the mainstream method of recording financial gain data. This involved advice services aggregating gain by benefits or awards instead of recording at the individual level. This change in recording prevented calculation of individual average gain and meant that the overall number of cases that achieved financial gains was not recorded for monitoring purposes.

- As advice services did not record a separate source of referral for those from the Special Needs in Pregnancy and antenatal group work services, the data for these referral groups should be treated with caution as they may be estimates.

- The time allocated to the HWC project by Health Improvement leads, derived from the online survey, may be open to misinterpretation, as further feedback suggests that some respondents recorded their own time allocated to the project, whilst others included input from other team members.

9 Discussion

The Healthier, Wealthier Children project was an innovative partnership approach to tackling the high levels of child poverty throughout NHSGGC, an area comprising almost a quarter of the Scottish population. In Glasgow city in 2012, 33% of children, equivalent to 36,000, were living in poverty[6] which compares with a UK rate of 17%[7].

While there has been very little change in these national figures since 2004-05[8], the latest annual report on Scotland's child poverty strategy[9] notes that the current UK government's austerity and welfare reform measures will drive the UK relative child poverty rate up to 24% by 2020, resulting in an additional 50,000 children in Scotland living in poverty. Predictions about the impact of the welfare reforms indicate that they will result in a £2 billion loss in welfare spend across Scotland by 2014-15[10], which will have an effect on the most vulnerable groups in society.

There is a wealth of evidence on the negative impact of poverty on children's health, wellbeing and life chances, including effects on mortality, health at birth, growth, physical morbidity, psychological and developmental disorders[11] and low educational attainment and future earning capacity in adult life[12]. The annual report on Scotland's child poverty strategy[9] also reminds us of the shocking fact that children born in the poorest areas can expect to live 14 years less than those in wealthier areas.

Therefore, action to reduce child poverty is not only imperative to achieve fairness and social justice, but should also represent a core dimension of preventing such significant health inequalities from occurring in the first place. The 'Christie Commission Report' into the reform of public service delivery in Scotland has already highlighted the pressing need for integrated services to achieve positive outcomes, by prioritising prevention, reducing inequalities and promoting equality, in the context of constrained public spending[13].

9.1 HWC project – operational and strategic activities

The HWC project exemplifies the key reforming principles of the 'Christie Report' by delivering an integrated approach to addressing child poverty that involves health, local authority and voluntary sector partners working towards maximising income and providing financial advice and support for families at risk of, or experiencing poverty. Despite operating during phase two with reduced ring-fenced funding, there were 2,487 referrals to advice services over the twelve month period (a drop of only 29 referrals from phase one, which covered a fifteen month period), wider staff engagement involving social work and primary care staff, and subsequent annual financial gain of just over £2.3 million for women and families.

Between the launch of the project in October 2010 and March 2013, there was a cumulative total of 5,003 referrals to advice services, which led to just over £4.5 million in total annual financial gain for pregnant women and families across NHSGGC.

To achieve these outcomes, health improvement staff continued updating frontline staff directly working with pregnant women and families on the latest welfare reforms, promoting the project and delivering specific training. Delivering these activities alongside money advice staff, ensured that frontline staff, particularly midwives and health visitors, continued referring women and families to advice services. Money

advice services also endeavoured to continue offering flexible appointments in the form of outreach services and telephone appointments, as initiated in phase one.

In addition to these activities within the mainstream HWC referral pathways, two pilot projects produced notable results in terms of referrals, financial gain and increased wellbeing for vulnerable groups. Both pilots benefited from dedicated input from health improvement and advice staff, with the children's hospital pilot planning to seek additional funding to extend this service to outpatient clinics. It is also noteworthy that half of those referred within the hospital were from other health board areas across Scotland, which may be indicative of a much wider trend of 'hidden need'.

At a strategic level, there was evidence that the project was being integrated across a range of NHSGGC and CH(C)P plans, performance reporting mechanisms and strategic groups, particularly child and maternal health and financial inclusion groups. From September 2013 onwards, the project was subsumed into the NHSGGC Financial Inclusion Strategic group. This strategic NHS group will continue to provide updates to the NHSGGC Child and Maternal Health Strategy group.

Although NHSGCC was the lead partner, some of the six local authority areas operating across NHSGGC reported that the project was an agenda item within Children Services planning groups or alternative planning structures. In Glasgow, the HWC project is now a part of commissioned mainstream advice services and has been included within the city's forthcoming poverty action plan, thus ensuring ongoing action on child poverty. However, there was less clear evidence of project embedding in the five authority areas outside Glasgow city.

9.2 Sharing HWC project lessons

At a national level, HWC steering group members were involved in a short-term working group led by NHS Health Scotland, the national health improvement agency, with the aim of sharing lessons from the project more widely in a forthcoming resource aimed at supporting local Community Planning Partnerships (CPPs) in their efforts to tackle child poverty across Scotland. This resource could also provide support to other health board areas, given that no other health board area in Scotland has implemented a similar, system-wide preventative approach to address child poverty.

There is a compelling case to strengthen the role of local authorities in addressing child poverty across Scotland by sharing HWC project lessons. A recent research study involving Scottish local authorities noted that only half of the council officers surveyed felt that child poverty was a political priority in their area, with only 16% having developed an action plan to address child poverty[14]. Addressing these gaps is vital as new research reveals that local authorities are the single most significant provider and commissioner of money advice services across Scotland with an estimated annual investment of £20 million[15].

More widely, a recent report from the Campaign to End Child Poverty group has noted that, with the UK government devolving more decisions about how families are supported to local authorities, actions to address child poverty at local level can make a difference[16]. Moreover, important public health policy changes in England will involve local authorities taking a more central role in improving population health and tackling

inequalities[17]. Therefore, there may be scope to share HWC project lessons across the UK and elsewhere.

9.3 Future mainstreaming of the HWC project

Evaluation of the phase two period from April 2012 to March 2013 has demonstrated that the HWC model, when mainstreamed within routine services with reduced ring-fenced support, has continued to sustain impact and deliver substantial benefits to families. That said, although the phase two funding, and the commitment of all partners, allowed maintenance of the project, the capacity to build on the phase one achievements and expand the project was a challenge. It is recognised in the literature that mainstreaming initiatives requires a long lead-in time, typically three to five years after implementation, and the stability of resources is one of the factors that influences program sustainability[18]. Arguably, the HWC project has reached a critical mainstreaming juncture: identifying alternative funding streams to enable further embedding and expansion of the HWC model is crucial.

A recent paper on mitigating the impact of the welfare reforms, prepared on behalf of the Scottish Council for Voluntary Organisations, identified the positive returns on investment from the HWC project during phase one and from other similar approaches[19]. In addition to advocating an expansion of these approaches to other client groups and locations, the paper strongly recommended that consideration be given to establishing a 'Financial Security Change Fund' to support the integration of a diverse range of income maximisation, welfare and money advice programmes, enhance the capacity of credit unions, and extend effective approaches more widely. The author suggests that this new fund could seek matched funding from the financial services sector and domestic energy suppliers.

The concept of developing change funds has already been established across a range of Scottish Government policy areas, such as reducing reoffending, reshaping care for older people and shifting early years services away from crisis management towards preventative responses. Lessons from these approaches, and forthcoming Scottish Government plans to integrate health and social care services across Scotland, could support the establishment of a Financial Security Change Fund.

10 Conclusions and recommendations

The HWC project provides clear evidence demonstrating that different sectors and workforces, working successfully together, can lead to a range of impressive outcomes for pregnant women and families at risk of, or experiencing, poverty. However, despite the reported gains achieved in tackling child poverty over the last two and a half years, there remains a significant risk that these will be reversed by current austerity and welfare reform measures. Based on the evidence from the HWC evaluation, we make the following recommendations to enable continued action on child poverty across three geographical levels:

NHSGGC

- With child poverty rates expected to increase, it is important to extend workforce engagement with the HWC project to include other health, social care, education and voluntary sector staff groups. This will require the protection and strengthening of resources and capacity across the range of sectors and workforces engaging with this agenda.

Local authorities and NHS boards

- In Scotland, local authorities have an important leadership role to play within Community Planning Partnerships and are the most significant providers and commissioners of money advice services. Based on the experience described in this report, there is a strong case for wider adoption of the HWC partnership model within local Community Planning Partnerships across Scotland.

- Similarly, as NHSGGC is the only NHS health board area in Scotland to have implemented a system-wide preventative approach to addressing child poverty, there is a need for other board areas to engage actively with local partners to strengthen their strategic responses to addressing child poverty.

Scotland and beyond

- Scottish Government plans to integrate health and social care services will involve significant change processes within local areas. Building on past experience of ‘change funds’, there is a potential opportunity to establish a ‘change fund’ aimed at promoting financial security and tackling poverty across Scotland. This could support the development costs involved in establishing HWC-type partnerships prior to their mainstreaming.

- There are also opportunities to share HWC project lessons across the UK and beyond, linked, for example, to the policy changes in England leading to local authorities taking a more central role in tackling health inequalities and to the UK government’s commitment to devolving more decisions about how families are supported to local authorities.

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Appendix 1. Phase one project areas and staffing

Table 1: Phase one Local HWC project delivery structures across NHSGGC

Local Area	Total HWC Staff		Local HWC Advice Services
	9.5 Development Officer (DO)	8.5 Advice Worker (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.

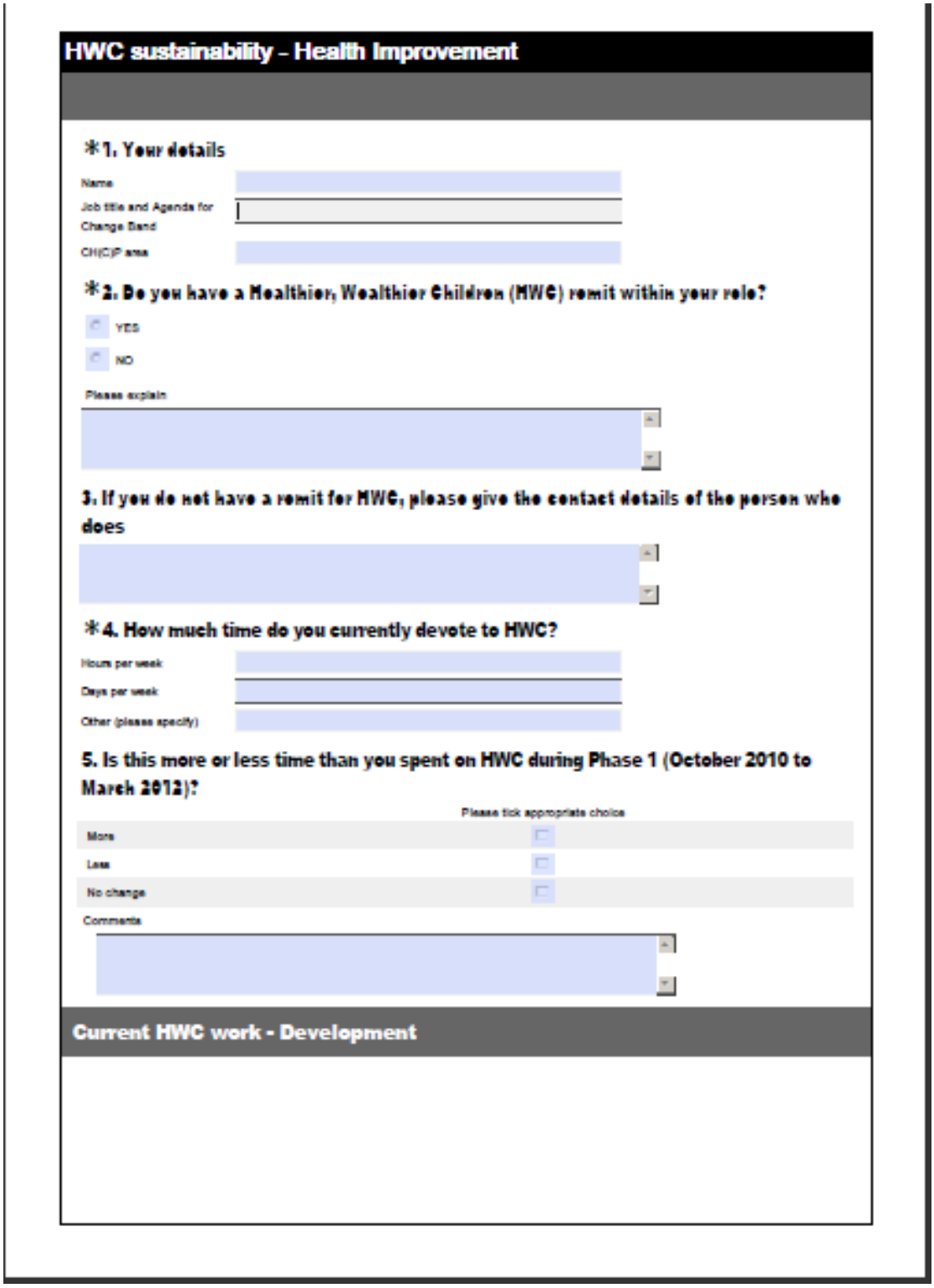
Appendix 2. Evaluation Tools

1. Survey monkey questionnaire (used with Health Improvement Seniors in each of the eight CH(C)P areas across NHS GGC).

2. Telephone interview schedule for interviews with nine commissioned money advice managers.

3. Interview schedule for a face-to-face interview with a key senior informant within NHSGGC

1. Survey monkey Health Improvement questionnaire.



HWC sustainability – Health Improvement

***1. Your details**

Name

Job title and Agenda for Change Band

CH(C)P area

***2. Do you have a Healthier, Wealthier Children (HWC) remit within your role?**

YES

NO

Please explain

3. If you do not have a remit for HWC, please give the contact details of the person who does

***4. How much time do you currently devote to HWC?**

Hours per week

Days per week

Other (please specify)

5. Is this more or less time than you spent on HWC during Phase 1 (October 2010 to March 2012)?

	Please tick appropriate choice
More	
Less	
No change	

Comments

Current HWC work - Development

HWC sustainability – Health Improvement

6. Please tell us if you are currently involved in any of the following aspects of HWC development

	YES	NO
Encouraging health visitor referrals	☐	☐
Encouraging midwife referrals	☐	☐
Encouraging uptake of advice	☐	☐
Other development work	☐	☐

If Other, please give details

7. Are you involved in the following capacity-building work in your area?

	YES	NO
Ongoing training (HI staff)	☐	☐
Ongoing training (other Early Years staff)	☐	☐
Dissemination of HWC outputs	☐	☐
Dissemination re. welfare reforms	☐	☐
Other (please give details below)	☐	☐

Please give further details

HWC sustainability – Health Improvement

8. Do you have a role in any of the following activities?

	YES	NO
Local HWC planning group	☐	☐
Local child poverty planning group	☐	☐
Engagement with midwives	☐	☐
Engagement with health visitors	☐	☐
Engagement with money advice services	☐	☐
Membership of child poverty groups	☐	☐
Membership of financial inclusion groups	☐	☐
Membership of children's services planning groups	☐	☐
Other (please give details below)	☐	☐

Further details

9. In relation to action on child poverty, what do you think are the key challenges for :

Pregnant women and families

Health improvement teams

Money advice services

Funders and commissioners of services

10. In relation to action on child poverty, what do you think are the key opportunities for :

Pregnant women and families

Health improvement teams

Money advice services

Funders and commissioners of services

11. How would you describe the legacy of the HWC project?

12. Have you any other comments?

2. Interview schedule for telephone interviews with money advice managers

ADVICE MANAGER TELEPHONE INTERVIEW GUIDE

1. HWC provision – general/staffing

    - which service, where
    - how does HWC currently fit within your service,
      i.e. dedicated/non-dedicated advisor/ i.e. is it generic staff picking up child poverty work - difference between now and previously; hours worked, involvement in other work – ratio of hours for each strand of work. Other health projects/social work/welfare reform/generic money advice service work.
      Contract dates of HWC staff

2. HWC service delivery – methods, etc.

    - Method of delivery - general approach,
      Outreach, home visits, telephone screening, advice service appts.
      Do you follow a contact protocol for failure to attends and hard to reach groups
    - Has this changed from before?

3. Effects of new funding (2012-13) regime

    - Impact on generic money advice service? i.e. Onward referrals (8%) – what's happening now ie. within service/external referrals
    - Level of service provision (previously Tier 1& 2 – is there much Tier ¾ now with pregnant women & families). If so please describe types of interventions?

4. Level and extent of local partnership working (2012-13)

    Current level of partnership work
    - Contact with HI team - ? attend local HWC planning groups, child poverty groups, children's services planning groups. ? feed into any community planning subgroups.
    - Describe levels of engagement with HVs/MWs – any reported changes?

5. 2012-13 opportunities/challenges – embedding HWC work

    - Purpose of extra funding to embed child poverty work in money advice services + health improvement

    - What are the key challenges and opportunities facing:
      a) pregnant women & families
      (b) money advice service/health improvement
      (c) funders/commissioners – policy & strategy

    - Key strengths/opportunities? Ditto.

6. How would you describe the legacy of the HWC project?

7. Have you any other comments?

3. Interview schedule for face-to-face interview with a key senior informant

PHASE 2 - KEY INFORMANT TOPIC GUIDE

1. Which local and/or national groups do you attend/feed into? (HWC and wider financial inclusion activities)
(I,.e. Child and Maternal Health Strategy Group, Financial Inclusion Strategy Group, Health Improvement and Inequalities Group, etc)

- Do you have the opportunity to raise HWC at these meetings?
  – links with COSLA/Health Scotland and HS plans to link in with national Early Years Collaborative.

2. Within your role as chairperson of the HWC Steering Group, what do you think have been the key opportunities for/challenges of embedding the project at strategic level?
- Local level
- Board wide
- National level
  (6 Las – different SOA priorities)

3. What do you think – from the project's experiences to date are the main workforce challenges to integrating HWC?
- For Health Improvement teams
- For Front-line staff
- For Money Advice Services
- For others – i.e. education etc.

4. Likewise, what do you think are the main workforce opportunities for integrating HWC?
- For Health Improvement teams
- For Front-line staff
- For Money Advice Services
- For others

5. **What do you think the main sustainability challenges are for HWC?**
- New partnerships
- New funding arrangements
- Strategic home for HWC/child poverty
- Where central support should be located (CIT other commitments)

6. **Also, do you think there are any sustainability opportunities for HWC?**
- New partnerships
- New funding arrangements
- Strategic home for HWC/child poverty
- Central support
- *CHPC structures & proposed Integration of Adult Health & Social Care Bill*

7. **Looking at the difference between phase 1 (pilot) and phase 2 of the project, what do you think are the main differences or lessons for the future?**
- Organisational
- Delivery
- Outcomes

- Funding (Glasgow vs non-Glasgow – Gain contract etc.)

8. Have you any thoughts on where we go from here to raise the profile of HWC nationally?

9. Have you any other comments?

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