

A Healthy Start for Liverpool

How can we improve
the uptake of the
Healthy Start
Scheme in Liverpool?

Full Report
September 2022



CONTENTS

1.	FOREWORD by Dr Naomi Maynard	3
2.	WHAT IS THE HEALTHY START SCHEME?	4
3.	CONTEXT	5
	a. National	5
	b. Transition to digital	5
	c. Local	6
4.	RESEARCH QUESTIONS AND METHODOLOGY	8
5.	POLICY OVERVIEW	9
	a. Welfare Food Scheme (1940 – 2006)	9
	b. Healthy Start (2006+)	9
6.	BEST PRACTICE EXAMPLES	11
7.	FINDINGS	13
	a. Views of parents and carers	13
	b. Views of frontline professionals	14
	c. Local Management and Co-ordination	16
	d. Training and Workforce Development	17
	e. Vitamin uptake	19
	f. Marketing and Communications	20
8.	RECOMMENDATIONS	23
	a. National	23
	b. Local	23
9.	NEXT STEPS	25
10.	APPENDICES	26
11.	REFERENCES	31

1. Foreword

The Healthy Start Scheme is a lifeline for so many pregnant women and families with young children, providing access to good food: fruit, vegetables, milk and vitamins which are so important to give your child the best start in life. It certainly was for me, when back in 2014 my husband and I welcomed our first son whilst we were both students: the weekly benefit meant our family could have fresh fruits and vegetables at a time when money was tight.

But so many people who could be a part of this scheme are missing out. In 2021 in Liverpool nearly three quarters of a million pounds, set aside for the Healthy Start Scheme, went unclaimed.

This is outrageous.

This project marks a first step towards ensuring this doesn't happen again. Through working with parents, children's centre staff, health visitors and our public health colleagues, we have produced a series of local and national recommendations – practical steps that can be taken to improve the uptake of the Healthy Start Scheme both here in Liverpool and beyond.

Dr Naomi Maynard, Good Food Programme Director, Feeding Liverpool



2. WHAT IS THE HEALTHY START SCHEME?

The UK's Healthy Start Scheme (hereafter 'Healthy Start') was first introduced in 2006 by the Department of Health and Social Care (DHSC), replacing the Welfare Food Scheme which had been in existence since 1940. It is a statutory public health initiative in England, Wales, and Northern Ireland¹ with a stated goal of providing a nutritional safety net and improving access to a healthy diet for low-income families.

Healthy Start is available to all women under the age of 18 (regardless of their income), and is means-tested for women aged 18 and over who are 10+ weeks pregnant, and for families with a child or children under the age of 4, who qualify via one of the following benefits:

- Income Support
- Income-based Jobseeker's Allowance
- Income-related Employment and Support Allowance (ESA)
- Child Tax Credit with a family income of £16,190 or less*
- Working Tax Credit run-on (paid for 4 weeks if your working hours, or your partner or carer's, go to less than 16 hours per week)
- Pension Credit (which includes the child addition)
- Universal credit with a total family 'take-home pay' for this period of no more than £408

If you're not a British citizen but your child is, you can also ask for an application form to be sent to you via email² if all of the following are true:

- you have at least 1 British child under 4 years old
- your family earns £408 or less per month after tax
- you cannot claim "public funds" (e.g., benefits) – either because of your immigration status or because you do not have an immigration status³

Participants receive free vitamins⁴ and £4.25 per week, to be spent on fruit, vegetables, and milk for each child under the age of 4. This is increased during the first year of a child's life to £8.50.

If a participant remains eligible from 10 weeks into pregnancy until their child is age 4, they will receive approx. £1,200 via the scheme. This amount makes a significant difference to some of Liverpool's lowest income households, improving the quality and quantity of good food their household consumes.

1 In 2019, the Scottish Government introduced Best Start Foods – replacing Healthy Start – with different eligibility criteria, a higher weekly payment, and included fresh eggs, along with milk, fruit, vegetables and formula in the list of what parents can purchase, as well as the ability to use the card to pay for online shopping.

2 Healthystartclaim@dhsc.gov.uk

3 For full eligibility criteria see Appendix 1 and www.healthystart.nhs.uk/how-to-apply/

4 This is the least well used aspect of the scheme, and even in those areas where provision of vitamins was universal (as had been the case in Liverpool between April 2014 to March 2016), take-up was often below 10%. The biggest barrier identified was a lack of access, particularly for those families who were not accessing children centres.

3. CONTEXT

a. National

Despite Healthy Start having been in place for over 16 years, there is a distinct lack of understanding about the scheme, with confusion over eligibility, and significant inconsistencies in how it is co-ordinated across the country.

Take-up of the scheme has been steadily declining nationally since 2015, down from 73% to 51% in 2020 (Parnham et.al 2021). The initial introduction of Universal Credit in 2016 in particular impacted Healthy Start negatively, leading to a reduction in take-up when the application form did not recognise this benefit.

National uptake in 2021 was just 57%. Research from Sustain, The Alliance for Better Food and Farming found that that over 2 million eligible people missed out, resulting in an estimated £69 million loss to families.

The government is also spending considerably less each year on Healthy Start, and reaching far fewer beneficiaries than anticipated⁵ (Crawley et al 2018). It is estimated that the annual cost of Healthy Start is now at around 50% of the original budget suggested. One reason given for this is that access to the scheme is not automatic, with beneficiaries needing to apply.

Promotion of Healthy Start is the responsibility of local public health teams and health professionals. As such, uptake and awareness amongst professionals can vary widely between regions and even within sub-regions. According to Parnham et al (2021) “uptake is strongly determined by health professionals signposting participants in pre- and post-natal healthcare appointments”. In this regard, the Children’s workforce and voluntary and community sectors also have a significant role to play in supporting health professionals in promoting the scheme.

b. Transition to a digital scheme

In November 2021, the NHS Business Services Authority (NHSBSA), an Arm’s Length Body of the Department of Health and Social Care (DHSC), took over responsibility from the Healthy Start Issuing Unit for delivering Healthy Start.

In March 2022, Healthy Start transitioned from being a paper-based scheme, where participants received vouchers each month, to become a digitalised scheme, where payments are uploaded onto a pre-paid MasterCard (every 4 weeks), which can be used at any retailer that accepts MasterCard payments.

The need to ensure families could easily access the new digital scheme was critical, with a decade of austerity, a move to Universal Credit, benefit sanctions, changes to benefit

5 In 2011 there were 717,066 eligible beneficiaries for Healthy Start and a take-up rate of 80%, with Government spending £89.3m. In 2018, there were now just 499,697 eligible beneficiaries and a 66% uptake. Government spend was now almost half that of 2011, at £46.96m. Source: Data from the Healthy Start Issuing Unit. In 2022 there were 499,893 eligible beneficiaries, similar to 2018 numbers, and an average take-up of 70%. While there are no updated figures on Government spend for this period, it is likely to be slightly higher given the increase in vouchers to £4.25 per participant, but still below the 2011 spend.

thresholds, a cost of living crisis, and reduced support for families who have more than two children, all being linked to an increase in food insecurity in the UK. Since the scheme went live, there have been over 345,000 successful applications⁶, with over 107,000 of these coming from households new to Healthy Start.

While broadly welcomed, the move to digital has also brought a number of additional barriers, not least for those families experiencing digital exclusion, issues with smartphones (e.g. a lack of mobile data), and little or no internet access at home. Furthermore, existing beneficiaries did not automatically move onto the digital scheme but had to reapply to continue to receive Healthy Start, which has meant that, inevitably, some people slipped through the net.

The Guardian estimated that nationally 52,000 existing beneficiaries for Healthy Start have been unable to re-apply. When added to those many other eligible households who have never made a claim, this adds up to a significant amount of funding not flowing into local economies and the homes of some of our poorest families (Clark, June 2022).

In March 2022, the last time data was made available, of the 547,719 total eligible beneficiaries to the Healthy Start Scheme, 394,358, or just 73%, were accessing the vouchers either in paper or digital form. No further data has been made available, but the expectation, which is further stated on the NHS Healthy Start website, is that when the April 2022 data is released, these figures will be lower. This is because not all those on the paper voucher scheme have joined the digital scheme, either because they fell out of eligibility or have not completed a digital application form. In August 2022, we are still waiting on the updated figures of take-up of Healthy Start in each local authority area.

c. Local

In Liverpool, where one in three adults is food insecure, one in two adults are not eating 5 fruit and vegetables a day, and one in three children are living in poverty, it is vital that every eligible person is able to access Healthy Start.

Locally, Healthy Start figures reflect the national picture. Take-up has fluctuated– peaking when Healthy Start was first introduced at 80% but dropping as low as 59% in 2020. **Table 1** below demonstrates these fluctuations, by comparing the first month statistics were released, and then every March up to 2022, which is the last time the Government released data. Given the Government’s inability to release any data on the Healthy Start uptake since the paper vouchers were phased out⁷, and in light of The Guardian’s reporting, these numbers may yet fluctuate further.

Thousands of eligible people in Liverpool are therefore missing out on Healthy Start - a huge loss to families struggling to cover the rising cost of living. In 2021 in Liverpool an estimated £758,521.24 went unclaimed rather than supporting households with access to fruit, vegetables, milk, and vitamins.

6 499,893 people were eligible for Healthy Start in March 2022, Source: Healthy Start England Uptake Data

7 At the time of writing, Sustain, an alliance of organisations and communities working together for a better system of food, farming and fishing, sent a letter to the Department of Health & Social Care requesting an update on the Healthy Start data. They were informed that “data on the Healthy Start scheme, the number of beneficiaries on the digital scheme will be made available as soon as possible” (April 2022)

Table 1

Year	Total eligible	% take-up
April 2015	7,013	80%
March 2016	6108	79%
March 2017	6118	70%
March 2018	6179	69%
March 2019	5680	66%
March 2020	6660	59%
March 2021	7497	60%
March 2022	6889	73%

Table 1: Liverpool take-up figures for every March (apart from Year 1) since Healthy Start figures were made available

4. RESEARCH QUESTIONS AND METHODOLOGY

Given this context, Feeding Liverpool's research, led by Rachel Flood, focused on understanding how existing beneficiaries and frontline professionals view the scheme, uncovering any barriers that could prevent eligible people from taking up Healthy Start, and identifying solutions to address this.⁸

The research focused on the following core questions:

1. What is the current level of understanding and awareness of the Healthy Start Scheme in Liverpool?
2. Why is take-up not higher amongst eligible parents/carers in the city?
3. How can we improve take-up across the city and what is needed to deliver this?

To answer these questions we have:

- Visited five Children's Centres, speaking to staff and parents/carers
- Designed a questionnaire which we left with Children Centre staff to complete with parents/carers
- Held two focus groups with Health Visitors and representatives from the Voluntary and Community Sectors to better understand their levels of awareness and ideas for improving take-up
- Interviewed a number of colleagues within Housing, Public Health, the Citizens Advice Bureau, and the Local Authority
- Reviewed best practice case studies nationally to better understand what might work in the city to improve take-up of the scheme, particularly the vitamin element

There are some gaps in our findings; at the time of writing, we had been unsuccessful in engaging with midwives, GPs, and any parents/carers from the BAME community. This is a concern, and should be picked up as a further action following on from this report.

⁸ This research was kindly funded by Torus Foundation

5. POLICY OVERVIEW

a. Welfare Food Scheme (1940 – 2006)

The nutritional health of pregnant women and children is well known, and it is widely accepted that sub-optimal nutrition at these stages of the life cycle has intergenerational effects which perpetuate deprivation. The National Institute for Health and Clinical Excellence (NICE) guidance document, Maternal and Child Nutrition (2006), stated “There is a recognised need to optimise nutritional status before pregnancy, during pregnancy...and in the early years of life. The nutritional status of the pregnant woman influences the physical and mental development of the foetus...[and] ensuring children are well nourished in the early years is very important.” In addition, given that the link between poor nutrition and low socio-economic status is not in question, there is a real need for any system put in place to be efficient and effective to ensure that parents in low-income groups (and their babies) are receiving the nutrition they need at the earliest point possible.

Given the above, we have had some form of the Healthy Start scheme in this country since 1940, when the **Welfare Food Scheme (WFS)** was introduced as a war-time measure to ensure the provision of an adequate diet under rationing conditions for pregnant women and families with **children under 5**. Winston Churchill said of the Scheme: “there is no finer investment for any country than putting milk into babies”. The scheme provided tokens to buy milk, infant formula, and vitamins, to expectant and nursing mothers. Initially universal, over the ensuing decades the criteria for entitlement became further restricted to low-income families receiving certain benefits.

b. Healthy Start (2006+)

On average, over 700,000 milk tokens were issued to families across the UK every month, with roughly one in five children under the age of five depending on them (CAB, 2006). With the introduction of **Healthy Start for children under 4**, four-year-olds were now excluded from the scheme, but the nutritional value of the scheme was broadened to include fruit and vegetables, and a fixed value voucher (as opposed to tokens). The scheme was also designed to be more closely linked to the NHS; the idea being that needing a health professionals’ signature on the application form would encourage women on a low income (who were less likely to register with a midwife or doctor early in their pregnancy) to eat a healthy diet.

The Healthy Start scheme (piloted in Cornwall and Devon from November 2005 and rolled out nationwide from November 2006) replaced tokens with weekly vouchers that could be used to buy fresh fruit and vegetables, as well as milk and formula, from a wide range of participating retail outlets including supermarkets, milkmen, greengrocers, retail pharmacies and community food initiatives. Healthy Start vitamins were also available, free of charge, to those within the scheme. The scheme was initially accessed via a paper application form, which had to be counter-signed by a health professional (designed to emphasise early contact with a health professional) who should also ensure they offer advice and information on healthy eating and breastfeeding.

Families received one voucher per week for each pregnant woman or for each child aged between 12 and 48 months, and two vouchers per week for babies under the age of 12 months. Vouchers were sent directly, by post, to beneficiary families every four weeks. Coupons were

also sent out which could be exchanged for Healthy Start vitamins, every 8 weeks. In 2006, each voucher was worth £2.80 per week, per child under the age of 4. In 2009 this increased to £3.10 and didn't increase again until April 2021 when it changed to £4.25 a week (or £8.50 for those with children under 1).

In relation to eligibility and uptake of Healthy Start, this has been declining over a number of years⁹. It is estimated that there are approximately 500,000 eligible beneficiaries in the UK, which is a 30% reduction since 2011. This decline in eligibility is likely due to a number of factors, one being that the maximum annual income Healthy Start participants can earn has not changed since 2009 – (for those on Universal Credit a different income threshold is in place) – despite there having been increases in the minimum wage and the introduction of the national minimum wage. What this has done, is to push more families out of eligibility for Healthy Start, reflected in the declining number of beneficiaries, despite many families' financial circumstances either not changing or worsening as a result of price increases and rising housing costs. This is perhaps best demonstrated by comparing how (in today's money) this £16,000 maximum income would have been worth more like £23,000 in 2009. In addition, it has been suggested that 8 out of 10 pregnant women under the age of 18 are missing out on the scheme because they do not know about it, and in interviews with low-income women in Scotland, it was suggested that the Healthy Start vouchers were not taken up because of lack of awareness, which was cited as a major factor, particularly when women were pregnant (Crawley and Dodds, 2018).

The reduction in eligibility can also not be accounted for by a reduction in the birth rate, as this has decreased by just 6% in the same period. Therefore, this reduction, against a backdrop of increasing hardship among low-income families has been dubbed 'incongruous' (Crawley and Dodd, 2018).

Further details on evaluations undertaken around WFS and Healthy Start can be found in Appendix B, with many of their findings echoing those within this report including:

- Management and co-ordination of the scheme
- Training of frontline staff
- Low uptake of vitamins
- Many women learning about the scheme AFTER the birth of their child

9 When Healthy Start was first proposed, it was suggested it would reach 800,000 people in low-income families. In 2006, it was reported by Rosie Winterton in a Parliamentary question that, under the Welfare Food Scheme, about 700,000 people were getting milk tokens. While totals for Healthy Start have fallen from 717,066 in 2011 to 499,697 in 2018 (Lucas et al, 2018).

6. BEST PRACTICE EXAMPLES

We undertook desktop research to identify any examples of best practice nationally which could be replicated locally. Below are some of the examples we found, which are specifically aimed at increasing uptake:

Brighton & Hove Food Partnership

Brighton and Hove undertook a city-wide campaign redesigning posters which they delivered to over 1,500 organisations. These localised posters were displayed on buses, in libraries, foodbanks, community centres, GPs, and pharmacies. They also established a social media campaign to sit alongside this, and partners embedded Healthy Start within their own organisations, adding stickers to 'red books' to remind health visitors and midwives to talk about Healthy Start. They also delivered 23 bitesize training sessions marketed as "families and food poverty" but with a focus on Healthy Start. This training was targeted towards VCS organisations as well as frontline professionals. During the course of this work, they found that uptake in one postcode was at 80%, which was much higher than the city average of 65%. What they found was that one children's centre receptionist was proactively promoting the scheme and encouraging everyone who used the centre to apply.

Croydon Food Poverty Alliance

Croydon created local designs of their Healthy Start publicity and promotional materials using a number of key messages such as "Pregnant? Children under four? On welfare benefits? Don't miss out on free healthy start vouchers worth up to £900 per child". They also created a Healthy Start advert for a local magazine which was delivered to all 155,000 homes in the Borough and reviewed their existing Healthy Start information on their webpages. In addition, they set up a mailbox for parents and carers who needed advice and support and used social media to advise families of changes to the scheme. Finally, they provided training to frontline professionals supporting vulnerable families who are at risk of food poverty and went out to speak to GP networks directly to engage them in promoting Healthy Start.

South Gloucestershire Food Poverty Alliance

South Gloucestershire held focus groups to better understand the experiences of families. They found that the main issues were a lack of awareness, and inconsistency of knowledge and understanding on various aspects of the scheme by professionals. Health professionals, particularly Health Visitors and Community midwives, were seen as key to supporting families to apply for Healthy Start so they arranged further focus groups to get a better understanding of their perceived role in the application process and the barriers they feel get in the way.

Southwark Good Poverty Alliance

Southwark also held focus groups with eligible families to understand barriers in applying for Healthy Start, and when using the vouchers. They then held further focus groups with frontline professionals. While, similar to our research, all who took part were very positive about the vouchers, there was still confusion about what they could be used for and where. As such, they planned to deliver further face-to-face training. Southwark also has a Healthy Start Steering Group, and they led the promotion of the vouchers and in developing Healthy Start Champions Training which will focus on increasing the knowledge and confidence of professionals in discussing the vouchers with families. Champions will be recruited from a number of teams

and organisations who work with families across the borough.

Shropshire Food Poverty Alliance

Identified that Healthy Start was not commonly included alongside other benefits when families check their eligibility to benefits. Locally they worked with their CAB to ensure that Healthy Start is included in their systems and raised in benefit check discussions.

Halton Borough Council

Halton has an Early Years Forum which brings together public health, health improvement, children's services, midwifery, health visitors, infant feeding lead and children's centres. They are responsible for co-ordinating plans to promote Healthy Start, and since 2015 there has been universal access to Healthy Start vitamins. A social media marketing plan was run to enhance awareness of the scheme along with pop-ups, leaflets and posters. As a result, uptake increased to 83%, compared to 66% nationally in May 2018, however a decline was noted when Universal Credit was introduced. Halton very much saw their success as being down to better partnership working and supporting families with form filling.

Greenwich, London

Responsibility for Healthy Start sits within the Health Improvement and Determinants of Health division of Public Health, ensuring a close link with other complementary agendas such as childhood obesity and food poverty. The programme to promote Healthy Start is co-ordinated centrally by the Public Health team, with promotion of Healthy Start included in the service specifications for Health Visiting and Midwifery. Healthy Start is also identified as a key performance indicator for all Greenwich Children's Centres. A multi-agency steering group has been established to oversee an annual improvement plan which has helped to co-ordinate activities centrally and improve communications between partners.

7. FINDINGS

A number of key messages emerged from the research, which were consistently reflected across all stakeholders. These can be grouped under the broad headings used below.

a. Views of Parents and Carers

Summary: Parents in receipt of Healthy Start were incredibly positive, with many parents recognising the aims of the scheme and stating that it was a great help to them.

Knowledge/awareness: There was a general understanding of the benefits of the scheme and what it was trying to achieve: “to give kids at least one-a-day”, “access to fresh food”, “make it easier to get healthy food”. However, there was less knowledge of Healthy Start more broadly. For example, one mum did not know that the balance of the card could be checked at an ATM, or that the balance rolled over for any money not spent. Another said she was not aware that Healthy Start could be claimed when pregnant, but given the varying levels of knowledge and awareness amongst the frontline professionals we spoke to, (see below) this is not surprising. One Health Visitor summed up the need for a more consistent, co-ordinated campaign when they said “families are that overwhelmed and we give them a lot of information and at each contact¹⁰ we mention Healthy Start, but it’s like we’ve not had that conversation. Healthy Start needs to be drummed into them so everyone who has contact is promoting it”

Eligibility: Most parents we spoke to found out about and/or started to receive Healthy Start after their baby was born. Only 3 out of the 14 completed questionnaires (or 21%) received Healthy Start when pregnant, and these were all reported within the same Children’s Centre. Several parents we spoke to were not eligible for Healthy Start but were struggling to cope.

Website/Telephone: While not many parents had made use of the Healthy Start website (apart from applying), all found the application process easy. However, many reported issues when contacting Healthy Start – with one mum saying, “it took 4 hours to try and get hold of someone so I private messaged them on Facebook and after a week someone got back to me”. This reflects a much wider issue nationally with many parents/carers frustrated at their inability to contact Healthy Start through any of the channels provided.

Benefits: All families stated that the money from Healthy Start made a difference to them as “helps when need milk” and enables parents to “give proper food instead of pizzas”, and “gives them (children) more fruit and veg”. In addition, the move to digital was a good one, as “it was less intrusive at the checkout” and “I had trouble with the paper voucher as one shop would charge me to use them”.

Challenges: The move to a digital scheme has meant parents need to keep checking the card to find out what balance is left. The internet was also referenced as a barrier to registering. This was further reinforced by frontline professionals who stated, “a lot of families find it difficult to access the internet or don’t have the resources or funds, or internet access, and these are the families who would have brought the paper form with them to the Well Baby Clinics” (Health Visitor)

¹⁰ Health Visitors have five universal contacts at 28 weeks pregnant, birth visit between day 10 and 14, follow-up visit between 6 and 8 weeks, then development reviews at 1 and 2 years old

Black and Minority Ethnic (BAME): one parent who was Asian, and eligible for Healthy Start did not apply because they didn't understand the process, and they referenced 'language barriers' as being the main reason. There is an opportunity to undertake more targeted engagement with BAME communities and organisations to ensure knowledge, understanding and promotional materials (in other languages) are available. The training of the wider frontline should also assist with this.

Ideas: one parent suggested it would be useful to develop an app for smartphones which could be used to check Healthy Start balances, message Healthy Start about any issues, and receive reminders about collecting vitamins.

b. Views of Frontline Professionals

Summary: Professionals expressed a real passion and commitment for the scheme and what it can deliver, but issues around levels of knowledge, awareness of changes to the scheme, and capacity to deliver an effective promotional campaign are hampering efforts to increase take-up.

Knowledge/awareness: All professionals were incredibly passionate about Healthy Start but it was apparent that levels of knowledge about the scheme varied greatly e.g. some did not know about the move to digital or that pregnant women could apply. Without exception, all staff said they would welcome training as they felt like they were finding out about Healthy Start in "fragments", and often from the parents themselves. "A lot of people don't know about Healthy Start and Children's Centres are not doing as much as they could" (Children's Centre staff). In addition, there was limited awareness (if any) of the resources available on the website to promote Healthy Start or that that these could be tailored to their local organisations. This further supports our thinking that the issue around take-up in Liverpool is not parents/carers not wanting to access the scheme, but rather that they either don't know about it (or it takes too long to apply) and/or they don't understand what it is for. One Children's Centre stated that some families received Healthy Start but didn't use it as they thought "it was only for vitamins" and that "people need to know more about it because they're never going to use it when we have a lot of families saying my kids don't eat fruit and veg".

Eligibility/applying: All frontline professionals referenced many parents/carers who they knew were eligible being turned down. For example, there were many parents/carers who had children eligible for Free School Meals (FSM) but were subsequently turned down for any younger children through Healthy Start. The move to digital had also caused some issues with many Children's Centres referring to families who had been on the paper vouchers trying to move to digital but being told they were no longer eligible. Staff reported that they would like help with 'how to challenge' the system when families who they know are eligible are turned down. For example, one Children's Centre worker gave an example of a mum who worked as a dinner lady for 10 hours a week who was turned down. While the move to a digital system has brought many benefits (reducing stigma associated with the use of vouchers etc.) it has also had some unintended consequences, and digital exclusion was mentioned as a consistent barrier. The move from a paper to digital application meant that many families were struggling to apply, with one Children's Centre worker referencing that "a lot of our family's access to technology is in Cash Converters". In addition, a lack of ICT knowledge, or families not having a smart phone (or sufficient mobile data) were referenced as barriers to take-up. One Health Visitor stated that "a lot of families struggled when it went online", and this is a particular issue for families who were more transient. All staff also said that the move to digital meant

it was now harder to support parents with their applications as they can't sit with them to complete it, and that not all parents had smartphones to apply. "You've got a new-born baby and a toddler running around then have got other pressures (over and above Healthy Start) so families almost want us to do it for them". In addition, the move to digital also brings barriers for those living more chaotic lives, those with low levels of literacy/ICT skills and/or for whom English is not their first language. Issues with the wider benefits system were also regularly raised, with one example given of a mum who had her benefits stopped and could then not apply for Healthy Start and so her "7-week-old baby was also penalised". There was also a concern that those who were entitled to Healthy Start being entitled to a number of other benefits/schemes and that those who did not qualify (but were just outside this threshold) who staff were more concerned about. One Children's Centre worker stated that "any discretionary items we now receive – petrol vouchers etc. – we give to other (non-Healthy Start) families" One worker suggested that Alexandra Rose vouchers¹¹ "should not go to the ones who are getting Healthy Start but to those who don't qualify".

Website/Telephone: Issues with the website and telephone number were repeatedly raised, with many stories shared of parents/carers not being able to get through to discuss their claim. All agreed that the telephone number should be Freephone as some parents can't use this facility if they are struggling with credit for their phones. The difficulty in staff being able to support parents with their application now it is digital, coupled with the significant issues that parents/carers have mentioned with accessing someone at Healthy Start to speak to, means that potentially some parents have 'fallen out' out of Healthy Start, or given up as it was too hard. This was reinforced by a Health Visitor who stated, "I do think a lot of people know about Healthy Start but from my experience a lot of families have said 'well I do try to ring them, and I've just given up' and then they want you to do it for them".

Vouchers: There were some concerns raised over what the money/vouchers were being spent on, with one worker stating, "the shops around here will let them spend it on anything". Some staff also raised concerns over the ability to be able to 'roll-over' money received on the card, and how this could then be used for other things. They compared this to the Alexandra Rose vouchers which can only be used for fruit and vegetables in allocated shops, not major supermarkets. Alexandra Rose also tracks the spend of who is using the vouchers and for what. However, another said "our job is not to police the scheme but to make sure that those who are eligible receive it". Issues remain around access to shops, with one area (Anfield) stating that there were only two large supermarkets (neither of which was a budget shop like Aldi or Lidl) and many families needed to access transport to get to and from these shops. Otherwise, the only other option was to use smaller, high priced local shops and one Children's Centre worker stated that "one dad did his weekly shop in the corner shop" as this was the most convenient (but also higher priced) option.

Covid: Children Centre staff and Health Visitors both referenced the impact of covid, particularly in relation to how Health Practitioners were engaged with Children Centres and the delivery of services. Pre-covid, Children's Centres would have Well Baby, Booking-in, and Post-Natal clinics with midwives, and Health Visitors would "be in every week doing a clinic

¹¹ The Rose Vouchers – distributed through Children's Centres in London, Glasgow, Liverpool, and Burnley – is a Fruit & Veg Project that helps families on low incomes to buy fresh fruit and vegetables and supports them to give their children the healthiest possible start. To be eligible for Rose Vouchers families should meet the criteria for the Healthy Start voucher scheme for pregnant women and families in receipt of benefits

alongside (our) stay and play, doing development checks, weaning sessions and immunisation clinics', all of which gave opportunities to promote the messages of Healthy Start from all angles. However, because of Covid, Health Visitors moved to virtual assessments and joint sessions in Children's Centres ceased, but discussions are now ongoing around how these can be re-introduced, and Children's Centre and Health Visitors all said they would welcome their return. Children's Centre staff also referred to the usefulness of 'alerts' they received of the births and pregnancies in their area as this gave them a list of people to contact. This meant they could undertake assertive outreach with parents/carers not on their books and promote Healthy Start to those who were eligible at the earliest stage possible. The feedback suggested that these alerts were now coming monthly but could still be 'sporadic' as the impact of Covid continues to cast a shadow.

Black and minority ethnic (BAME): while some Children's Centres reported having refugee and asylum seekers attending their centres, none knew about the changes to the scheme in terms of eligibility¹². Barriers to applying for those whose first language is not English was referenced many times, and with the move to digital, Children's Centre staff expected these groups to be further disadvantaged as parents were also less likely to be computer literate.

c. Local Management and Co-ordination

Summary: Best practice examples suggest that Healthy Start is most effective when it is 'owned' by a person acting as a Lead and supported by a multi-agency Steering Group of senior frontline professionals. Currently within Liverpool, Healthy Start is "no-one's job"; there is no coherent, co-ordinated strategy for Healthy Start. This has led, unintentionally, to an element of 'pot-luck' for beneficiaries with their awareness of the scheme being dependant on who they came into contact with (both during and after their pregnancy).

Previous research (Lucas et al, 2013) conducted in 13 Primary Care Trusts in England found that most Primary Care Trusts (PCTs) had someone acting as a Healthy Start Lead responsible for overseeing a group of professionals from Public Health, midwifery, health visiting and local authorities etc. The involvement of senior staff in this working group was seen as vital to ensure that any changes in practice could be effectively implemented. Within Liverpool, our research found quite early on that the absence of any such role was hampering efforts to increase uptake, as quite literally the work was 'falling between two stools' as no-one 'owned-it'. The creation of a Healthy Start Lead is our number one recommendation; it is a clear gap but with its introduction would quickly support a much more coherent and co-ordinated response to implementation and promotion of the scheme and vitamins.

While there was a great deal of passion for the scheme amongst professionals, many of whom would like to do more (if only they knew more), this lack of consistency in information, knowledge and awareness inevitably meant that many eligible families were missing out on its benefits.

12 Some families may be eligible if they have at least 1 British child under 4 years old, the family earns £408 or less per month after tax, they cannot claim (e.g. benefits) either because of your immigration status or because you do not have an immigration status

Key findings:

- All frontline professionals we spoke to agreed that things would be easier if someone (council/public health) co-ordinated Healthy Start for the city and if a multi-agency group was created to oversee this work
- The importance of Children’s Centres receiving the Birth and Pregnancy List for their area so that staff can proactively engage with parents/carers and undertake a pregnancy visit and information on the Children’s Centre
- Covid has impacted upon work to promote the scheme, not least as several jointly run sessions in Children’s Centres with Health Visitors had been scaled back or stopped entirely
- The need to engage more effectively with midwives and GPs – both groups were contacted but did not respond to requests to participate in the research. Relationships need to be developed within these important sectors, if any significant improvements are to be made to how Healthy Start is implemented in Liverpool
- The need to ensure that staff are focusing on signing up families to Healthy Start, particularly those who are more likely to be missing out given their circumstances (transient, chaotic lifestyles, substance misuse, domestic abuse etc.)
- Making Healthy Start part of the council’s early help training /social care assessments – so that staff are aware of the scheme and promoting it during these important assessments with families who are struggling to cope
- Reviewing support for those families not eligible for Healthy Start, as many staff were very concerned about these families being more food insecure than those who are eligible, with one stating that the “threshold is very low and lots don’t meet this but are also struggling” (Children’s Centre Worker)

d. Training and Workforce Development

Summary: The knock-on effect of Healthy Start not being ‘owned’, is directly affecting the knowledge and awareness of the scheme amongst the wider workforce. Many frontline professionals, for example, only found out about the transition to the digital scheme from the families themselves. Also, most were not aware about more recent changes affecting some families with no recourse to public funds. All frontline professionals stated that they would welcome additional training, to ensure that they can be more proactive and confident in offering the scheme to potential beneficiaries.

Given that the effective implementation of Healthy Start in any locality is dependent upon the knowledge and awareness of frontline staff – mainly midwives, health visitors, nursery nurses and Children’s Centre staff – and that our evidence has pointed to significantly varying levels of awareness, the importance of developing a comprehensive workforce development programme cannot be underestimated. It became very clear, very early on, that there was confusion around the Healthy Start process which can be summarised as follows:

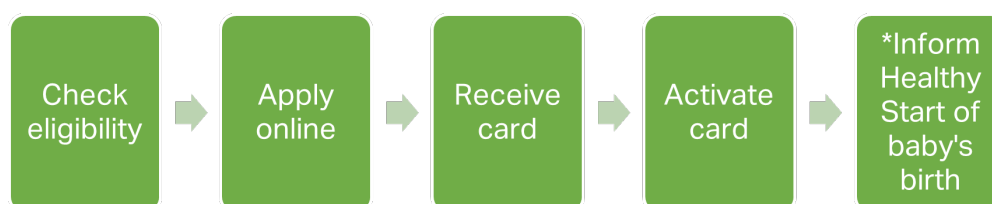


Diagram 1: Application process (*is for those women who start using Healthy Start from pregnancy. All other Healthy Start applicants, those who have already had their baby, will just need to follow the process up to the Activate Card point).

Understanding of this was inconsistent across the city, and dependent on stakeholders' own research, and/or eligible parents/carers informing them of any changes. In addition, knowledge and awareness of Healthy Start in the voluntary and community sectors, as well as housing associations (we spoke to staff in Cobalt Housing and Torus Foundation) was also limited. Therefore, families struggling to cope, who are reaching out to such organisations are not being directed towards this additional source of support.

Key findings:

- Not all staff within Children's Centres were aware that the Scheme could be accessed by women from 10 weeks into their pregnancy.
- A focus group with the Health and Wellbeing Network (a group of voluntary and community sector organisations) revealed a worrying lack of knowledge and awareness of the Healthy Start.
- Many staff across all sectors were not aware that the scheme had moved to digital which is a significant concern and highlights the need for resources to be made available for a management/co-ordination role.
- As with the move to digital, many staff not aware that those without recourse to public funds could now apply if certain criteria were met.
- Knowledge and awareness across the city was inconsistent and 'patchy' which led to a degree of 'pot luck' for parents/carers as to who they spoke to and when they found out about Healthy Start.
- There was a worryingly low level of awareness of Healthy Start within the voluntary and community sectors – which again points to the need for more co-ordinated and targeted training.
- All staff without exception reported that they had received no formal training on the Healthy Start scheme and would very much welcome any additional support / training. One Children's centre worker even stated that "this (the conversation with the researcher) is the best Healthy Start training we have had".
- Support to understand and access the scheme is needed for parents/carers who have low levels of literacy and/or are not computer literate.
- Training for staff to effectively support any parents/carers who are not (computer) literate to assist them in applying – this will require Children Centre's staff being able to access IT and Health Visitors referring parents to resources where computers are available e.g., libraries.
- Lack of clarity on the eligibility for non-UK nationals, as well as wider issues around the benefits system more generally, with many staff unsure about recent changes, need to be addressed in any training programme.

e. Vitamin uptake

Summary: This was the least well known and least promoted element of Healthy Start, a fact that is reflected in the very low take-up of the vitamins across the city.

“Parents are more interested in cash than vitamins, and some think the vitamins come off their balance” Children’s Centre Worker.

The importance of the vitamins element of the Healthy Start Scheme cannot be underestimated. The Healthy Start website states that Healthy Start vitamins are important because:

- 8% of children under 5 in the UK do not have enough vitamin A in their diet
- families in lower-income groups tend to have less vitamin C in their diet
- all pregnant and breastfeeding women and young children are at risk of vitamin D deficiency (teenagers, younger women and those from ethnic minorities are particularly at risk)

Pregnant women, women with a child under 12 months and children aged up to 4 years who are receiving Healthy Start vouchers are entitled to free Healthy Start vitamins. These contain vitamins A, C and D for children aged from birth to 4 years, and folic acid and vitamins C and D for pregnant and breastfeeding women.

We found this to be the least well used and least understood part of the scheme. Even in those areas where provision of vitamins was universal (as had been the case in Liverpool between April 2014 to March 2016), take-up was still very low, and often below 10%. The biggest barrier identified was a lack of access, particularly for those families who were not accessing children centres.

The vast majority of parents/carers spoken to during visits to the children centres stated that they did not use this element. The move to digital has not helped with what was already a low base, as the new process means that beneficiaries must show their Healthy Start card as evidence of their entitlement to vitamin drops, which they can receive every 8 weeks. However, there is now no ‘reminder’ of this as with the paper scheme and parents we spoke to stated that they “forget they are available now I’m on the card”. It was suggested that this was because “the paper vouchers made it clear when you could pick them up as the monthly voucher would say void until the week you could use it. Now there is nothing to remind you”. Only two out of 14 completed questionnaires (or 14%) said they were making use of the Healthy Start vitamins and when asked why, one parent said, “Can’t be bothered with them, I eat healthy anyway”, while another said, “don’t know about them” and another mentioned “uncertainty around where to get them” and “thought just for babies”.

These comments very much tie in with our findings around vitamins and a lack of knowledge and miscommunication amongst frontline professionals. “I think there has been a real miscommunication about vitamins over the years. It used to be a case of all babies having Healthy Start vitamins regardless...these mixed communications probably does translate into uptake. It was much easier when we have them out ourselves as it meant we (Health Visitors) didn’t forget to talk about it”. Both Children’s Centre staff and Health Visitors referenced how the vitamins element of the scheme used to be much more successful. One Children’s Centre

worker said that “it used to be brilliant” when vitamins were universal and ‘we were inundated’. This was further backed up by a Health Visitor stating that “take-up was really good then”. However, since the move to digital “people don’t know they’re entitled to it” with one Children’s Centre stating that ‘we have only given out 3 vitamins since the card came out” with another saying “People don’t pick them up because they don’t know about them and/or don’t know why they’re important or think they’ve got a healthy diet already. They are not promoted enough – no-one knows until someone tells you!”.

A further barrier, given that Children’s Centres are the main source for distribution, is that not all families live close to a Children’s Centre, so there could be a cost implication if they need to get a bus to pick them up – “we need to make it easier for people” (Health Visitor). There was also a further suggestion that not all families “access children’s centres as they’ve either got a stigma attached to them that they’re only for people who have social worker involvement, and because a lot of the groups did go where they were really targeted and so not all families access Children’s Centres and that will be one of the barriers for accessing vitamins as well”.

Key findings:

- The need to better promote access points as this is the biggest barrier – as “you don’t know what you don’t know”, and if people don’t know where/how to access vitamins then they will continue to go to waste.
- Issues around promoting vitamins to parents/carers are made harder by the misinformation/myths around Healthy Start and what it can/can’t be used for and the mixed messages around vitamin usage. The recommendation for improved Training around Healthy Start should help to remedy this.

f. Marketing and Communications

Summary: While all Children Centres visited promoted the scheme, we found that they were using out of date information and did not know where to access the new digital card promotional literature. The lack of a strategic communication plan has directly affected awareness and knowledge of the scheme amongst all stakeholders, and opportunities to develop more localised leaflets and posters, which other parts of England have used to great effect, have been missed.

Underpinning all the recommendations we have made in this report is the development of improved marketing and communication of Healthy Start across the city. Promotion at this local level has been incredibly useful in a number of best practice sites, and a more co-ordinated approach to marketing and communication is needed to ensure all sites have the most up-to-date promotion materials and are aware of the ability to download and tailor materials directly from the Healthy Start website.

Key findings:

- All frontline staff (Health Visitors and Children’s Centres) stated that they promoted Healthy Start, and most Children’s Centres had posters and leaflets promoting the scheme. However, the information was out-of-date, and inconsistent. Having a more co-ordinated approach would ensure that there is a mechanism for sharing the most

up-to-date information and to ‘check’ on the promotion/publicity of Healthy Start across the city, in all venues where children and their families are in attendance.

- Healthy Start isn’t a one-off offer; people’s circumstances and benefit entitlements fluctuate over time, in some cases monthly (e.g. when on a zero hours contract). It is important that this message is communicated, and that people are regularly reminded to check eligibility, even if they have previously been refused.
- The use of a Healthy Start tick box to remind Health Professionals in their contacts with families has supported greater awareness of the scheme, and Children’s Centres, who are now actively engaged in wider poverty reduction measures, are also promoting the scheme. However, we need to extend this and continue to encourage staff to have Healthy Start conversations, including within Housing Associations and the CAB who often advise families around benefits.
- The Healthy Start national resources (website, telephone number and promotional material) were not widely used/known about and numerous references were made to difficulties in contacting Healthy Start via email, telephone, or social media channels. This is just one of many recent posts taken from the Healthy Start Facebook page: “I’ve been waiting months for my claim to be sorted, it’s an absolute joke. I’ve also just had a new baby and can’t get through on the phone and no reply to emails. I’m owed money from last December and I’m getting nowhere with this. Utterly fed up bring back the paper vouchers!!!” (Posted June, 2022).
- While there are clearly some women who are signing up to Healthy Start when pregnant, despite many Children’s Centre staff not being aware that they could benefit at this point, they can then fall off the radar as they (and frontline professionals) don’t know that parent needs to inform Healthy Start of the baby’s birth. Women who are Healthy Start recipients in pregnancy need to inform either DWP/HMRC or Healthy Start when their baby is born¹³ so that they can continue to receive Healthy Start. However, many women (and frontline professionals) are not aware of this, so this needs to be communicated much more effectively as otherwise it can cause significant issues and delays in receiving Healthy Start, at a time when many families are going through major upheavals. Communicating this key message, along with ensuring that any training developed supports staff with a much greater understanding of the process, underpins most of our recommendations.
- Prior to the digital transition, the receptionist in one of the Children’s Centres we visited was very active in promoting the scheme, using social media channels, and helping people to complete the (paper) form. We need to establish and communicate what the ‘expectation’ is for each Health Professional, and the Children’s Workforce, around their role in Healthy Start – how they promote it, and what they should be doing as a minimum etc.

13 Parents should speak to HMRC or DWP to ensure their child is included on their benefit claim so that your payment can be issued. For those on Universal Credit, they will need to phone Healthy Start to tell them the baby’s name and date of birth. Without this, payments may stop after 8 weeks and parents will need to reapply.

- “It’s not called labour for nothing, and we need to better prepare women for the reality, which is very different” (Children’s Centre worker). Several professionals referenced the fact that childbirth, and the early years, are a time of upheaval for many families, and the opportunity to promote Healthy Start can sometimes get lost in the reality of childbirth and looking after an infant. Therefore, professionals felt that we needed to better ‘time’ our communications and that we might need to explore opportunities to rationalise the information new parents/parents receive as they are often bombarded with information at a time when they have no ‘head space’ for this. As a result, key Healthy Start messages can often get lost, or are not seen as the most important issue to promote. Bringing GPs into the Healthy Start conversation will help with this, as many women visit the GP in the early stages of their pregnancy, when Healthy Start messages may have a better opportunity to be taken on board.
- There are also missed opportunities to promote the scheme wider, as we do not currently engage with the PVI sector (which further links in with the wider management and co-ordination recommendation). “They (the PVI sector) should be handing out information as they have the 2 and 3 year old offer” (Children’s Centre Worker).
- There was also no clear evidence of any direct promotional work targeted towards Black and Minority Ethnic (BAME) Groups.

8. RECOMMENDATIONS

a. National

1. **Review and consider extending the eligibility threshold for Healthy Start:** to enable more families to benefit from the scheme.
2. **Invest in a national Healthy Start communications campaign:** to increase awareness and uptake.
3. **Resume monthly publishing of national uptake data:** There has been no published data on the uptake of Healthy Start since the scheme moved to a digital one in March 2022. Without this data it is impossible for any local authority area in the country to be able to understand the impact of this transition.
4. **Collect and publish data that can be integrated at a local level:** Including data on those who do not take up the scheme. This will enable local authorities to develop targeted interventions.
5. **Review the requirement to confirm a baby's birth:** Families need to inform Healthy Start after a baby is born to continue receiving the benefit. This element of the process is not well understood by families or professionals and may result in some families missing out.
6. **Improve support processes for families contacting Healthy Start:** Getting through to the national telephone number is particularly problematic; more needs to be done to assist families to access support so their claim can be processed as quickly as possible.
7. **Make the vitamins element of the scheme universal:** to support the health of all women during pregnancy and children up to their 4th birthday.
8. **Identify a system to remind families to collect vitamins:** Vitamin uptake is already very low nationally, yet the move to the digital card has delivered an unintended consequence in that there is now no 'reminder' of when parents need to collect their vitamins, as had been the case with the paper voucher.
9. **Develop a Healthy Start App:** To address support issues, enable families to check their card balance and deliver reminders of when vitamins need to be collected.
10. **Review and streamline the application system for eligible families with No Recourse to Public Funds.**

b. Local

Local Management and Co-ordination

1. **Identify a Healthy Start Lead:** To manage and co-ordinate Liverpool's approach to Healthy Start – this person should also be responsible for the implementation of the local recommendations within this report.
2. **Establish a cross-sector Healthy Start working group.**
3. **Identify a single point of contact for complex cases:** someone, for example, from Public Health or Citizens Advice Liverpool who can support frontline staff with complicated applications (e.g. people with No Recourse to Public funds, or on legacy benefits).
4. **Engage GPs in the promotion of the scheme:** The research suggested that for many pregnant women, the first person they engage with about their pregnancy is the GP and

that this is an optimum time in their pregnancy to promote the vitamins and digital card.

5. **Identify a lead midwife to join the Healthy Start working group**
6. **Target promotion of Healthy Start to children/families requiring Early Help Assessments and Social Care Assessments.**
7. **Explore maximizing community-based support for baby wellbeing: Plus joint working opportunities between Health Visitors and Children's Centers to provide a two-pronged approach to the promotion and support for families.**

Training and Workforce Development

1. **Deliver Healthy Start training:** To the children's workforce, frontline health professionals and the voluntary and community sector.
2. **Produce a 'Liverpool-ised' set of Frequently Asked Questions:** To support staff.
3. **Engage with the Private Voluntary and Independent (PVI) childcare sector:** Many two-year-olds accessing funded early education, are doing so in PVI settings, where there has been limited engagement and promotion of Healthy Start.
4. **Identify Healthy Start Champions from a variety of sectors:** To support the Healthy Start Lead and working group to deliver training, promote best practice and identify opportunities, as a group, to improve up-take.

Vitamin uptake

1. **Children Centre staff monitor vitamin uptake:** To enable the Healthy Start working group to better understand where vitamins are being accessed and where localised strategies are needed.
2. **Deliver training on vitamins to frontline professionals:** Including details on what is offered, why, benefits, recommended intake, where to collect etc.
3. **Review opportunities for Health Visitors to provide vitamins.**
4. **Explore opportunities for a return to Universal Vitamin distribution to increase uptake.**

Marketing and Communication

1. **Develop a Liverpool Healthy Start marketing and communications plan:** To promote the scheme and distribute up-to-date information and promotional materials. This should be led by the Healthy Start Lead and reviewed by the working group. This may include the development of a Healthy Start newsletter, 'key messages' documents for frontline staff, and targeted leaflets for midwives and Health Visitors to use during routine visits.
2. **Embed Healthy Start into wider 'contacts' and discussions led by a variety of sectors:** for example, Healthy Start could be made reference to by Housing Associations and advice networks when undertaking benefits checks, and by Children's Centres and Social Workers in all Early Help/Statutory assessments.
3. **Ensure Healthy Start is promoted across a range of websites/directories:** for example, the Early Help Directory, LiveWell Directory, Liverpool City Council and Come2Gether websites and professional materials, and on the websites of Housing Associations and VCS organisations.

9. NEXT STEPS

While there is a lot to commend about the Healthy Start Scheme in Liverpool, not least the dedication and hard work of staff across the public sector working to support families who need help, there is much more that can be done.

During 2022 Feeding Liverpool have taken the following actions to increase awareness about Healthy Start:

- Trained 80 new Healthy Start Community Champions: volunteers and staff members from foodbanks, community food spaces and housing associations
- Provided promotional materials to community food spaces in Liverpool
- Supported community food spaces to be able to accept payments via the Healthy Start cards
- Distributed 10,000 leaflets advertising Healthy Start to families via the Holidays and Activities Food programme
- Publicised Healthy Start through local media channels
- Joined a national campaign, led by Sustain, highlighting the challenges experienced during the transition to the digital scheme
- Supported calls made by national charities such as Sustain and Feeding Britain for the widening of eligibility to the Healthy Start Scheme

It should be our aim that every person who is eligible for Healthy Start in Liverpool knows about the scheme, and is, where necessary, supported to apply.

This report and the accompanying recommendations have set out the steps needed to achieve this goal. Once a Healthy Start Lead is identified and established, supported by a multi-agency steering group, some quick wins can be achieved, and momentum built around promoting the scheme and ensuring a much higher uptake in the city.¹⁴

¹⁴ This report was authored by Rachel Flood and Dr Naomi Maynard, for further information please email naomi@feedingliverpool.org

10. APPENDICES

Appendix A – eligibility criteria

Healthy Start is available to all women under the age of 18 (regardless of their income), and women who are 10+ weeks pregnant, or families with a child(ren) up under the age of 4 who qualify for one of the following benefits:

- Income Support
- Income-based Jobseeker’s Allowance
- Income-related Employment and Support Allowance (ESA)
- Child Tax Credit with a family income is £16,190 or less*
- Working Tax Credit run-on (paid for 4 weeks if your working hours, or your partner or carer’s, go to less than 16 hours per week)
- Pension Credit (which includes the child addition)
- Universal credit with a total family ‘take-home pay for this period; of no more than £408

* Please note only eligible families claiming Universal Credit or Child Tax Credit can apply online. All other applications need to be made by email (healthy.start@nhsbsa.nhs.uk) or phone (0300 330 7010 Monday to Friday 8am to 6pm)

If you’re not a British citizen but your child is, you can also ask for an application form to be sent to you via email (Healthystartclaim@dhsc.gov.uk) if all of the following are true:

- you have at least 1 British child under 4 years old
- your family earns £408 or less per month after tax
- you cannot claim “public funds” (e.g., benefits) – either because of your immigration status or because you do not have an immigration status

Appendix B Previous Evaluations of Healthy Start Welfare Food Scheme

In 1999 the Government reviewed the Welfare Food Scheme (WFS) – the first and only major review in its then 60-year history¹⁵. With evidence suggesting that the WFS provided little incentive to breastfeed, and that providing a choice of food items other than milk would improve the scheme at no extra cost, a proposal was made in 2002 to introduce a new Healthy Start scheme. At the time of the review there were approximately 55,000 eligible pregnant women, and 808,000 young children (or 23% of the estimated population aged 0-4) receiving WFS.

While the review led to some changes (and improvements), including that pregnant women under 18 could receive support, it also highlighted several themes which remain for today's Healthy Start, themes that were further reflected in our research, including:

- The uptake of vitamin supplements was very low among all beneficiary groups, in contrast to milk uptake which was very high.
- Children from households eligible for WFS vitamin supplements were even less likely to take them than children from non-eligible households.
- Most mothers preferred to use their tokens for infant formula reflecting the low prevalence of breastfeeding.
- Recognition that many refugee children, potentially a nutritionally vulnerable group, were only entitled to welfare foods if their family was eligible for Income Support.
- Pregnant women not aware of their entitlement.
- Those for whom English is not their first language were particularly at risk because they did not have access to appropriate information and publicity.
- No materials directed at the PVI sector meaning that families were missing out on valuable information.
- Mixed messages around vitamins and what is needed during pregnancy and/or if breastfeeding (Department of Health,2002).

In 2003 the responsibility for the administration of milk tokens passed from the local benefits agency to HMRC, in the form of Child Tax Credits (CTC). Those in receipt of a particular rate of CTC, who met the means test, automatically received milk tokens, without the need for a separate application form. Prior to this, those who were entitled to milk tokens claimed them by attending their local benefits agency office and providing proof of their eligibility. While the move to CTC removed the need to apply, it did bring an array of issues which the CAB, in their report “Welfare Foods and Healthy Start” (2006), highlighted, with many, like those above, still prevalent in today's Healthy Start system:

- Clients reported delays in receiving milk tokens of between 4 weeks and 16 months
- HMRC only passed claimant data to the Department of Health every four weeks meaning that claimants whose awards were processed just after the transfer of information found themselves having to wait a further four weeks for their information

15 “Scientific Review of the Welfare Food Scheme, Department of Health (2000)

to be passed to the Department of Health.

- Claimants who experienced problems applying for tax credits saw a knock-on effect on being able to access the scheme.
- Many pregnant women were not informed of their entitlement to milk tokens and subsequently either struggled financially or the baby didn't get vital nutrition.

“Welfare Foods and Healthy Start” Citizens Advice Bureau (CAB), 2006

A number of criticisms around the introduction of Healthy Start's monetary voucher were identified by the CAB, including:

- The move from a milk token to a monetary voucher (worth £2.80 when launched, meant that a claimant with a child under 1 was entitled to receive two vouchers, worth £5.60). However, this left some parents unable to buy the same items provided under the old token system (where a token was worth 7 pints of milk or 900g of infant formula. Infant formula for example cost £5.98 in major supermarkets in 2006, leaving a shortfall of £0.38 per week.)
- In addition, some parents/carers by the nature of where they live/access to services and amenities found that the costs of buying items varied, both from one area and shop to another, and over time.

Healthy Start Vouchers Study: The view and experiences of parents, professionals, and small retailers in England

In 2013, Lucas et al were commissioned by the Department of Health to gain a real-life view of the operation of the Healthy Start scheme within disadvantaged communities by seeking out the views and experiences of women, professionals, and independent retailers on the Healthy Start vouchers and vitamin use. Key findings (grouped under the headings within our local research) from what has been the only significant piece of research on Healthy Start nationally, found that:

View of parents/carers and frontline professionals

- Most families found accessing the scheme easy
- Most parents reported receiving minimal information from health professionals about how they could use their food vouchers to improve their family's health
- Most families found using the vouchers easy and had good access to places to spend their vouchers
- 90% of all Healthy Start vouchers issued are used by beneficiaries
- Healthy Start phone line reported to work well, but less so for those families with just mobile phones as it was expensive to call
- Eligibility criteria too stringent leaving some families on a 'cliff edge' as many low-income families who might benefit fall outside the Healthy Start scheme

Local Management and Coordination

- Most Primary Care Trusts (PCTs) had someone acting as a Healthy Start Lead and most had established a working group, or tasked an existing group, to oversee the

implementation of Healthy Start

- While take-up of the scheme is estimated to be 80%, little is known about the household characteristics associated with participation in Healthy Start, it is suggested that those not participating are likely to be those families with chaotic lives, including unplanned disruptions in housing and those experiencing domestic abuse and/or abusing drugs/alcohol as they are less likely to prioritise applying; those who speak English as a second language; and those whose income fluctuates
- GPs are rarely involved at any level with the Healthy Start scheme, despite their contact with eligible families, and often being the first port of call for many expectant mothers
- Some parents (particularly those under 18) did not understand the process for notifying Healthy Start after their baby's birth and so dropped out of the scheme at this point
- Training and Workforce Development
- While professionals had a good knowledge of the scheme, most frontline staff stated that they would benefit from training or regular updates on Healthy Start
- Most professionals not making use of the resources available on the Healthy Start website

Vitamins

- Most PCTs focused their efforts on developing schemes to increase the uptake of free vitamins (e.g., providing them universally to all pregnant women) but despite these efforts, few pregnant women and children were taking Healthy Start vitamins
- Parents reported confusion over vitamins about where to access them (most felt they should be available from supermarkets/pharmacies) and what they were needed for, which they said health professionals were also unsure about
- Marketing and Communications
- A reliance on health professionals to promote the scheme meant eligible pregnant women frequently learnt of the programme after birth
- Pregnant women are less likely to participate in the scheme because of poor awareness

Healthy Start: What happened? What next?

In 2018, Crawley et al reviewed the development of the Healthy Start Scheme and what has happened since it was introduced. Key findings from this report, grouped under our report headings, are further echoed in our own research included:

View of parents/carers and frontline professionals

- The scheme was valued by recipients

Local Management and Co-ordination

- Local areas need to work more effectively with the VCS sector to find out how families who do not have English as a first language can be supported to apply
- Healthy Start should be clearly signposted in any city-wide or local food poverty action plans
- Those co-ordinating Healthy Start should link in with other public health initiatives
- In each local authority area, a Healthy Start Lead/Guardian should be appointed who is a senior member of staff responsible for co-ordinating activities around Healthy Start across organisational boundaries – this role should provide an annual report to the Director of Public Health on uptake of Healthy Start in the local area
- A move to digitisation needs to consider those vulnerable families who may have

limited access to technology, live in areas where internet speeds are lower, or where retailers may not have the technology to receive a card payment

- Co-ordinated work between health, social care, and welfare rights workers is needed to ensure that all eligible families are encouraged to apply
- Beneficiaries need to be consistently supported in how best they can use their vouchers
- Women at their first ante-natal appointment (booking-in) at about 12 weeks are often over-loaded with information and advice and may need specific support to apply for Healthy Start
- The £408 threshold for Universal Credit is from any paid work the recipient may undertake – claims are checked every 4 weeks and if a recipient goes a period of 12 weeks earning over £408, receipt of the Healthy Start vouchers will stop – this is likely to disadvantage seasonal workers

Training and Workforce Development

- Training of professionals is crucial to increase uptake

Vitamins

- Healthy Start vitamins reported as being hard to access in some areas
- Every eight weeks families in the Healthy Start scheme receive Healthy Start vitamin coupons which can be exchanged for vitamins – these are classed as food supplements so there are no restrictions on who can give them out
- In some areas Health Visitors and Midwives carry Healthy Start vitamins with them to ensure families receive them
- Each local authority makes a return to the Department of Health indicating the number of vitamins distributed
- The short shelf life of the children's vitamin drops (approx. 10 months) has caused significant wastage

Marketing and Communications

- Research from the Scottish Government suggested that only 55% of women in their first pregnancy and 67% in subsequent pregnancies were aware of the Healthy Start scheme antenatally (Scottish Government, 2018a)
- Nationally there is a lack of consistent support and promotion among health professionals at a local public health level
- Local areas should promote healthy start in settings that pregnant women and young families visit
- Many women will not know about the scheme before their first pregnancy and are unlikely to be eligible if they are working more than a few hours a week, unless they are under 18 years of age – better communication needed

11. REFERENCES

Citizens Advice Bureau, Welfare Foods and Healthy Start, CAB evidence on the provision of milk tokens (2006)

Clarke, J, Thousands of families miss out on healthy food benefit due to IT failures, The Guardian, 12 June 2022

Crawley H, Dodds R, The UK Healthy Start Scheme: What happened? What next? First Steps Nutrition, 2018

Department of Health, Healthy Start: Retailer Research Summary, 2012

Department of Health, Scientific review of the Welfare Food Scheme, 2002

Food Power (2022), www.foodpower.org.uk

Lucas et al, Healthy Start Vouchers Study: the views and experiences of parents, professionals, and small retailers in England, 2013

Machell et al “Making the most of Healthy Start – a practical guide”, First Steps Nutrition, 2014

Moonan M, Maudsley G, Hanratty B, Whitehead M, An exploration of the statutory Healthy Start vitamin supplementation scheme in North West England, BMC Public Health, 2022

Parnham et.al, Is the healthy start scheme associated with increased food expenditure in low-income families with young children in the United Kingdom, BMC Public Health (2021)

Sustain, Making the most of Healthy Start: a toolkit for local action (March 2022, second edition), University of Bristol School for Policy Studies and the Institute of Education, University of London



@goodfoodlpool



@goodfoodliverpool



@goodfoodliverpool

Visit feedingliverpool.org/goodfoodplan

