NHS GREATER GLASGOW AND CLYDE FINANCIAL INCLUSION EVALUATION PROJECT

LITERATURE REVIEW

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CONTENTS

SECTION 1: INTRODUCTION

Approach

This literature review was designed to inform the development of the *Healthier, Wealthier Children*[1] evaluation process, and to provide a contextual and theoretical base for the evaluation plan and final report. It is envisaged that this review will be used as a tool to inform each aspect of the evaluation process, rather than as a 'stand-alone' piece of work.

Due to the time-limited nature of the project and constraints of reporting, a systematic review of the literature was not undertaken. Instead, a more pragmatic and iterative approach was adopted, although one always cognisant of the project aims and objectives.

Using the aims and objectives outlined in the project specification[2] as a starting point, themes were identified and then explored further in an effort to inform the evaluation design and provide a theoretical framework that would shape the research questions and evaluation plan. The following three broad themes were identified:

1. The policy and political context in which the project operates;

2. The impact and extent of poverty on children and women at a national and local level;

3. The emerging evidence on the potential benefits of income maximisation and welfare benefits advice services delivered in a healthcare or partnership setting. Other salient themes, such as successful partnership working, service delivery and strategic development, were also identified as the review evolved.

The review process included searches of academic databases, government and academic websites, and advanced web-based searches[3]. In addition, two comprehensive literature reviews, one by Wiggan and Talbot (2006) and another by Dobbie and Gillespie (2010), proved particularly useful in identifying academic and grey literature on similar types of interventions and evaluations. Documents used in the review include peer-reviewed journal papers, book chapters, research reports, policy documents and statistical reports.

Background

The UK has one of the highest levels of child poverty in Europe. A recent UNICEF report, highlighting child inequality in over twenty developed countries, ranked the UK in the bottom two-fifths, alongside such countries as Hungary, Slovakia and the Czech Republic (United Nations Children's Fund, 2010). The picture in Scotland is

[1] *Healthier, Wealthier Children* is a 15-month financial inclusion project funded by the Scottish Government that aims to help pregnant women and families with young children living in low-income households access local money advice and income maximisation services. The project is being delivered by NHS Greater Glasgow and Clyde in collaboration with local authority and voluntary sector partners.

[2] See Appendix 1.

[3] Academic databases included ASSIA, CINAHL and IBSS. Websites included the Scottish Government, Scottish Parliament, Department for Work and Pensions, Europa (European Commission), Institute for Fiscal Studies, Joseph Rowntree Foundation and the UK Poverty Site.

equally bleak. Recent findings from the *Growing Up in Scotland* study found that more than one in five children in Scotland were living in persistent poverty (Barnes et al., 2010).

In 1999, the UK Labour Government pledged to eradicate child poverty by 2020, and halve it by 2010, allocating a significant amount of public money to the task. Although good progress was made during the period 1999/00 to 2004/05, figures for both the UK and Scotland show that little has changed in the past 6 years, with the consensus now being that the 2020 targets are unlikely to be met (Bradshaw, 2011). In the current economic climate, with deep and far-reaching reductions to public spending and significant changes to the welfare benefits system, there is greater pressure on the Scottish Government to tackle child poverty with fewer economic resources (Mooney, 2011).

Poverty, Children and Women

The relationship between child poverty and inequality has been clearly established and well documented. In a review of the literature, Griggs and Walker (2008) highlight the link between poverty and poor outcomes across a range of areas including health, education and social wellbeing. The authors found a large body of evidence that suggests children born into low-income households are more likely to experience developmental problems from birth and accumulate greater health risks later in life. The authors also highlight the bi-directional relationship between poverty and health; that poverty can lead to poor health outcomes, but also that poor health can lead to poverty. In a review of qualitative studies, Ridge (2010) found a wide range of negative outcomes for children living in poverty, including anxiety, unhappiness, insecurity, poor self-esteem and lack of confidence. The author also found that poor housing could have a negative impact on a child's health and their ability to establish and maintain friendships.

Griggs and Walker (2008) also found a strong link between child poverty and poor educational outcomes. The authors argue that this relationship is, at least in part, a result of the developmental and cognitive difficulties that growing up in poverty creates for low-income children. They also highlight other factors, such as limited access to quality pre-school education and poor schooling in disadvantaged areas, which adversely affect a child's development. Ridge (2010) also found evidence that children living in poverty were vulnerable to bullying and isolation at school, often resulting in non-attendance and even exclusion.

There is also a large body of evidence suggesting that women, and especially those with children, are more vulnerable to poverty. Studies have found that more women live in poverty than men, and that women are more likely to work in part time and/or low-paid jobs (Smith and Middleton, 2007). Women are also more likely to have caring responsibilities, which often limit their capacity for paid work; and lone parents – the vast majority of whom are women – are at a greater risk of poverty due to the difficulties in combining employment and family responsibilities (Griggs and Walker, 2008; European Commission, 2010). A recent analysis of intra-household incomes by Lister (2010) reveals a 'hidden poverty' whereby women's individual incomes were lower than men's, especially in low-income households. The author also found that low-income women are more likely than men to go without in order to provide for their families, as well as doing most of the management of poverty and debt, a factor that is likely to impact adversely on their mental health and wellbeing. There is also substantial evidence that families with disabled children, refugees, most ethnic minorities and women with drug problems are at even greater risk of poverty (see

Smith and Middleton, 2007; Lindsay et al., 2010; Netto et al., 2011; Shaw et al., 2007).

Reading et al. (2002) also remind us that pregnancy and the period after birth can result in significant changes to financial circumstances, including loss of earnings, increased costs of a larger family, and the possible need for a larger house. The responsibility of looking after a young child often makes adapting and responding to a change in financial circumstances more difficult. Of course, the impact of these changes in household circumstances is likely to be even greater for those women living in or at-risk of poverty.

In short, the large body of evidence found in the literature highlights the far-reaching and multi-faceted consequences of child poverty. As Griggs and Walker observe:

> *"Low income, material deprivation, poor housing, disadvantaged neighbourhoods and schools, parental stress and social exclusion, all recognised attributes of poverty, seem individually and possibly cumulatively, to negatively shape the lives of children with short and long-term consequences" (2008: 24).*

SECTION 2: POLICY CONTEXT

UK Welfare Reforms

Before looking at the current policy context in more detail, it is worth highlighting that this project is being piloted against the backdrop of significant reductions in public spending and substantial reform to the UK welfare benefits system.

In June 2010, the new coalition UK Government announced its intention to cut welfare benefits by £11billion by 2014/15. A few months later the Government announced a further £7billion cuts to welfare benefits in the Comprehensive Spending Review, bringing the total 'savings' to £18billion per annum by 2014/15 (Taylor-Gooby and Stoker, 2011). In tandem with the reform of the welfare benefits system, the Coalition Government has proposed nearly £36billion cuts in public spending; a figure that will, by 2014/15, see spending on public services in the UK fall below the United States for the first time ever (Taylor-Gooby and Stoker, 2011).

Although a full discussion of the anticipated impact of these cuts is beyond the scope of this review, emerging evidence suggests that the proposed changes to key benefits are likely to have a significant impact on low-income households, particularly women and children (Bradshaw, 2011). Early analysis suggests that as women and children are the main recipients of benefits such as child benefit, child tax credit and housing benefit, they will actually bear 72% of the cuts (Taylor-Gooby and Stoker, 2011). Another report highlights that women will be affected more by the public service cuts, as they are generally higher users of these services than men (Women's Budget Group, 2010). The authors of the report also point out that job losses in the public sector are more likely to affect women as they form the majority of public service employees.

Recent geographical analysis on the likely impact of the welfare reforms suggests that poorer areas are likely to be affected more by these changes than more affluent areas (Franco, 2010). A recent report on the likely impact on the most vulnerable citizens of Glasgow highlights the reach and scale of the reforms, and questions the ability of local public services to respond to the consequences. Changes to child benefit, for example, will affect over 65,000 claimants in the city, which with an estimated annual loss per claimant of £74, will result in an estimated £5million loss to the Glasgow economy (Kerr, 2011). Changes to housing benefit are likely to result in a loss of more than £10million for the city and its most vulnerable citizens, which may increase risk of homelessness and place further pressure on local government services and resources. Welfare advice agencies are also likely to see an increase in demand for income maximisation, welfare advice and representation services once the welfare reforms are implemented (Kerr, 2011).

Although the full impact of the reforms are, at present, unknown, they are likely to increase the need and demand for income maximisation and welfare advice services across many parts of Greater Glasgow and Clyde. The proposed cuts to public services are almost certain to impact on the ability of these services to meet this growing demand and need for income maximisation and welfare advice amongst low-income families.

Scottish Government Priorities

Child poverty is a cross cutting issue which affects a range of public policies. Although a number of key factors directly affecting child poverty are still reserved by the UK Government – in particular welfare and taxation – others, such as health and education, are devolved to the Scottish Government.

The Scottish Government has set out a clear, overarching, 'central purpose' to *"focus the Government and public services on creating a more successful country, with opportunities for all of Scotland to flourish, through increasing sustainable economic growth"* (Scottish Government, 2007a: 1). This central purpose is at the apex of a National Performance Framework and all Scottish Government policy and strategy is positioned within this national framework (see Sinclair and McKendrick, 2009).

To monitor its performance, the Scottish Government has outlined 15 National Outcomes, which describe in detail what the Government aims to achieve over the next 10 years. Poverty and income inequality can be found in the following outcome:

- We have tackled the significant inequalities in Scottish society (Scottish Government, 2007b).

The framework also aligns poverty and income inequality with improving outcomes for children and young people through the following:

- Our children have the best start in life and are ready to succeed;
- We have improved the life chances for children, young people and families at risk (Scottish Government, 2007b).

Progress in relation to these outcomes will be measured through a series of National Indicators:

- Decrease the proportion of individuals living in poverty;
- Increase healthy life expectancy at birth in the most deprived areas;
- Increase the proportion of school leavers in positive and sustained destinations (Scottish Government, 2007b).

In order to deliver these outcomes and reach its targets, the Government has published three key policy frameworks – *Achieving Our Potential*, *Equally Well* and the *Early Years Framework* – that outline its strategy for tackling child poverty and income inequality in Scotland. In accordance with the principles and values of *Getting It Right for Every Child* – a key delivery mechanism for these strategies – each framework highlights an approach that aims to improve outcomes for all children and young people.

Achieving Our Potential

In 2008, the Scottish Government published its anti-poverty strategy *Achieving Our Potential: a Framework to Tackle Poverty and Income Inequality in Scotland.* The document has several overarching objectives:

- Reducing income inequalities;

- Introducing longer term measures to tackle poverty and the drivers of low-income;
- Supporting those experiencing poverty or at risk of falling into poverty;
- Making the tax credit and benefits systems work better for Scotland (Scottish Government, 2008a).

Although the document reminds us that making the welfare benefits system 'work better for Scotland' can only be achieved through political channels, it does acknowledge that the other objectives fall within the policy domain and political powers of the Scottish Government. Moreover, the framework explicitly locates the strategy within a partnership model between the Scottish Government, local authorities and their partners (such as the NHS), calling upon each partner to support the Government's national targets and deliver higher levels of social equality.

In line with the UK Government, the focus of the framework is not a greater redistribution of income, instead it favours employability and maximising household incomes through increasing up-take of benefits, especially for those vulnerable groups at greater risk of poverty.

The policy focus is to provide greater *financial inclusion* and to help people avoid falling into hardship, *"whether as a result of economic downturn, health, family or personal problems"* (Scottish Government, 2008a: 15). In particular, the Scottish Government has highlighted *income maximisation services* as one of the key modes of tackling income inequality and supporting those experiencing poverty[4].

This financial inclusion approach is also visible in the Government's economic strategy, observed in the 'solidarity' target:

- To increase overall income and the proportion of income earned by the three lowest income deciles as a group by 2017 (Scottish Government, 2007a: 17).

The Scottish Government's rationale for targeting the three lowest income deciles is based on the position that focusing on those people currently below the poverty line should not be at the expense of those at risk of poverty.

Although *Achieving Our Potential* is, in many respects, the 'flagship' policy for addressing income inequality, it clearly recognises that poverty is inextricably linked to wider inequalities in society and, therefore, aligns itself closely with the *Equally Well* and *Early Years* strategies in a 'joined-up' approach to reducing poverty and inequality in Scotland.

Equally Well

Equally Well is the report of the Ministerial Task Force on Health Inequalities (Scottish Government, 2008d). It was launched in June 2008 and was followed up in December of the same year with an action plan to support its implementation (Scottish Government, 2008c). The plan identifies a range of factors contributing to health inequalities, and pays considerable attention to the strong correlation between poverty and poor health, citing many examples of the way poverty impacts on health, e.g. higher mortality rates from the 'big killer' diseases (Scottish Government, 2008d). The Task Force recognised that, if health inequalities in the wider population are to

[4] See Section 4 for more information on financial inclusion and income maximisation services.

be reduced, inequalities in the early years must be addressed in both the short and long-term.

Among the many recommendations in the Task Force report, two are particularly relevant to this project:

- The Scottish Government should help people to maximise their income and encourage them to take up means-tested benefits by extending this activity through intermediary organisations such as healthcare services;

- Universal public services should build on examples of effective financial inclusion activity, to engage people at risk of poverty with the financial advice and services they need (Scottish Government, 2008d).

Complementing and overlapping each other, the recommendations highlight the potential for income maximisation services to reduce poverty and income inequality. As the Task Force claimed, this approach will have a positive impact because *"removing the stress caused by debt will improve people's health and wellbeing"* (Scottish Government, 2008d: 27). *Equally Well* also advocates an approach that increases the capacity and effectiveness of universal services to deliver better outcomes for low-income families, in addition to identifying welfare advice services as an effective way of engaging vulnerable groups.

At a deeper level, the Task Force called for a fundamental shift in service delivery. Among the recommendations, is the need to establish a better *"understanding of client pathways or routes into, through, between and out of the range of services"*, particularly with clients who are more disadvantaged and who rely on greater support and intervention (Scottish Government, 2008d: 43). An example is provided, of attendance at a hospital out-patient appointment presenting an opportunity for health staff to identify financial needs that may contribute to ill health.

In the 2010 report, reviewing progress with implementation of *Equally Well*, the Task Force reiterated its position in relation to the *"need to prioritise and sustain public services which directly support the most vulnerable people"* through income maximisation (Scottish Government, 2010b: 21).

In short, *Equally Well* outlines a strategy for tackling poverty that explicitly charges universal public services, such as health, to deliver better outcomes for children in low-income households across Scotland.

The Early Years Framework

The other 'big' social policy document is the *Early Years Framework,* which aims to *"give every child in Scotland the best start in life"* by preventing education, health and employment inequalities from being passed from one generation to the next (Scottish Government, 2008b). Clearly, this contributes to the National Outcomes outlined previously in this section, namely: *"our children have the best start in life and are ready to succeed"* and *"we have improved the life chances for children, young people and families at risk"* (Scottish Government, 2008b).

The framework outlines four principles of early intervention designed to underpin and cut-across a range of strategies:

- To reduce inequalities and enable all to have the same outcomes and opportunity;
- To take action to identify those at risk of not achieving these outcomes and take action to prevent that risk materialising;
- To make sustained and effective interventions where these risks have materialised;
- To shift the focus from service provision to building the capacity of individuals, families and communities to secure outcomes for themselves, using high quality, accessible public services (Scottish Government, 2008b).

The *Early Years Framework* highlights several 'elements of change' necessary to ensure improved outcomes and generational change. One of these is *"breaking cycles of poverty, inequality and poor outcomes in and through early years"* (Scottish Government, 2008b: 16). Citing a strong correlation between poor outcomes and poverty, this element focuses on the period from early pregnancy to children aged three, arguing that this is most critical period of a child's life and the one that has the greatest bearing on their outcomes. Based on this position, the framework outlines a strategy for national and local partners to develop and deliver a co-ordinated approach to early years by refocusing service delivery on the period from pregnancy through to aged three.

This approach is mirrored in another element of change: *"using the strength of universal services to deliver prevention and early intervention"* (Scottish Government, 2008b: 17). The aim here is to build the capacity of core services, many of which will be in contact with vulnerable families on a regular basis. Inevitably, due to the period that the Government has chosen to focus on, key services such as antenatal, postnatal, community nursing, childcare and pre-school are all likely to have an important role to play in recognising need and identifying those groups at risk of poverty.

The other 'element of change' directly relevant to this project is the one that promotes *"more effective collaborations between the public and the third sector"* (Scottish Government, 2008b: 18). Although acknowledging there has been some progress in this area, the Government concedes that the public and third sectors *"could and should work better"* and looks to develop models of service delivery with common goals and shared outcomes that will strengthen relationships between the public and third sector. As the document suggests, *"a lot of people doing at least a little to effect change will achieve much more than a few people doing a lot"* (Scottish Government, 2008b: 16).

In summary, the *Early Years Framework* outlines a strategy to tackle poverty and income inequality from pre-birth through the critical early years of a child's life. In tandem with *Equally Well*, it places an expectation on public and third sector services to work together in building and sustaining partnerships that deliver better outcomes for vulnerable young children in Scotland.

Getting it Right for Every Child

Getting it Right for Every Child, one of the delivery mechanisms for these frameworks, takes an integrated approach to service provision and delivery. Its overarching aims and objectives are to:

- Build solutions with and around children and families;
- Enable children to get the help they need when they need it;

- Support a positive shift in culture, systems and practice;
- Working together to make things better (Scottish Government, 2008d).

Getting it Right for Every Child establishes a set of 14 principles and values, and 10 core components, which place the child firmly at the centre of planning and action. One of these values and principles – promoting the wellbeing of individual children and young people – is based on an understanding of how children and young people develop in their families and communities and another – taking a whole child approach – recognises that what is going on in one part of a child's life can affect other areas of his or her life. The other principle particularly relevant to this project, is the one that recognises children and young people need practitioners to work together to provide the best possible support (Scottish Government, 2008d).

In essence, *Getting it Right for Every Child* underlines the need for *"appropriate, proportionate and timely"* support for children through multi-agency intervention and prevention (Scottish Government, 2008d: 16). For practitioners, this means placing the child at the centre of service delivery and developing a shared understanding within and across agencies to ensure better outcomes for vulnerable children and their families.

Child Poverty Strategy for Scotland

However, despite the implementation of these strategies, as was noted in the previous section, levels of child poverty in Scotland have remained largely unchanged since 2004/05, suggesting that – at least in these early stages of implementation – there has been little impact at a population level.

Perhaps mindful of the lack of progress in this area, the Scottish Government published its *Child Poverty Strategy for Scotland* in March 2011 (Scottish Government, 2011a). The strategy underlines the Government's commitment to addressing child poverty and outlines its approach to meeting the 2020 targets laid down by the Child Poverty Act 2010. Perhaps unsurprisingly, the strategy veers little from the path laid out by the 'big' three discussed above, with the new approach underpinned by broadly similar principles:

- Early intervention and prevention: breaking cycles of poor outcomes;
- Building on the assets of individuals and communities and moving away from a focus on deficits;
- Ensuring that children and families needs are at the centre of service design and delivery (Scottish Government, 2011a).

Echoing the other frameworks, the strategy continues to emphasise maximising household incomes, and working with local and national partners to 'drive change' (Scottish Government, 2011a). While not suggesting a 'new' position or policy direction per se, the strategy does provide a renewed focus on child poverty and one that offers a more coherent and unified approach from the Government.

National and Local Developments

As would be expected, these strategic frameworks have shaped recent policy developments at an operational and service level. The recent Scottish Government maternity care framework, for example, highlights *"increasing promotion of financial inclusion support to families such as income maximisation services, financial capability support and money and debt advice services"*, as a key indicator and

outcome for maternity care (Scottish Government, 2011f: 20). Other documents, such as the recent Scottish Government guidance frameworks for child health and antenatal services, continue to promote effective collaboration across services and professions in an effort to improve patient care and outcomes for vulnerable groups (Scottish Government, 2011c; Scottish Government, 2011e).

At a local level, policy developments in recent years highlight the prominence given to child poverty across NHS Greater Glasgow and Clyde (NHSGGC). The most recent report by the Director of Public Health, for example, identifies child health and wellbeing as a priority for NHSGGC and highlights measures currently underway that address some of the problems facing vulnerable children in the early years (NHS Greater Glasgow and Clyde, 2008). These actions include proposals for service change and interventions that aim to address the social circumstances that negatively affect child development. Another key development was the establishment of the Glasgow Health Commission in 2008, which recommended a change in culture among local partners towards a 'child friendly' city, refocusing resources and supporting parents and young children in the early years (Glasgow Health Commission, 2009).

Within NHSGGC, a Financial Inclusion Strategy Group has been established to oversee financial inclusion activity across the area. This group has a broad remit and aims to identify the most effective types of interventions; establish connections between services; influence policy and strategy; develop performance indicators; create opportunities to share tools and developments that support financial inclusion; and develop appropriate pathways between acute and community services (NHS Greater Glasgow and Clyde, 2011). The Glasgow City Children's Services Child Poverty Sub Group is another key group that has recently established a framework for action to tackle child poverty in Glasgow (Glasgow City Children's Services Child Poverty Sub Group, 2010).

Other notable developments include the publication of NHSGGC's *Inequalities Policy Framework* and *Responding to the Recession, Employability and Financial Inclusion Policy Framework,* which consider a gendered understanding of poverty and child poverty essential (NHS Greater Glasgow and Clyde, 2010b; NHS Greater Glasgow and Clyde, 2010c). These documents are part of a range of policy and planning frameworks to guide the planning of services in NHSGGC. In addition, the *Equality Scheme 2010-13: Making the Difference Together,* has many actions that incorporate a gendered approach, which aids work on child poverty across Greater Glasgow and Clyde (NHS Greater Glasgow and Clyde 2010a).

This board-wide approach has been replicated at a Community Health/Care Partnership (CH/CP) level as well. Children's Services in the former East Glasgow CHCP, for example, developed a *Children and Inequalities Strategy* that brought together health, education, social, housing and voluntary services, with the aim of addressing high levels of poverty and poor educational attainment in the area. Partners came together to explore possible actions that could be taken within core services for children and their families that would contribute to achieving its objectives.

All of these developments can be understood as part of a wider strategy by NHSGGC to increase the awareness and knowledge of health professionals about the social issues that affect patients' health and equip them with the skills and knowledge to refer patients to the appropriate service (Dobbie and Gillespie, 2010).

In summary, child poverty is an issue that cuts across several public policy areas, with the 'big three' social policy frameworks (*Achieving Our Potential*, *Equally Well* and the *Early Years Framework*) outlining the Government's strategy for tackling child poverty in Scotland. This approach, underpinned by a commitment to effective public and third sector partnership working, clearly identifies income maximisation as one of the key approaches to tackling income inequality. This position, which is consistent with *Getting It Right for Every Child* and is evident in recent developments across Greater Glasgow and Clyde, continues to receive support and prominence in the new *Child Poverty Strategy for Scotland*.

SECTION 3: CHILD POVERTY IN SCOTLAND

Poverty

Poverty is a complex and multi-faceted problem that continues to blight some of the richest countries in the world (United Nations Children's Fund, 2010; European Commission, 2011). Although inter-related and inextricably linked, McKendrick (2011a) argues that there are four broad causes of poverty:

- Individual factors (the behaviour or 'failings' of individuals);
- Social factors (the characteristics of some groups that make them more vulnerable to poverty, e.g. children, women, ethnic minorities);
- Political factors (the nature and extent of government intervention);
- Economic factors (the strength of the economy and degree of income distribution).

The author argues that 'individual' factors are of limited value in explaining the *levels* and *extent* of poverty in Scotland, suggesting that the other three – social, political and economic – factors are the root cause of the problem. This argument would infer that any attempt to address poverty must take account of each of these dimensions and, crucially, how they relate to one another.

Measuring Child Poverty

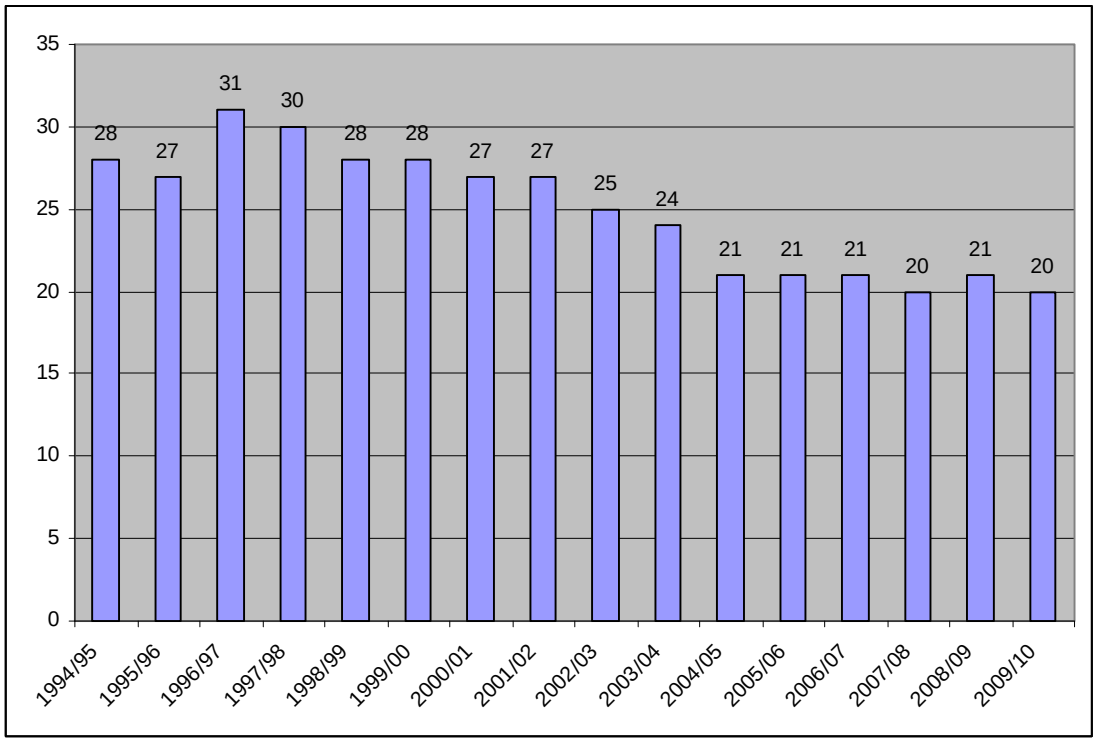
There are four official ways of measuring child poverty in Scotland: *absolute low-income*, *relative low-income*, a combination of *material deprivation and low-income* and *persistent low-income* (Wakefield, 2008; McKendrick, 2011b). Although each of these measures contributes to a more nuanced and better understanding of the scale and extent of child poverty, perhaps the easiest one to understand, and certainly the most widely used, is *relative low-income*. This measure – the number and proportion of children in households whose *equivalised income before housing costs is below 60% of the median income*[5] in the same year – is essentially a measure of whether the poorest families are keeping pace with the growth of incomes in the economy as a whole. Although in many respects a rather rudimentary measure that fails to take account of other factors – such as personal assets or the persistency of poverty – for simplicity, this is the measure of **relative child poverty** that will be used and referred to in the remainder of this document.

[5] 'Equivalisation' is the process whereby incomes are adjusted to reflect household composition and size, putting them on a like-for-like basis. The median is the income value which divides a population into two equal sized groups when ranked by income. For example, in 2009/10 the UK median income for a single person with no children was £276 per week (pw); for a couple with no children it was £413pw; for a single parent with two children it was £495pw and for a couple with two children it was £631pw (Scottish Government, 2011d).

Child Poverty in Scotland

Official figures for *relative child poverty* in Scotland are available from the mid-1990s to 2009/10 and are presented in Chart 1 below.

Chart 1: Children living in relative poverty (below 60% of UK median income in the same year, before housing costs) as a percentage of Scottish households: 1994/95 to 2009/10 (Source: Scottish Government, 2011d)



The chart shows a steady decrease from its peak of 31% in 1996/97 to 21% in 2004/2005, where it has more or less remained ever since (currently 20% in 2009/10). In other words, despite good progress over an eight-year period, little has changed in the last six years.

Inevitably, national figures hide huge variations across regions and areas. However, due to the limitations in the way the data are collected, robust figures at a local area level are not currently available. The Scottish Government is in the process of providing comparable local data to address this issue, but currently recommends using a 'proxy' measure of child poverty at a local level, known as **low-income households**. This figure, known as *the proportion of children that are dependent on out of work benefits or Child Tax Credit more than the family element*[6], is the only figure currently available at a local level.

Although useful for estimating levels of child poverty at a smaller geographical level, it is important to note that *low-income households* is **not** equivalent to the *relative child poverty* measure discussed above, even though the terminology is very similar. One should bear this in mind when using and comparing the following data.

[6] Child Tax Credit (CTC) is made up of two elements: the *family* and *child* element. The family element is paid to each family entitled to CTC (a household income of less than £40,000). The child element is paid for each child, but tapers off at a rate of 39% as earnings increase above £16,040 per year.

Low-income Households in Greater Glasgow and Clyde

Figures for *low-income households* are available from 2005/06 to 2008/09 for each local authority in Scotland with those within the Greater Glasgow and Clyde area shown in Table 1 below.

***Table 1: Percentage of children living in households that are dependent on out of work benefits OR Child Tax Credit more than the family element* (Source: Scottish Government, 2010a)**

LOCAL AUTHORITY	**2005/06**	**2006/07**	**2007/08**	**2008/09**
East Dunbartonshire	28%	29%	29%	31%
East Renfrewshire	28%	29%	29%	31%
Glasgow City	58%	58%	59%	62%
Inverclyde	52%	53%	53%	55%
Renfrewshire	45%	46%	46%	48%
West Dunbartonshire	53%	54%	55%	57%
SCOTLAND	**44%**	**45%**	**45%**	**47%**

Three key findings emerge from the Table:

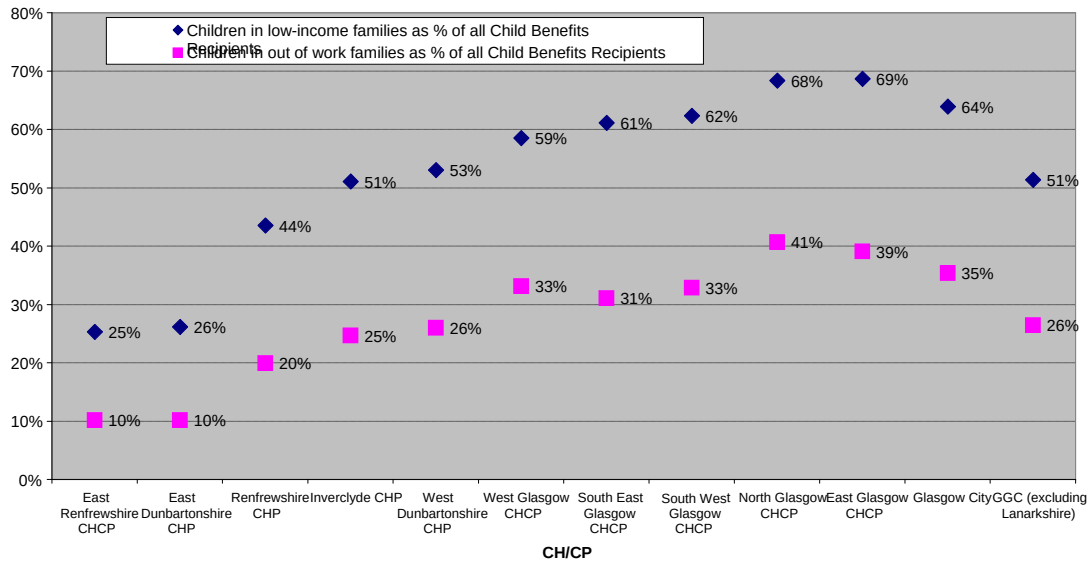
1) There is a significant difference between local authorities: from 31% in East Dunbartonshire and East Renfrewshire to 62% in Glasgow City in 2008/09;

2) The numbers have increased across each local authority since 2005/06;

3) The national figure for *low-income households* in 2008/09 (47%) is more than double that for *relative child poverty* (21%) in the same year – see Chart 1 above.

Further analysis by the Glasgow Centre for Population Health (GCPH) has broken these data sets down to CH/CP level. Chart 2 below provides data for *low-income households* alongside figures for the proportion of families receiving 'out of work benefits', presented for each CH/CP in Greater Glasgow and Clyde in 2006.

Chart 2: Children in workless and low-income households (in families on out of work benefits) by Greater Glasgow and Clyde CH/CP, 2006 *(Source: HM Revenue & Customs data; SNS)*



The pink 'boxes' show, for each of the NHSGGC CH/CPs, the proportion of children living in **out of work families** as a percentage of all Child Benefit recipients. This ranges from 10% in East Renfrewshire and East Dunbartonshire to around 40% in East and North Glasgow. These figures are noticeably lower than those presented in Table 1.

The blue 'diamonds' show the proportion of children in **low-income households** (i.e. those families receiving out of work benefits and/or child tax credits) as a percentage of all Child Benefit recipients. Proportions range from a quarter in East Renfrewshire and East Dunbartonshire, to almost 70% in East and North Glasgow[7].

Based on these figures and the estimated number of children living in each area, Table 2 provides an estimate for the number of children in each CH/CP who are living in low-income families. The lower and upper estimates highlight the range of children in each CH/CP *who are dependent on out of work benefits or child tax credits* respectively (i.e. *low-income households*).

[7] These figures correspond (i.e. comparable) to the data presented in Table 1 above.

Table 2: Estimated number of children in low-income families by CH/CP, based on the percentage of children living in households that are dependent on out of work benefits OR Child Tax Credit more than the family element (Source: Glasgow Centre for Population Health)

CH/CP	***0-4 total children per CH/CP area***	***% Children in out of work families***	***% Children in low-income families***	***Lower estimate of eligible children***	***Upper estimate of eligible children***
East Renfrewshire	4885	10%	25%	489	1221
East Dunbartonshire	5021	10%	26%	502	1305
Renfrewshire	9331	20%	44%	1866	4106
Inverclyde	4271	25%	51%	1068	2178
West Dunbartonshire	4971	26%	53%	1292	2635
West Glasgow	6684	33%	59%	2206	3944
South East Glasgow	5927	31%	61%	1837	3615
South West Glasgow	6981	33%	62%	2304	4328
North Glasgow	5643	41%	68%	2314	3837
East Glasgow	6433	39%	69%	2509	4439

These findings indicate that areas such as East Glasgow have somewhere between 2500 and 4500 children living in *low-income households*. All other areas of Glasgow and Renfrewshire have at *least* 1500 children living in *low-income households*, with West Dunbartonshire and Inverclyde both having a minimum of a 1000. Even in more affluent areas, such as East Renfrewshire and East Dunbartonshire, there are estimated to be at least 500 children living in *low-income households*.

Although as previously mentioned, these figures **do not** indicate the number of children living in *relative poverty* (according to the Scottish Government's definition – see Chart 1), they do suggest there are a high number of children living in *low-income households* across NHSGGC.

SECTION 4: BENEFITS OF INCOME MAXIMISATION FOR SERVICE USERS AND SERVICE PROVIDERS

This section outlines the wide range of benefits that income maximisation and welfare advice services can provide for service users and service providers. However, before we look at each of these 'benefits' in turn, it is perhaps useful to clarify what we mean by income maximisation and how it relates to the broader concept of financial inclusion.

Financial Inclusion and Income Maximisation

Financial inclusion is a relatively new idea that encompasses a wide range of services including money and debt advice, income maximisation work, financial capability and management support, and awareness raising and service provision around banking, insurance and access to affordable credit (Dobbie and Gillespie, 2010). This broad concept is neatly encapsulated in the definition adopted by NHSGGC:

> *"Financial inclusion means that individuals have access to appropriate financial products and services. This includes people having the skills, knowledge and confidence to use these products and services."*

While not always directly related to a low-income, financial exclusion is often associated with poverty, with the former often seen as either the cause or consequence of the latter. As Sinclair et al. (2009) observe, high levels of financial exclusion among low-income households often reflect the hardship associated with living on a low wage or welfare benefits for long periods. This observation is mirrored in the profile of the financially excluded, which includes disproportionate numbers of lone parents, the unemployed and those living on welfare benefits (Goodwin et al. 2000).

Income maximisation and welfare rights advice[8] is broadly defined as expert advice concerning entitlement to and claims for welfare benefits and other sources of income (Adams et al., 2006). This process may involve a review of eligibility for welfare benefits, tax credits etc. and assistance with new claims or appeals (e.g. help with completing forms, making telephone calls on behalf of clients etc). In addition to these 'core' services, some advisors may offer debt and money advice, or refer clients onwards to other specialist advice agencies and services.

In a comprehensive review of the literature, Wiggan and Talbot (2006) found a number of reasons why some individuals fail to claim the benefits they are entitled to, including: a lack of awareness regarding eligibility; the complexity of the welfare benefits system; the stigma associated with claiming benefits; a previous negative experience of claiming; a reluctance to be subjected to intrusive health and financial questions and a belief that claiming is simply not 'worth it'. The authors argue that these barriers demonstrate an acute need for services that offer accessible and expert advice on welfare benefits and that welfare rights services, in particular, are strategically placed to meet this need. Of particular relevance to this project is the authors' claim that providing income maximisation and welfare advice services for people on low-incomes is particularly useful in ameliorating the effects of poverty,

[8] For the purposes of this review, income maximisation and welfare rights advice are used interchangeably throughout this document.

and where it is able to engage with 'hard to reach' groups and improve take-up of entitlements, can make a substantial difference to people's lives.

However, in addition to advice and assistance with welfare applications, income maximisation and debt management, the Scottish Government believes income maximisation services can improve financial knowledge and capabilities, which, in turn, will lead to greater financial inclusion (Scottish Government, 2008a). The Government's position is that vulnerable groups, such as single parents and women on low-incomes, are more likely to be at risk of poverty due to poor financial decision-making (Scottish Government, 2008a). This lack of 'financial capability' can affect the depth and extent of poverty, and the new child poverty strategy includes a concerted effort to address this issue through financial capability work (Scottish Government, 2011a). A two-pronged approach is favoured: the need for individuals on low-incomes to manage their financial affairs better, and have the confidence and skills to choose appropriate financial products and services. In a counter-argument, Dobbie and Gillespie (2010) point to the evidence that many people living on a low-income often have very good budgeting skills and that what is necessary for good money management is an adequate income. In other words, although financial capability may help ameliorate the effects of poverty, it is not a substitution for maximising the income of those in or at risk of poverty.

Poverty and Debt

Before looking at the evidence of income maximisation work in a healthcare setting, it is worth highlighting the link between poverty and over-indebtedness. Although they are often bi-directional (with many people in poverty amassing large debt due to their low-income and over-indebtedness often leading to poverty) they are not inextricably linked. Many people who are over-indebted are not living in poverty, and not all people living in poverty are over-indebted (Dearden et al., 2010; Orton, 2010). However, research has shown that families in debt are more likely to be lone parents, families with young children and those with very low-incomes, often because they are less likely to have access to low interest mainstream credit, instead relying more on higher cost credit options such as doorstep lenders and cash converter lenders (Dobbie and Gillespie, 2010).

Income Maximisation Services in Healthcare Settings

Several research studies and evaluations have pointed to the potential financial and non-financial 'benefits' of income maximisation services based in healthcare settings[9] for 'hard to reach' groups' (Abbott et al., 2006; Greasley and Small, 2005b). Of particular interest to this project is the finding of one study that found many vulnerable groups at risk of poverty, including families with young children and those with drug problems, were not necessarily in regular contact with GP based services. Instead, they were often more likely to be in contact with other parts of the NHS, such as Maternity and Addiction Services (Abbott and Hobby, 2003). As a result, the authors argue that these types of services are better placed to identify vulnerable groups who might benefit from access to advice and income maximisation services than are primary care services. In other words, although many of the studies highlighted below identify benefits for service users and providers, there is not a 'one size fits all' model that ensures success. What is required is the delivery of income maximisation services that are appropriate and accessible for different individuals and groups (Dobbie and Gillespie, 2010).

[9] 'Healthcare setting' is a broad term, used here to denote any type of health service, setting or clinic.

Benefits for Service Users

The increasing use of welfare rights advice services in healthcare settings has resulted in a small, but growing, body of evidence on the potential benefits for service users (see Moffatt et al., 2004; Wiggan and Talbot, 2006). Although the literature highlights different models of service delivery and ways of working, much of the evidence points to a range of potential benefits that include financial gain, greater financial knowledge and capability, and small, but important improvements in mental health and wellbeing.

Financial Gain

All studies and evaluations demonstrated financial gains for many service users, either through increased income and/or reduced debt (e.g. Reading et al., 2002; Greasley and Small, 2005b; Mackintosh et al., 2006). Although there are variations in the amounts generated for different service users either within the same service or between different services, this can often be attributed to various factors such as the location of the service, lifespan of the intervention, target population and levels of service provision. However, all the studies that measured financial gain identified positive outcomes for a large number of service users at an individual and population level (see Adams et al., 2006).

Moffatt et al. (2006) identified three dimensions of financial gain as a result of increased income and/or benefits: affordability of *necessities*, such as buying better quality food, paying household bills, preventing debt etc.; managing *occasional expenses* such as clothes, household equipment, furniture etc; and having *extra income* as a means of dealing with potential emergencies or the ability to save.

One study found the increased income was used by some patients to buy better quality and healthier food, while others used it to help with the cost of household heating bills (Abbott and Hobby, 2003). Another study found that increased income and resources led to a higher level of spending on educational and recreational goods, services and transport – all indicators related to social and economic exclusion (see Wiggan and Talbot, 2006).

One significant finding from the literature is evidence that even relatively small increases in income could have a sustained and positive impact on individuals' experience of financial hardship and social exclusion (Moffatt et al., 2004; Wiggan and Talbot, 2006). This finding is echoed in a qualitative study that looked at over-indebtedness, where the author found little distinction (in relation to coping financially) between those service users who were debt free and those whose levels of debt were reducing after receiving advice (Orton, 2010).

Financial Knowledge

Only a few studies have looked at the other potential benefits of welfare advice. One important longitudinal qualitative study on the impact of debt advice on low-income families found that individuals who sought advice from an advisor particularly valued receiving 'information and options' (Orton, 2010). The 'information' was highlighted by many as useful in dealing with specific situations and debt more generally, and the 'options' was thought important for those service users who had chosen to pursue a different course of action after speaking with the advisor. In a way, this is closely linked with the theme of 'reassurance and manageability' discussed below, in that practical information provided service users with some sense of reassurance about their financial situation.

Interestingly, the author only found a slight increase in financial confidence, which was often tempered by some form of financial caution (e.g. sticking with current financial arrangements even when other cheaper options were available). However, the author argues that this may be due to budgeting issues rather than an inherent lack of financial confidence. Perhaps more significantly, the author found that financial knowledge was largely irrelevant to many on a low-income, as many recipients observed that decisions to borrow, for example, were often based on limited options rather than lack of awareness or knowledge of financial products and services.

Financial Capability

Orton's study also found evidence that some service users who received advice displayed greater financial capability. This could be seen by those service users who thought themselves better equipped to deal with their financial situation (e.g. employing practical tips such as telling creditors only to send letters). Some service users thought this type of action brought a sense of 'empowerment' and increased confidence, although not perhaps, *financial* confidence, amongst participants in the study. Significantly, a positive change was identified by those people who reported a reduction in debt as well as those without debt; suggesting, perhaps, that 'manageability' of debt was just as important as being debt free for many participants. A similar finding was found in a study by Gillespie et al. (2009), which looked at the impact of money and debt advice for service users with mental health problems.

Mental Health and Wellbeing

Although the evidence to suggest that access to welfare rights advice services lead to greater financial knowledge and capabilities is somewhat limited, there is more in the literature to suggest these types of services have the potential to improve the social and mental wellbeing of patients (e.g. Abbott, 2002; Moffatt et al., 2004; Greasley and Small, 2005b; Abbott et al., 2006; Moffatt et al., 2006).

In one study, Greasley and Small (2005a) found that welfare advice improved patients' health and quality of life by reducing the anxiety and stress caused by adverse socio-economic circumstances. Another qualitative study of individuals from socially and economically deprived areas found that those individuals who experienced an increase in resources identified a range of health benefits, including improved sleeping patterns and diet, improvements in their relationship with their partner and a decrease in their sense of loneliness (Moffatt et al., 2004).

Another study found an improvement in psychosocial health, which the authors attributed to a combination of factors including increased spending on goods and a reduction in anxiety over financial worries (Abbott et al., 2006). The authors argue that the latter enabled participants to communicate more effectively with their GP, leading to more effective medical intervention. Moreover, the authors found that even small improvements in 'quality of life' were highly valued by patients.

Moffatt et al. (2006) found evidence of participants having greater 'peace of mind' following the easing of financial worries. Some people in the study thought that the process of talking to an advisor put their worries into a broader perspective and found reassurance in the fact that there was an individual and organisation that could help with their money worries. The authors found that participants valued the *"chance to*

talk, and having someone take an interest, suggesting that the welfare consultation itself had a therapeutic effect" (Moffatt et al. 2006: 167).

Orton (2010) also found evidence that advice led to a change in people's *"ability to cope"* with bills and credit commitments, thereby leading to an improved sense of wellbeing. This sense of 'reassurance', which others have described as the 'counselling' or 'therapeutic' aspect of advice, is particularly noteworthy, as evidence suggests that the constant worry and perceived intractability of a difficult financial situation can contribute to a lack of mental wellbeing (Moffatt et al., 2006; Dearden et al., 2010).

For many service users, the sense of reassurance was closely associated with the 'manageability' of an adverse financial situation. In their review of the literature, Dobbie and Gillespie (2010) found that manageability of the situation (e.g. re-negotiating debt repayments) was found to be particularly important for participants, as it often lead to a reduction in stress and anxiety.

However, there is little evidence in the literature that demonstrates improvements in physical health. In their review, Dobbie and Gillespie (2010) provide a number of possible explanations for this, including the short time period of most studies, which they argue is likely to account for the relatively modest results with regards physical health (see also Mackintosh et al., 2006). Another explanation, offered by Dobbie and Gillespie (2010), is the nature and extent of the health condition at the point of intervention, which may outweigh the 'effectiveness' of the intervention. Finally, they also suggest that even if this type of intervention does not improve physical health per se, it may prevent further deterioration in an existing health condition or help people manage their existing health problems better.

Families with Young Children

Evidence of the impact of income maximisation services in a healthcare setting on families with young children is very limited, primarily because most studies have largely concentrated on older patients. However, one study, by Reading et al. (2002), specifically looked at the benefits of providing a citizens advice service in a primary care setting for families with children less than one year of age. The authors found that over half of those families who sought welfare benefits saw some financial gain. Interestingly, the authors found that the relationship between health visitor and patient had a key influence on whether families used the advice service. Qualitative findings from the study, for example, found that women who used the advice service tended to have a *"more empathic relationship with their health visitor and commented that the health visitor was willing to talk about their financial and social stresses, as well as encouraging them to use the advice service"* (Reading et al., 2002: 42). In contrast, the relationship between the health visitor and those women who chose not to use the advice service was thought to be more focussed on health and development issues, rather than social and economic circumstances.

In summary, although there is, at present, very limited evidence of improvements in physical health, there is substantially more evidence which suggests improvements in the social and mental wellbeing of patients. Although these improvements were often relatively small, studies found that patients often valued them highly.

Benefits for Service Providers

In addition to gains for service users, some studies have suggested there are potential benefits for service providers as well. These include benefits for health and income maximisation workers, improvements in service engagement with 'hard to reach' groups and more effective service delivery.

Staff Performance

In one study, by Greasley and Small, the authors found a number of positive outcomes for health service providers, including: greater awareness and knowledge of welfare benefits and rights amongst health professionals; a reduction in the use of resources and face-to-face time with patients on non-health related matters; and evidence of a more holistic approach to patient care and improvements in the relationship between healthcare workers and patients (cited in Wiggan and Talbot (2006: 25).

In another important study on the impact of advice services in GP practices in Wales, Borland and Owens (2004) found a number of benefits for staff, including taking a lot of work 'off the shoulders' of GPs; helping to improve the doctor's relationship with the patient and higher levels of confidence among staff in offering advice. Another study, by Sherr et al., found that GPs who worked in a practice with an 'in-house' welfare rights advice service were more likely to raise welfare issues with patients than those without an on-site welfare advice service (cited in Wiggan and Talbot, 2006: 25). The authors of the study also found evidence that patients were more likely to seek information from health staff on welfare issues if they were aware that a dedicated advice service was available for them to use.

Although a few studies have found some reservations among staff about extending the responsibility of healthcare, most appeared to welcome the presence of welfare advice services, as they were seen to address patients' socio-economic needs, while reducing the amount of time spent by staff in dealing with welfare benefits issues (see Greasley and Small, 2005a).

Service Engagement

The literature also shows that these types of interventions can be successful at reaching 'hard to reach' groups. In their review, Dobbie and Gillespie (2010) found that many vulnerable and hard to reach groups (including younger families, adults with disabilities, some black and minority ethnic groups and mental health service users) often benefited from advice services offered in a healthcare setting.

In one study, Greasley and Small (2005b) found that one of the advantages of this type of intervention is that it can provide access to advice services for people who may not use mainstream advice services, including patients with mental health problems and some women from South Asian communities. The authors argue that this is due to the greater continuity with the same advisor and the ability to deliver home visits, which was particularly valued by some patients.

Another study by Sherr et al., found that individuals who received welfare advice in GP surgeries benefited from a more relaxing and comfortable environment than traditional mainstream advice services, lowering barriers and increasing take-up amongst vulnerable groups as a result (cited in Wiggan and Talbot, 2006: 25).

However, Dobbie and Gillespie (2010) caution against relying solely on clear and accessible referral pathways as a means of engaging 'hard to reach' groups. As with other public services, effective engagement with these groups requires a service that is resourced and responsive enough to meet the *individual* needs of users, rather than merely offering a 'different' service for 'hard to reach' groups.

Service Delivery and Partnership Working

Dobbie and Gillespie (2010) believe that good practice in delivering income maximisation services in a healthcare setting is achieved through partnership working with local specialist advice agencies. As noted in Section 3, the rhetoric of partnership working is commonplace in current policy, despite being a contested concept. Although by no means 'definitive', Dowling et al. adopt the following definition of partnership:

> *"A joint working arrangement where partners are otherwise independent bodies cooperating to achieve a common goal; this may involve the creation of new organisational structures or processes to plan and implement a joint programme, as well as sharing relevant information, risks and rewards"* (2004: 310).

As the authors suggest, this definition is compatible with other terms, including 'cooperation' and 'collaboration'. The idea of 'collaborative advantage' – in which both the common and individual goals of organisations are forwarded by collaborating – is ubiquitous in the policy 'literature' and is often promoted as the best way of tackling those social problems that often fall 'between the gaps' (Vangen and Huxham, 2006). This, arguably, chimes with the rationale behind recent developments in offering welfare advice services in partnership with local healthcare services, which aim to tackle poverty through more effective collaborative working between health and advice agencies.

Dowling et al. (2004) have developed a useful framework for understanding and evaluating successful partnerships. The framework provides two measures of success: *process* and *outcome* measures. Process measures focus on the relationship between partners and the 'health' of the partnership, whereas outcome measures focus on whether partnerships lead to more efficient and effective services, and improved outcomes for service users.

As would be expected, each measure has multiple dimensions and levels. This provides us with a useful tool in which to evaluate the 'success' of a partnership across a range of measures.

Process measures relate to the following:

(i) Levels of engagement and commitment of partners;
(ii) Levels of agreement about the purpose of and need for the partnership;
(iii) Levels of trust, reciprocity and respect between partners;
(iv) Favourable environmental features;
(v) Accountability arrangements, assessment and monitoring of the partnership;
(vi) Leadership and management of the partnership.

Outcome measures relate to:

(i) Improvements in the accessibility of services to users;
(ii) More equitable distribution of services;
(iii) Improvements in the efficiency, effectiveness or quality of services;
(iv) Improvements in the experiences of staff;
(v) Improvements in areas of the service users' life (or reductions in likely deteriorations).

One study of welfare advice delivered in a healthcare setting that specifically looked at both process and outcome measures, found the acceptability and success of the project was often determined by the commitment and support of health staff (Greasley and Small, 2005a). The authors found a strong correlation between the level of enthusiasm for the project amongst health staff and the number of referrals in that setting. In contrast, where referrals were less, they found a lack of commitment to the service and awareness about the role of the advice worker and the service offered. This finding is consistent with Dobbie and Gillespie (2010), who argue that the most successful services tend to be those in which health workers fully support the initiative; where welfare rights advisors are an integral part of the health clinic or centre; and where healthcare staff are fully aware of the service on offer.

In their evaluation of welfare advice services delivered in family practices, Greasley and Small (2005a) found some evidence of engagement and commitment among staff; some agreement about the purpose of the partnership and some level of reciprocity and respect between staff: all of these being process measures. The study also highlighted improvements in the experience of staff and improvements in the service users' life (i.e. financial gain), which are all outcome measures. However, although the authors found a strong correlation between processes and outcomes, they could not prove *causality*, as the outcomes may have been the result of other internal or external factors that had little or nothing to do with the partnership per se. As Dowling et al. (2004) remind us, it is often difficult to attribute outcomes to partnership arrangements, as unlike process measures, they are rarely exclusive to partnerships. This is a crucial point to remember when evaluating the success of any partnership model.

One aspect that is largely missing in the literature is evidence of any strategic development of these types of services beyond the lifespan of the project. There are several possible reasons for this: the short-term nature of many of the projects; the fact that many of the interventions were delivered 'in-house', where the income maximisation worker was part of the healthcare service (rather than part of a service delivered by an external partner) and because most evaluations have tended to focus on other aspects of the project (e.g. financial or health outcomes) rather than explore the strategic or policy implications of the intervention. One notable exception is the Glasgow Association for Mental Health Money Advice Development Project, which developed and implemented a strategy to support the money advice needs of mental health service users and their carers. In their evaluation, Dobbie and Gillespie (2009) found the project created a 'very sustainable model for service development' because it was about improving the reach and impact of existing mainstream services, rather than about creating a new service.

Another important aspect of partnership working, found in the wider literature, is the tension that may exist between partners. Some authors have found that partnerships between health and social care, for example, often have a power imbalance, where health tends to dominate the partnership (Cook et al., 2007). This can have a negative effect on levels of engagement and commitment, where one partner feels

'unequal' in the partnership. These factors are likely to affect the long-term success and sustainability of a partnership model of working.

Other studies have highlighted organisational barriers, where services are *"structured in bureaucratic patterns, characterized by self-interests, inflexibility and resistance to change"* (Stern and Green, 2005: 270). Clearly, this would affect a range of process measures, including levels of engagement and commitment, and levels of trust, reciprocity and respect between partners. This 'unfavourable environment', is hardly conducive to effective partnership working and highlights the way in which organisational structures and cultures intersect in ways that can either be favourable (e.g. where organisational structures and processes are flexible and responsive enough to enable cultural change in the workplace or workforce) or detrimental to effective collaborative working (e.g. where institutional barriers and workplace practices impede efforts to change cultural attitudes and behaviours) (see Scott et al., 2003).

One final notable aspect of partnership working is that, despite the policy rhetoric, partnerships are not, in themselves, necessarily 'beneficial'. Partnership working may, for example, enable more harmonious relationships or even reduce costs, yet fail to improve outcomes for service users (Dowling et al., 2004). Attractive as many of these process measures of success may be, in the end the *"primary purpose of partnership working should be to deliver better outcomes to service users"* (Cook et al., 2007: 4).

In conclusion, the small, but growing literature base suggests a range of benefits for service users including financial gain, greater financial knowledge, increased financial capability, and improvements in social and mental wellbeing. The literature also points to additional benefits for service providers, including enhanced staff knowledge and performance, more effective engagement with 'hard to reach' groups and improved service delivery through partnership working and collaboration. However, there is little in the current research evidence that establishes a causal link between process and outcome measures, nor is there much evidence on the strategic development or policy implications of providing income maximisation services in a healthcare setting.

SECTION 5: CONCLUSION

Poverty affects one in five Scottish children. In most parts of Greater Glasgow and Clyde, it is almost certainly more prevalent than this – perhaps significantly so. The proportion of children living in *low-income households* in Inverclyde and West Dunbartonshire, for example, is more than 50%; in some areas of Glasgow, it is almost 70%. Even in more affluent areas, such as East Dunbartonshire and East Renfrewshire, the proportion is still around one in four.

Poverty has a negative impact on a child's educational, health and social development, as well as their family and home environment. Research shows that many vulnerable groups, including women, most minority ethnic groups, and adults with drug problems are at a greater risk of poverty. Within these groups, many will have young children.

Despite a political commitment and range of policy initiatives to tackle child poverty, figures for Scotland have changed little in the last six years. In the current economic climate, with unfolding, significant reductions in public spending and major changes to the welfare benefits system, few, if any, now expect poverty to be 'eradicated' by the end of this decade.

In an acknowledgement of the scale of the problem, as well as the challenge that lies ahead, the Scottish Government has produced three 'big' social policy frameworks that, collectively, aim to tackle child poverty in Scotland. These documents – A*chieving Our Potential, Equally Well* and the *Early Years Framework* – clearly identify financial inclusion and income maximisation in particular, as a key intervention in tackling income inequality and poverty. At the heart of this approach is an expectation that national and local agencies must work in partnership if they are to ensure better outcomes for young children in Scotland. The recent publication of the *Child Poverty Strategy for Scotland* reaffirms this position and approach.

A growing body of evidence suggests there are a range of potential benefits of providing income maximisation and welfare advice services in a healthcare setting. Benefits that have been found in previous studies include financial gain, greater financial knowledge, increased financial capability, and improvements in the social and mental wellbeing of service users. Benefits for service providers include greater staff knowledge and awareness, more effective engagement with 'hard to reach' groups and improved service delivery through partnership working with third sector partners.

However, there is little in the literature about the challenges of attributing successful outcomes to partnership processes, nor is there much recognition or discussion about the strategic or policy implications of these types of interventions. It is in this area – policy and strategy – in particular that the evaluation of this financial inclusion project could potentially contribute new research findings and add to the existing evidence base of potential benefits for service users and providers.

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APPENDIX 1: PROJECT AIMS AND OBJECTIVES

The project aims are based on evidence demonstrating that families are at risk of child poverty when they are trapped in a low pay/no pay cycle and that risk increases with particular life events such as around the time of the birth of a child and relationship breakdown.

Income maximisation can help families deal with child poverty and to prevent families falling into child poverty if identified and referred on at an early stage through universal health and Early Years service provision.

The main purpose of the Project is to support the development of expertise within financial inclusion services and health structures for addressing child poverty in order to set up sustainable information and referral routes beyond the lifetime of the Project.

The two ***aims*** of the Project are to:

- Test out partnership models of providing income maximisation advice at a local level; and
- Build action on child poverty into mainstream children and families services and financial inclusion services beyond the life of the project.

The main ***outcomes for the income maximisation service*** are expected to be as follows:

- Higher numbers of families with young children receiving financial inclusion information, advice and support
- Improved financial awareness for pregnant women, new families and families with young children
- Additional income generated for families using the service
- Improved debt management in the target group as a result of the service
- Agreed models of good practice for financial inclusion support for families at risk of child poverty.

The main ***outcomes for the development work*** are expected to be as follows:

- Health, social and early years staff across the CH/CP areas having improved knowledge of benefits available for pregnant women and families with young children
- CH/CP staff having improved knowledge of the availability and accessibility of local financial inclusion services
- Clear referral and information pathways for pregnant women and families with young children between health, social and early years services and financial inclusion services local to a CH/CP
- Guidelines for future contracting of financial inclusion services for pregnant women and families with young children at risk of child poverty, based on evidence of local need and successful models of practice.

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